MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Neilson Place

Facility Address:
1000 Anne Street NW

Facility City:
Bemidji

State: Minnesota | **ZIP:** 56601 | **County:** Beltrami

Report Number:
H5039013

Time of Visit:
6:00 p.m. to 8:30 p.m.
8:00 a.m. to 4:30 p.m.
8:00 a.m. to 1:15 p.m.

Date of Visit:
February 14, 15, and 16, 2017

Date Concluded:
April 17, 2017

Investigator's Name and Title:
Jessica Sellner, RN

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was emotionally abused by staff when staff asked the resident questions about whether or not the camera in the residents room was on.

It is alleged that a resident was neglected when staff left the resident wet and soiled without providing assistance to the resident and the resident had bedsores in areas covered by the incontinence brief. The resident required a specific sling for transfers which has not been ordered resulting in the resident almost falling out of the sling during a transfer.

- [x] Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- [x] State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- [x] State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- [x] State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, abuse occurred when, under the direction of administration, facility staff constantly questioned the resident, significantly decreased interactions with the resident, and treated the resident differently after the resident installed a video camera in their private room to feel safe. Facility staff were directed by administration to ask the resident about turning the camera off every time they provided cares, and if the resident said no staff were instructed to tell the resident s/he would need to be moved to another room for cares to be performed. The resident told multiple staff s/he did not want to be constantly asked about the video camera.

The resident required extensive assistance from staff for all transfers and activities of daily living. The resident signed a notarized consent requesting a video camera be installed in his/her room. The consent indicated the resident did not want to discuss the video camera and requested staff to not pressure the resident into turning the camera off.

Staff were directed by administration every time they went into the resident's room to ask if they may turn the camera off while providing cares as the camera made staff uncomfortable. If the resident refused to have the camera turned off, staff were directed to inform the resident they would need to bring him/her into another room to provide cares. Review of the residents progress notes indicated multiple conversations staff had with the resident regarding the residents mental anguish related to staff treatment of the resident after the video camera was installed. The progress notes indicated the resident was tearful, felt staff treated him/her differently due to the video camera, and staff interaction had lessened due to the video camera.

When interviewed, the resident stated s/he installed the video camera in his/her room because of how the facility staff treated the resident, not providing cares including wound cares and incontinence cares, along with not providing cares timely. The resident did not want to be asked about the video camera by facility staff. S/he stated that staff started to treat him/her differently after the camera was installed, the resident felt like s/he was being ignored. The resident stated the video camera made him/her feel safe and s/he had made it clear to staff that s/he did not want to be asked about the camera every time staff came into his/her room. The resident stated that staff do not talk to him/her like they used to before the installation of the camera, and would ask about turning the camera off even before they were all the way in his/her room. The resident stated this treatment by the facility staff caused him/her to become emotionally upset.

When interviewed, 11 staff stated the resident told staff s/he did not want to discuss the video camera, however, staff were instructed by administration to ask the resident about the camera every time they provided cares. Staff stated they treated the resident differently after the video camera was installed by not going into the resident's room as much, not engaging in conversations with the resident, and by only focusing on providing care and then promptly leaving the resident's room. Staff felt they needed to watch what they were saying to the resident because of the camera.

Other allegations regarding the resident not being changed timely, skin care, a near fall, and ordering of a proper sling were reviewed. The resident had an individualized comprehensive assessment completed for toileting, turning and repositioning, and pressure ulcers. Interventions were developed and implemented by staff according to the assessment and according to the needs of the resident. Incontinence care was provided to the resident following the resident's care plan.

The residents medical record was reviewed for the last year and no near fall was documented from the sling. Staff were interviewed and facility incident reports were reviewed. There was no documentation regarding a near fall from the sling. Staff stated the sling used for transfers with the resident was a universal sling, and had been assessed as safe for the resident to use. The resident was interviewed and had no safety concerns regarding the mechanical lift and sling.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☒ Abuse ☐ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Neglect is not substantiated

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☒ Abuse ☐ Neglect ☐ Financial Exploitation. This determination was based on the following:

Administration instructed facility staff to ask the resident every time they went into the resident's room about turning the camera off, and instructed staff to tell the resident s/he would need to be moved to another room for cares to be performed if s/he refused to have the camera turned off. This treatment caused the resident emotional distress.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 2 - Abuse

"Abuse" means:

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records

☒ Care Guide

- [x] Medication Administration Records
- [x] Weight Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Social Service Notes
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] Laboratory and X-ray Reports
- [x] Therapy and/or Ancillary Services Records
- [x] ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

- [x] Hospital Records

Additional facility records:

- [x] Resident/Family Council Minutes
- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Three

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact complainant, attempts were made on:

Date: Time: Date: Time: Date: Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Three

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 12

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact:

Date: Time: Date: Time: Date: Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

- [x] Personal Care
- [x] Nursing Services
- [x] Call Light
- [x] Infection Control
- [x] Use of Equipment
- [x] Cleanliness
- [x] Dignity/Privacy Issues
- [x] Safety Issues
- [x] Transfers
- [x] Facility Tour
- [x] Incontinence

Was any involved equipment inspected: ◉ Yes ○ No ○ N/A

Was equipment being operated in safe manner: ◉ Yes ○ No ○ N/A

Were photographs taken: ◉ Yes ○ No Specify: Administration instruction for staff on video camer

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Bemidji Police Department

Bemidji City Attorney

Beltrami County Attorney

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5039013. As a result, the following deficiencies are issued.	F 000		
F 151 SS=G	483.10(b)(1)(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL (b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. (b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. (b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that 1 of 3 residents reviewed, R1, could exercise her rights as a resident of the facility when she installed a video camera in her private room on 2/1/2017 in order to feel safe. R1 stated after the facility found out about the camera she felt staff treated her differently. As a result of the camera the facility administration directed all staff upon entering the resident's room to state, "May I turn the camera off while I work with you as it makes me feel uncomfortable." The staff were also directed to tell the resident that if they were not able to turn the camera off they would take the	F 151		3/17/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/05/2017

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resident to another room to provide care. This resulted in actual harm for R1 who experienced psychosocial harm related to staff constantly questioning the resident about her right to have a camera in her room.

Findings include:

R1's care plan dated 2/4/17, indicated R1 required total staff assistance with all activities of daily living (ADL's) and assist of one staff with eating. R1 required a total body mechanical lift for all transfers.

During observation on 2/14/16, at 6:30 p.m. R1 was in her room laying in bed. On the wall there was a notarized document signed by R1 and family member (FM)-D titled, Consent To Electronic Monitoring. The consent indicated R1 had given consent to placement of the video camera in her room, and indicated, "I ask that staff members respect my consent to placement of the device and not talk to me about the device, tamper with the device, remove the device, or pressure me to turn off the device. The device is being used to better understand my care and to prevent maltreatment of me by staff and others." During observation of R1's room, there was a small plastic daisy sitting on a small end table in front of the residents bed which contained a video camera in the center of the flower.

R1's Progress Notes indicated on 2/1/17, at 3:50 p.m. staff had spoken with FM-D who stated a video camera was put into R1's room to protect the resident. R1 had signed a notarized consent for the video camera and the paper was hanging in R1's room.

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F 151	Continued From page 2 R1's Progress Note dated 2/4/17, at 10:30 a.m. indicated R1, "Was very tearful. RN [registered nurse] wiped tears with cool cloth and asked why she was so upset. Resident stated that she felt staff were upset with her because of the camera. RN assured her this was not the case. Staff are concerned for her and feel uncomfortable performing cares with a video recording. No one is angry with the resident. Resident feels interactions have lessened because of the video camera." The progress note also indicated the resident, "Said this is her home and the camera has changed how it feels here. She began to cry again. RN explained that if the time comes that she is too distressed about the camera, staff RN may ask permission, on camera, to permanently disable it. Unplug it, remove batteries." R1's Progress Note dated 2/7/17, at 11:12 a.m. indicated the nurse was completing a mood and mental evaluation on R1 and the resident started crying and stated, "People treat her differently because of the camera in her room." R1's Progress Note dated 2/8/17, at 1:30 p.m. indicated FM-D called the facility and requested staff put a tissue over the video camera instead of turning the camera because when staff turn the camera it is not always turned back in the right position. The Progress Note indicated the nurse called the director of nursing (DON) regarding FM-D's request to put a tissue over the camera, and the DON instructed, "The lawyer said to turn the camera so we need to stick to what they say." R1's Progress Note dated 2/14/17, at 8:31 p.m. indicated, "Prior to HS [hour of sleep] cares and assessment, staff asked resident if she wanted the camera covered and she stated yes 'no	F 151		

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peeking.' Camera covered with red hanky while resident was exposed."

R1's current Nursing Assistant care sheet (what the nursing assistants use to know specific cares on residents) dated 2/10/17, indicated R1 "Loves to visit with staff."

During observation on 2/14/17, at 7:00 p.m. four handwritten pieces of paper were hung up behind the nurses station on R1's unit. The handwritten paper directed staff when going into R1's room to ask the following questions. "May I turn the camera off while I work with you as it makes me uncomfortable?" If the resident said yes staff were directed to turn the camera off. If the resident responded no, staff were directed to respond, "Then I would like to do your cares in another area." Staff were directed to, "Document EVERY time you ask this question and what you get for a response." The other papers were titled R1's data collection for the camera, and contained boxes which were titled, quote what you asked R1, time, what was R1's response to what you ask, and action taken. Some of the data collection included:
2/1/17, at 4:45 p.m.- Staff stated to R1, "I don't consent to the camera you might have consented to the camera but I don't. I stated I can't turn it off [the camera] because of the papers in her room [the consent]." The resident response was documented as, "She stated then turn it off."
2/2/17, at 3:30 p.m.- "Asked to turn off camera. Refused and said we were the first people to ask to turn it off." The next entry was made at 4:12 p.m. on 2/2/17, which indicated, "Resident didn't want the camera off or to go to another room but agreed to turn the camera." The resident response was, "Agreed to have RN [registered

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F 151	Continued From page 4 nurse] in the room and could turn camera around." 2/6/17, at 5:55 p.m.- Staff asked the resident if they could cover the camera up. R1's response was documented as, "You're the only one who asks that you know. If you don't like it open your own place. That's what they tell you to say." The action taken was staff responding to R1, "Well, it makes me uncomfortable." Staff proceeded to do cares with the camera covered. 2/9/17, at 4:30 p.m.- "Is it okay if I turn the camera, I feel uncomfortable." The resident requested staff use the red handkerchief to cover the camera. A hospital progress note dated 2/6/17, indicated R1 was ill in November 2016, December 2016, and early January 2017, with a chronic infection. At that time she was unable to make any medical or legal decisions, however, she was now alert and orientated and it appeared the confusion and delirium had resolved. When interviewed on 2/14/17, at 6:45 p.m. FM-D stated since R1 had the video camera in her room, staff treated the resident differently. FM-D stated R1 liked to joke and laugh with the staff, however, since placement of the video camera staff only focused on the camera in the room, and avoid conversation and entering R1's room. FM-D stated R1 was upset about being treated differently and did not like being questioned about the camera every time staff came into her room. FM-D stated R1 had signed a notarized consent and talked to multiple staff and told them she agrees with the video camera in her room but staff would not stop asking. FM-D stated she had requested the facility not turn the camera to the side, or shut it off, because it is not put back in	F 151		

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the correct position after cares are complete. FM-D brought in a red handkerchief to cover the camera when staff are providing cares to R1 to ensure the residents privacy, however, most of the time staff just turn the camera and will not use the handkerchief.

When interviewed on 2/14/17, at 7:05 p.m. licensed practical nurse (LPN)-M stated the video camera was discovered hidden in R1's room about a month ago. About a week after the camera was found, the daisy video camera was placed by family on R1's end table in her room. LPN-M stated staff were initially instructed to turn the video camera off while in R1's room, and then a few weeks ago it changed to just turning the camera away from the resident and point it towards the wall. LPN-D stated FM-D had requested staff to just cover the camera instead of moving it or turning it off, but staff were directed by administration to turn the camera or shut if off. LPN-M stated she was aware R1 was upset and the resident had cried about the video camera. LPN-M stated R1, "Was in a difficult spot; we [staff] want it off; [FM-D] wants it on- the resident is in between." Administration told staff they had a right not to be videotaped, and LPN-M stated staff were confused because they didn't know if they should be turning the camera, shutting it off, or covering it up.

When interviewed on 2/14/17, at 7:30 p.m. Nursing assistant (NA)-E stated she was directed about two weeks ago to cover the camera when providing cares to R1. NA-E stated R1 gets "annoyed" with staff when they ask about the camera and often responds, "Yes! You know you can cover it!" NA-E stated when she goes into R1's room she says to the resident, "Can I cover

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F 151	Continued From page 6 it [video camera] because we don't want to be taped during cares." NA-E stated this was the instruction provided by administration to staff. During interview on 2/14/17, at 7:45 a.m. NA-F stated the video camera in R1's room was, "Causing a lot of commotion." NA-F stated there were NA's in the facility who did not want to provide cares to R1 and "steer clear" of R1's room. NA-F stated she tells R1 she is uncomfortable doing cares with the video camera and turns it towards the wall as she had been directed by administration. NA-F stated R1 was cognitively intact and, "This is too hard on the resident; we tell her every time we do cares we are uncomfortable with the camera." During interview on 2/15/17, at 8:50 a.m. director of nursing stated the facility policy did not allow any videotaping and staff had the right not to be videotaped. DON stated for staff protection they had been instructed to ask the resident about turning off the video camera every time they do cares. DON stated she was aware R1 felt staff didn't come around as much to talk with her since the video camera was in place. DON stated staff were directed to ask the resident to turn the video camera off, and if resident refused, they would take the resident to another room to provide cares. DON stated administration was aware of the notarized consent for the video camera signed by R1, however, the facility is currently having it reviewed to ensure it is a legal document. DON stated R1 was "Caught in the middle," between having the video camera in her room, and staff not wanting the video camera in the room. During interview on 2/15/17, at 9:50 a.m. R1	F 151		

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stated she has told "everyone" she is fine with the video camera in her room. R1 stated when staff ask her about the video camera she tells them to do what they want, "I am sick of it- I don't want to keep being asked!" R1 stated staff treat her differently because of the video camera and they are, "Cold; staff ignore me; they don't like the camera." R1 stated staff don't stay in her room and joke and talk with her anymore, and before staff were even all the way in her room and knew what she wanted, they were asking to turn the video camera off. R1 stated the video camera made her feel safe. R1 stated a couple weeks ago one of the nurses was, "In my face all morning long about the damn camera." R1 stated she finally responded to the nurse to either turn the camera off or get rid of it. R1 stated she talks and talks about the camera and says it is okay, however, staff continue to ask about it all day, everyday. R1 stated, "It pisses me off," when staff constantly talked about the camera because, "They [staff] know the routine!"

During a follow up interview on 2/15/17, at 10:40 a.m. DON stated she had just spoke with R1 and the resident wanted the video camera in her room, and staff would now just tell R1 they would be turning the camera off when doing cares instead of asking the resident every time. DON stated they were going to make this change so staff don't have to ask R1 about the camera constantly, but she will still have a chance to give input.

During interview on 2/15/17, at 11:00 a.m. NA-G stated she had been directed by administration to ask R1 to turn the camera off because she was uncomfortable with it on, and if the resident refused staff should take her to another room and

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provide cares. NA-G stated R1 was teary and told her she was sad because she felt staff treat her differently when they go into her room. NA-G stated she was aware some of the newer staff were nervous about going into R1's room with the video camera.

When interviewed on 2/15/17, at 11:15 a.m. NA-H stated when she goes into R1's room she asks the resident to turn the camera and, "Turns it no matter what."

When interviewed on 2/15/17, at 11:30 a.m. NA-I stated when she provided cares to R1 she tells the resident she is not comfortable providing cares with the video camera on and she turns the camera towards the wall. NA-I stated when R1 asked her to cover the camera with the handkerchief instead of turning it towards the wall she told the resident she was directed by administration to turn the camera and not cover it. NA-I stated R1 told her in the past she didn't want to deal with talking about the camera everyday.

When interviewed on 2/15/17, at 11:50 a.m. LPN-J stated staff were directed by administration that staff had a right to not be videotaped and were directed to tell the resident staff were uncomfortable with the camera on and they would be turning it towards the wall. LPN-J stated R1 told her she feels she was treated differently by staff because of the video camera in her room as staff does not joke and play around with her like they used to. LPN-J stated she can see staff treating the resident differently because they all have to watch what they say when the video camera is on. LPN-J stated she asked the DON if staff could cover the video camera with the handkerchief but was directed administration

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wanted the video camera turned towards the wall.

When interviewed on 2/15/17, at 12:15 p.m. unit manager (UM)-K stated staff were directed to ask R1 if they could turn the camera for their privacy, and if R1 said no staff would tell the resident they will do cares in another room. UM-K stated she felt the issues with the video camera made R1 more confused and guarded, and, "We have lost our joking relationship." UM-K stated staff get nervous with the camera in the room so they do treat the resident different. UM-K stated the video camera made staff uncomfortable, and she was aware she didn't go into R1's room as much as she did prior to the video camera. UM-K stated all the direction staff had been given regarding the camera was directed by administration.

When interviewed on 2/15/17, at 1:00 p.m. RN-L stated administration had directed staff to tell R1 they would be turning the video camera while doing cares, and if the resident did not want the video camera turned, staff would need to take the resident to another room to do cares privately. RN-L stated a few weeks ago R1 had refused to have the camera turned and would not go to another room to have cares provided. RN-L stated she spoke with R1 and the resident agreed to allow the camera to be turned if RN-L would stay in the room when the aides were providing cares.

When interviewed on 2/16/17, at 9:30 a.m. social worker (SW)-N stated staff were directed to tell R1 they were not comfortable providing cares with the video camera on and ask if they may turn it towards the wall. If the resident refused, staff would bring the resident to another room to provide R1's cares. SW-N stated after the video

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camera was discovered, the resident had a change in behavior. SW-N was not sure if the change was because of the actual video camera or because of the effects of the camera. SW-N stated recently R1 had refused to talk with her, so the DON was assessing the resident and changes in behavior. SW-N stated the resident had agreed to the camera since the camera had been installed, and she felt the resident was, "Unfairly put in the middle." SW-N stated the R1 still goes out to the dining room and activities, but, "She is being treated differently in her room." SW-N stated staff feel "threatened" because of the video camera and the facility needed to respect the staff rights to not be videotaped while providing cares.

When interviewed on 2/16/16, at 10:40 a.m. the administrator stated administration directed staff to alert the resident she was on camera and possible audio and staff would be turning the video camera towards the wall. However, the administrator stated the previous day staff were directed to turn the video camera off when providing cares instead of asking the resident. The administrator stated this change was made because she was not aware until the previous day the residents life was being affected by staff constantly asking the resident about the camera. The administrator stated staff were originally directed to ask the resident if they could turn the camera when doing cares because they were uncomfortable being on camera. The administrator stated she was aware R1 had signed a notarized consent to the video camera, however, that was currently being reviewed by the facility's legal team because the residents cognition varied at times and they wanted to ensure the resident understood the consent and

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F 151	Continued From page 11 that it was an actual legal document. The administrator stated a few weeks ago staff had discussed the consent to electronic monitoring with the resident and she understood at that time. The administrator stated the situation with the video camera had been assessed on a daily basis by multiple staff, however, she was unsure why no one had brought to her attention the effect staff treatment was having on the resident until the previous day, 2/15/17, approximately three weeks after the video camera had been in place. The facility policy titled, Photography and Video Imagining, Patient, Visitor, Workforce Member-Enterprise, revised on 2/3/17, indicated Video monitoring by family/ friends in a patients room must be approved by the bedside nurse. Family/ friends should be informed that the camera or monitor must be focused only on the patient and cannot be placed in a position that captures staff or other patients or activities in the room. Staff may ask the individual to stop taking pictures or recording at any time. The facility policy does not state how the resident's rights will be protected.	F 151		
F 223 SS=G	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical	F 223		3/17/17

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F 223	Continued From page 12 abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents reviewed, R1, was free from abuse. R1 installed a video camera in her room on 2/1/2017 to feel safe. The staff were directed by administration to ask the resident the same question about the camera every time they entered the room to provide care. The staff were also directed to tell the resident that if they were not able to turn the camera off they would take the resident to another room to provide care. R1 was tearful on multiple occasions due to staff constantly asking the resident about turning off the video camera as the resident wanted the camera left on. The resident stated the staff's interactions with her significantly decreased after the installation of the camera. Staff treatment of the resident resulted in actual harm for R1 who experienced mental anguish. Findings include: R1's care plan dated 2/4/17, indicated R1 required total staff assistance with all activities of daily living (ADL's) and assist of one staff with eating. R1 required a total body mechanical lift for all transfers. During observation on 2/14/16, at 6:30 p.m. R1 was in her room laying in bed. On the wall there was a notarized document signed by R1 and family member (FM)-D titled, Consent To Electronic Monitoring. The consent indicated R1 had given consent to placement of the video camera in her room, and indicated, "I ask that	F 223		

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staff members respect my consent to placement of the device and not talk to me about the device, tamper with the device, remove the device, or pressure me to turn off the device. The device is being used to better understand my care and to prevent maltreatment of me by staff and others." During observation of R1's room, there was a small plastic daisy sitting on a small end table in front of the residents bed which contained a video camera in the center of the flower.

R1's Progress Notes indicated on 2/1/17, at 3:50 p.m. staff had spoken with FM-D who stated a video camera was put into R1's room to protect the resident. R1 had signed a notarized consent for the video camera and the paper was hanging in R1's room.

R1's Progress Note dated 2/4/17, at 10:30 a.m. indicated R1, "Was very tearful. RN [registered nurse] wiped tears with cool cloth and asked why she was so upset. Resident stated that she felt staff were upset with her because of the camera. RN assured her this was not the case. Staff are concerned for her and feel uncomfortable performing cares with a video recording. No one is angry with the resident. Resident feels interactions have lessened because of the video camera." The progress note also indicated the resident, "Said this is her home and the camera has changed how it feels here. She began to cry again. RN explained that if the time comes that she is too distressed about the camera, staff RN may ask permission, on camera, to permanently disable it. Unplug it, remove batteries."

R1's Progress Note dated 2/7/17, at 11:12 a.m. indicated the nurse was completing a mood and mental evaluation on R1 and the resident started

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crying and stated, "People treat her differently because of the camera in her room."

R1's Progress Note dated 2/8/17, at 1:30 p.m. indicated FM-D called the facility and requested staff put a tissue over the video camera instead of turning the camera because when staff turn the camera it is not always turned back in the right position. The Progress Note indicated the nurse called the director of nursing (DON) regarding FM-D's request to put a tissue over the camera, and the DON instructed, "The lawyer said to turn the camera so we need to stick to what they say."

R1's Progress Note dated 2/14/17, at 8:31 p.m. indicated, "Prior to HS [hour of sleep] cares and assessment, staff asked resident if she wanted the camera covered and she stated yes 'no peeking.' Camera covered with red hanky while resident was exposed."

R1's current Nursing Assistant care sheet (what the nursing assistants use to know specific cares on residents) dated 2/10/17, indicated R1 "Loves to visit with staff."

During observation on 2/14/17, at 7:00 p.m. four handwritten pieces of paper were hung up behind the nurses station on R1's unit. The handwritten paper directed staff when going into R1's room to ask the following questions. "May I turn the camera off while I work with you as it makes me uncomfortable?" If the resident said yes staff were directed to turn the camera off. If the resident responded no, staff were directed to respond, "Then I would like to do your cares in another area." Staff were directed to, "Document EVERY time you ask this question and what you get for a response." The other papers were titled

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R1's data collection for the camera, and contained boxes which were titled, quote what you asked R1, time, what was R1's response to what you ask, and action taken. Some of the data collection included:
2/1/17, at 4:45 p.m.- Staff stated to R1, "I don't consent to the camera you might have consented to the camera but I don't. I stated I can't turn it off [the camera] because of the papers in her room [the consent]." The resident response was documented as, "She stated then turn it off."
2/2/17, at 3:30 p.m.- "Asked to turn off camera. Refused and said we were the first people to ask to turn it off." The next entry was made at 4:12 p.m. on 2/2/17, which indicated, "Resident didn't want the camera off or to go to another room but agreed to turn the camera." The resident response was, "Agreed to have RN [registered nurse] in the room and could turn camera around."
2/6/17, at 5:55 p.m.- Staff asked the resident if they could cover the camera up. R1's response was documented as, "You're the only one who asks that you know. If you don't like it open your own place. That's what they tell you to say." The action taken was staff responding to R1, "Well, it makes me uncomfortable." Staff proceeded to do cares with the camera covered.
2/9/17, at 4:30 p.m.- "Is it okay if I turn the camera, I feel uncomfortable." The resident requested staff use the red handkerchief to cover the camera.

A hospital progress note dated 2/6/17, indicated R1 was ill in November 2016, December 2016, and early January 2017, with a chronic infection. At that time she was unable to make any medical or legal decisions, however, she was now alert and orientated and it appeared the confusion and

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delirium had resolved.

When interviewed on 2/14/17, at 6:45 p.m. FM-D stated since R1 had the video camera in her room, staff treated the resident differently. FM-D stated R1 liked to joke and laugh with the staff, however, since placement of the video camera staff only focused on the camera in the room, and avoid conversation and entering R1's room. FM-D stated R1 was upset about being treated differently and did not like being questioned about the camera every time staff came into her room. FM-D stated R1 had signed a notarized consent and talked to multiple staff and told them she agrees with the video camera in her room but staff would not stop asking. FM-D stated she had requested the facility not turn the camera to the side, or shut it off, because it is not put back in the correct position after cares are complete. FM-D brought in a red handkerchief to cover the camera when staff are providing cares to R1 to ensure the residents privacy, however, most of the time staff just turn the camera and will not use the handkerchief.

When interviewed on 2/14/17, at 7:05 p.m. licensed practical nurse (LPN)-M stated the video camera was discovered hidden in R1's room about a month ago. About a week after the camera was found, the daisy video camera was placed by family on R1's end table in her room. LPN-M stated staff were initially instructed to turn the video camera off while in R1's room, and then a few weeks ago it changed to just turning the camera away from the resident and point it towards the wall. LPN-D stated FM-D had requested staff to just cover the camera instead of moving it or turning it off, but staff were directed by administration to turn the camera or

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shut if off. LPN-M stated she was aware R1 was upset and the resident had cried about the video camera. LPN-M stated R1, "Was in a difficult spot; we [staff] want it off; [FM-D] wants it on- the resident is in between." Administration told staff they had a right not to be videotaped, and LPN-M stated staff were confused because they didn't know if they should be turning the camera, shutting it off, or covering it up.

When interviewed on 2/14/17, at 7:30 p.m. Nursing assistant (NA)-E stated she was directed about two weeks ago to cover the camera when providing cares to R1. NA-E stated R1 gets "annoyed" with staff when they ask about the camera and often responds, "Yes! You know you can cover it!" NA-E stated when she goes into R1's room she says to the resident, "Can I cover it [video camera] because we don't want to be taped during cares." NA-E stated this was the instruction provided by administration to staff.

During interview on 2/14/17, at 7:45 a.m. NA-F stated the video camera in R1's room was, "Causing a lot of commotion." NA-F stated there were NA's in the facility who did not want to provide cares to R1 and "steer clear" of R1's room. NA-F stated she tells R1 she is uncomfortable doing cares with the video camera and turns it towards the wall as she had been directed by administration. NA-F stated R1 was cognitively intact and, "This is too hard on the resident; we tell her every time we do cares we are uncomfortable with the camera."

During interview on 2/15/17, at 8:50 a.m. director of nursing stated the facility policy did not allow any videotaping and staff had the right not to be videotaped. DON stated for staff protection they

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had been instructed to ask the resident about turning off the video camera every time they do cares. DON stated she was aware R1 felt staff didn't come around as much to talk with her since the video camera was in place. DON stated staff were directed to ask the resident to turn the video camera off, and if resident refused, they would take the resident to another room to provide cares. DON stated administration was aware of the notarized consent for the video camera signed by R1, however, the facility is currently having it reviewed to ensure it is a legal document. DON stated R1 was "Caught in the middle," between having the video camera in her room, and staff not wanting the video camera in the room.

During interview on 2/15/17, at 9:50 a.m. R1 stated she has told "everyone" she is fine with the video camera in her room. R1 stated when staff ask her about the video camera she tells them to do what they want, "I am sick of it- I don't want to keep being asked!" R1 stated staff treat her differently because of the video camera and they are, "Cold; staff ignore me; they don't like the camera." R1 stated staff don't stay in her room and joke and talk with her anymore, and before staff were even all the way in her room and knew what she wanted, they were asking to turn the video camera off. R1 stated the video camera made her feel safe. R1 stated a couple weeks ago one of the nurses was, "In my face all morning long about the damn camera." R1 stated she finally responded to the nurse to either turn the camera off or get rid of it. R1 stated she talks and talks about the camera and says it is okay, however, staff continue to ask about it all day, everyday. R1 stated, "It pisses me off," when staff constantly talked about the camera

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F 223	Continued From page 19 because, "They [staff] know the routine!" During a follow up interview on 2/15/17, at 10:40 a.m. DON stated she had just spoke with R1 and the resident wanted the video camera in her room, and staff would now just tell R1 they would be turning the camera off when doing cares instead of asking the resident every time. DON stated they were going to make this change so staff don't have to ask R1 about the camera constantly, but she will still have a chance to give input. During interview on 2/15/17, at 11:00 a.m. NA-G stated she had been directed by administration to ask R1 to turn the camera off because she was uncomfortable with it on, and if the resident refused staff should take her to another room and provide cares. NA-G stated R1 was teary and told her she was sad because she felt staff treat her differently when they go into her room. NA-G stated she was aware some of the newer staff were nervous about going into R1's room with the video camera. When interviewed on 2/15/17, at 11:15 a.m. NA-H stated when she goes into R1's room she asks the resident to turn the camera and, "Turns it no matter what." When interviewed on 2/15/17, at 11:30 a.m. NA-I stated when she provided cares to R1 she tells the resident she is not comfortable providing cares with the video camera on and she turns the camera towards the wall. NA-I stated when R1 asked her to cover the camera with the handkerchief instead of turning it towards the wall she told the resident she was directed by administration to turn the camera and not cover it.	F 223		

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F 223	Continued From page 20 NA-I stated R1 told her in the past she didn't want to deal with talking about the camera everyday. When interviewed on 2/15/17, at 11:50 a.m. LPN-J stated staff were directed by administration that staff had a right to not be videotaped and were directed to tell the resident staff were uncomfortable with the camera on and they would be turning it towards the wall. LPN-J stated R1 told her she feels she was treated differently by staff because of the video camera in her room as staff does not joke and play around with her like they used to. LPN-J stated she can see staff treating the resident differently because they all have to watch what they say when the video camera is on. LPN-J stated she asked the DON if staff could cover the video camera with the handkerchief but was directed administration wanted the video camera turned towards the wall. When interviewed on 2/15/17, at 12:15 p.m. unit manager (UM)-K stated staff were directed to ask R1 if they could turn the camera for their privacy, and if R1 said no staff would tell the resident they will do cares in another room. UM-K stated she felt the issues with the video camera made R1 more confused and guarded, and, "We have lost our joking relationship." UM-K stated staff get nervous with the camera in the room so they do treat the resident different. UM-K stated the video camera made staff uncomfortable, and she was aware she didn't go into R1's room as much as she did prior to the video camera. UM-K stated all the direction staff had been given regarding the camera was directed by administration. When interviewed on 2/15/17, at 1:00 p.m. RN-L stated administration had directed staff to tell R1 they would be turning the video camera while	F 223		

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doing cares, and if the resident did not want the video camera turned, staff would need to take the resident to another room to do cares privately. RN-L stated a few weeks ago R1 had refused to have the camera turned and would not go to another room to have cares provided. RN-L stated she spoke with R1 and the resident agreed to allow the camera to be turned if RN-L would stay in the room when the aides were providing cares.

When interviewed on 2/16/17, at 9:30 a.m. social worker (SW)-N stated staff were directed to tell R1 they were not comfortable providing cares with the video camera on and ask if they may turn it towards the wall. If the resident refused, staff would bring the resident to another room to provide R1's cares. SW-N stated after the video camera was discovered, the resident had a change in behavior. SW-N was not sure if the change was because of the actual video camera or because of the effects of the camera. SW-N stated recently R1 had refused to talk with her, so the DON was assessing the resident and changes in behavior. SW-N stated the resident had agreed to the camera since the camera had been installed, and she felt the resident was, "Unfairly put in the middle." SW-N stated the R1 still goes out to the dining room and activities, but, "She is being treated differently in her room." SW-N stated staff feel "threatened" because of the video camera and the facility needed to respect the staff rights to not be videotaped while providing cares.

When interviewed on 2/16/16, at 10:40 a.m. the administrator stated administration directed staff to alert the resident she was on camera and possible audio and staff would be turning the

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F 223	Continued From page 22 video camera towards the wall. However, the administrator stated the previous day staff were directed to turn the video camera off when providing cares instead of asking the resident. The administrator stated this change was made because she was not aware until the previous day the residents life was being affected by staff constantly asking the resident about the camera. The administrator stated staff were originally directed to ask the resident if they could turn the camera when doing cares because they were uncomfortable being on camera. The administrator stated she was aware R1 had signed a notarized consent to the video camera, however, that was currently being reviewed by the facility's legal team because the residents cognition varied at times and they wanted to ensure the resident understood the consent and that it was an actual legal document. The administrator stated a few weeks ago staff had discussed the consent to electronic monitoring with the resident and she understood at that time. The administrator stated the situation with the video camera had been assessed on a daily basis by multiple staff, however, she was unsure why no one had brought to her attention the effect staff treatment was having on the resident until the previous day, 2/15/17, approximately three weeks after the video camera had been in place. The facility policy titled, Photography and Video Imagining, Patient, Visitor, Workforce Member-Enterprise, revised on 2/3/17, indicated Video monitoring by family/ friends in a patients room must be approved by the bedside nurse. Family/ friends should be informed that the camera or monitor must be focused only on the patient and cannot be placed in a position that captures staff or other patients or activities in the room. Staff	F 223		

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F 223	Continued From page 23 may ask the individual to stop taking pictures or recording at any time. The facility policy does not state how the resident's rights will be protected.	F 223		
F 490 SS=G	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility administration directed all staff to treat 1 of 3 residents reviewed, R1, in such a manner that caused mental anguish to R1. This treatment of the resident started after the resident installed a video camera in her room to feel safe. Findings include: R1's care plan dated 2/4/17, indicated R1 required total staff assistance with all activities of daily living (ADL's) and assist of one staff with eating. R1 required a total body mechanical lift for all transfers. During observation on 2/14/16, at 6:30 p.m. R1 was in her room laying in bed. On the wall there was a notarized document signed by R1 and family member (FM)-D titled, Consent To Electronic Monitoring. The consent indicated R1 had given consent to placement of the video camera in her room, and indicated, "I ask that staff members respect my consent to placement of the device and not talk to me about the device,	F 490		3/17/17

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tamper with the device, remove the device, or pressure me to turn off the device. The device is being used to better understand my care and to prevent maltreatment of me by staff and others." During observation of R1's room, there was a small plastic daisy sitting on a small end table in front of the residents bed which contained a video camera in the center of the flower.

R1's Progress Notes indicated on 2/1/17, at 3:50 p.m. staff had spoken with FM-D who stated a video camera was put into R1's room to protect the resident. R1 had signed a notarized consent for the video camera and the paper was hanging in R1's room.

R1's Progress Note dated 2/4/17, at 10:30 a.m. indicated R1, "Was very tearful. RN [registered nurse] wiped tears with cool cloth and asked why she was so upset. Resident stated that she felt staff were upset with her because of the camera. RN assured her this was not the case. Staff are concerned for her and feel uncomfortable performing cares with a video recording. No one is angry with the resident. Resident feels interactions have lessened because of the video camera." The progress note also indicated the resident, "Said this is her home and the camera has changed how it feels here. She began to cry again. RN explained that if the time comes that she is too distressed about the camera, staff RN may ask permission, on camera, to permanently disable it. Unplug it, remove batteries."

R1's Progress Note dated 2/7/17, at 11:12 a.m. indicated the nurse was completing a mood and mental evaluation on R1 and the resident started crying and stated, "People treat her differently because of the camera in her room."

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F 490	Continued From page 25 R1's Progress Note dated 2/8/17, at 1:30 p.m. indicated FM-D called the facility and requested staff put a tissue over the video camera instead of turning the camera because when staff turn the camera it is not always turned back in the right position. The Progress Note indicated the nurse called the director of nursing (DON) regarding FM-D's request to put a tissue over the camera, and the DON instructed, "The lawyer said to turn the camera so we need to stick to what they say." R1's Progress Note dated 2/14/17, at 8:31 p.m. indicated, "Prior to HS [hour of sleep] cares and assessment, staff asked resident if she wanted the camera covered and she stated yes 'no peeking.' Camera covered with red hanky while resident was exposed." R1's current Nursing Assistant care sheet (what the nursing assistants use to know specific cares on residents) dated 2/10/17, indicated R1 "Loves to visit with staff." During observation on 2/14/17, at 7:00 p.m. four handwritten pieces of paper were hung up behind the nurses station on R1's unit. The handwritten paper directed staff when going into R1's room to ask the following questions. "May I turn the camera off while I work with you as it makes me uncomfortable?" If the resident said yes staff were directed to turn the camera off. If the resident responded no, staff were directed to respond, "Then I would like to do your cares in another area." Staff were directed to, "Document EVERY time you ask this question and what you get for a response." The other papers were titled R1's data collection for the camera, and contained boxes which were titled, quote what	F 490		

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you asked R1, time, what was R1's response to what you ask, and action taken. Some of the data collection included:
2/1/17, at 4:45 p.m.- Staff stated to R1, "I don't consent to the camera you might have consented to the camera but I don't. I stated I can't turn it off [the camera] because of the papers in her room [the consent]." The resident response was documented as, "She stated then turn it off."
2/2/17, at 3:30 p.m.- "Asked to turn off camera. Refused and said we were the first people to ask to turn it off." The next entry was made at 4:12 p.m. on 2/2/17, which indicated, "Resident didn't want the camera off or to go to another room but agreed to turn the camera." The resident response was, "Agreed to have RN [registered nurse] in the room and could turn camera around."
2/6/17, at 5:55 p.m.- Staff asked the resident if they could cover the camera up. R1's response was documented as, "You're the only one who asks that you know. If you don't like it open your own place. That's what they tell you to say." The action taken was staff responding to R1, "Well, it makes me uncomfortable." Staff proceeded to do cares with the camera covered.
2/9/17, at 4:30 p.m.- "Is it okay if I turn the camera, I feel uncomfortable." The resident requested staff use the red handkerchief to cover the camera.

A hospital progress note dated 2/6/17, indicated R1 was ill in November 2016, December 2016, and early January 2017, with a chronic infection. At that time she was unable to make any medical or legal decisions, however, she was now alert and orientated and it appeared the confusion and delirium had resolved.

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When interviewed on 2/14/17, at 6:45 p.m. FM-D stated since R1 had the video camera in her room, staff treated the resident differently. FM-D stated R1 liked to joke and laugh with the staff, however, since placement of the video camera staff only focused on the camera in the room, and avoid conversation and entering R1's room. FM-D stated R1 was upset about being treated differently and did not like being questioned about the camera every time staff came into her room. FM-D stated R1 had signed a notarized consent and talked to multiple staff and told them she agrees with the video camera in her room but staff would not stop asking. FM-D stated she had requested the facility not turn the camera to the side, or shut it off, because it is not put back in the correct position after cares are complete. FM-D brought in a red handkerchief to cover the camera when staff are providing cares to R1 to ensure the residents privacy, however, most of the time staff just turn the camera and will not use the handkerchief.

When interviewed on 2/14/17, at 7:05 p.m. licensed practical nurse (LPN)-M stated the video camera was discovered hidden in R1's room about a month ago. About a week after the camera was found, the daisy video camera was placed by family on R1's end table in her room. LPN-M stated staff were initially instructed to turn the video camera off while in R1's room, and then a few weeks ago it changed to just turning the camera away from the resident and point it towards the wall. LPN-D stated FM-D had requested staff to just cover the camera instead of moving it or turning it off, but staff were directed by administration to turn the camera or shut if off. LPN-M stated she was aware R1 was upset and the resident had cried about the video

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camera. LPN-M stated R1, "Was in a difficult spot; we [staff] want it off; [FM-D] wants it on- the resident is in between." Administration told staff they had a right not to be videotaped, and LPN-M stated staff were confused because they didn't know if they should be turning the camera, shutting it off, or covering it up.

When interviewed on 2/14/17, at 7:30 p.m. Nursing assistant (NA)-E stated she was directed about two weeks ago to cover the camera when providing cares to R1. NA-E stated R1 gets "annoyed" with staff when they ask about the camera and often responds, "Yes! You know you can cover it!" NA-E stated when she goes into R1's room she says to the resident, "Can I cover it [video camera] because we don't want to be taped during cares." NA-E stated this was the instruction provided by administration to staff.

During interview on 2/14/17, at 7:45 a.m. NA-F stated the video camera in R1's room was, "Causing a lot of commotion." NA-F stated there were NA's in the facility who did not want to provide cares to R1 and "steer clear" of R1's room. NA-F stated she tells R1 she is uncomfortable doing cares with the video camera and turns it towards the wall as she had been directed by administration. NA-F stated R1 was cognitively intact and, "This is too hard on the resident; we tell her every time we do cares we are uncomfortable with the camera."

During interview on 2/15/17, at 8:50 a.m. director of nursing stated the facility policy did not allow any videotaping and staff had the right not to be videotaped. DON stated for staff protection they had been instructed to ask the resident about turning off the video camera every time they do

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cares. DON stated she was aware R1 felt staff didn't come around as much to talk with her since the video camera was in place. DON stated staff were directed to ask the resident to turn the video camera off, and if resident refused, they would take the resident to another room to provide cares. DON stated administration was aware of the notarized consent for the video camera signed by R1, however, the facility is currently having it reviewed to ensure it is a legal document. DON stated R1 was "Caught in the middle," between having the video camera in her room, and staff not wanting the video camera in the room.

During interview on 2/15/17, at 9:50 a.m. R1 stated she has told "everyone" she is fine with the video camera in her room. R1 stated when staff ask her about the video camera she tells them to do what they want, "I am sick of it- I don't want to keep being asked!" R1 stated staff treat her differently because of the video camera and they are, "Cold; staff ignore me; they don't like the camera." R1 stated staff don't stay in her room and joke and talk with her anymore, and before staff were even all the way in her room and knew what she wanted, they were asking to turn the video camera off. R1 stated the video camera made her feel safe. R1 stated a couple weeks ago one of the nurses was, "In my face all morning long about the damn camera." R1 stated she finally responded to the nurse to either turn the camera off or get rid of it. R1 stated she talks and talks about the camera and says it is okay, however, staff continue to ask about it all day, everyday. R1 stated, "It pisses me off," when staff constantly talked about the camera because, "They [staff] know the routine!"

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During a follow up interview on 2/15/17, at 10:40 a.m. DON stated she had just spoke with R1 and the resident wanted the video camera in her room, and staff would now just tell R1 they would be turning the camera off when doing cares instead of asking the resident every time. DON stated they were going to make this change so staff don't have to ask R1 about the camera constantly, but she will still have a chance to give input.

During interview on 2/15/17, at 11:00 a.m. NA-G stated she had been directed by administration to ask R1 to turn the camera off because she was uncomfortable with it on, and if the resident refused staff should take her to another room and provide cares. NA-G stated R1 was teary and told her she was sad because she felt staff treat her differently when they go into her room. NA-G stated she was aware some of the newer staff were nervous about going into R1's room with the video camera.

When interviewed on 2/15/17, at 11:15 a.m. NA-H stated when she goes into R1's room she asks the resident to turn the camera and, "Turns it no matter what."

When interviewed on 2/15/17, at 11:30 a.m. NA-I stated when she provided cares to R1 she tells the resident she is not comfortable providing cares with the video camera on and she turns the camera towards the wall. NA-I stated when R1 asked her to cover the camera with the handkerchief instead of turning it towards the wall she told the resident she was directed by administration to turn the camera and not cover it. NA-I stated R1 told her in the past she didn't want to deal with talking about the camera everyday.

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F 490	Continued From page 31 When interviewed on 2/15/17, at 11:50 a.m. LPN-J stated staff were directed by administration that staff had a right to not be videotaped and were directed to tell the resident staff were uncomfortable with the camera on and they would be turning it towards the wall. LPN-J stated R1 told her she feels she was treated differently by staff because of the video camera in her room as staff does not joke and play around with her like they used to. LPN-J stated she can see staff treating the resident differently because they all have to watch what they say when the video camera is on. LPN-J stated she asked the DON if staff could cover the video camera with the handkerchief but was directed administration wanted the video camera turned towards the wall. When interviewed on 2/15/17, at 12:15 p.m. unit manager (UM)-K stated staff were directed to ask R1 if they could turn the camera for their privacy, and if R1 said no staff would tell the resident they will do cares in another room. UM-K stated she felt the issues with the video camera made R1 more confused and guarded, and, "We have lost our joking relationship." UM-K stated staff get nervous with the camera in the room so they do treat the resident different. UM-K stated the video camera made staff uncomfortable, and she was aware she didn't go into R1's room as much as she did prior to the video camera. UM-K stated all the direction staff had been given regarding the camera was directed by administration. When interviewed on 2/15/17, at 1:00 p.m. RN-L stated administration had directed staff to tell R1 they would be turning the video camera while doing cares, and if the resident did not want the video camera turned, staff would need to take the	F 490		

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	245039	A. BUILDING _____ B. WING _____	C 02/23/2017

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

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F 490	Continued From page 32	F 490		

resident to another room to do cares privately. RN-L stated a few weeks ago R1 had refused to have the camera turned and would not go to another room to have cares provided. RN-L stated she spoke with R1 and the resident agreed to allow the camera to be turned if RN-L would stay in the room when the aides were providing cares.

When interviewed on 2/16/17, at 9:30 a.m. social worker (SW)-N stated staff were directed to tell R1 they were not comfortable providing cares with the video camera on and ask if they may turn it towards the wall. If the resident refused, staff would bring the resident to another room to provide R1's cares. SW-N stated after the video camera was discovered, the resident had a change in behavior. SW-N was not sure if the change was because of the actual video camera or because of the effects of the camera. SW-N stated recently R1 had refused to talk with her, so the DON was assessing the resident and changes in behavior. SW-N stated the resident had agreed to the camera since the camera had been installed, and she felt the resident was, "Unfairly put in the middle." SW-N stated the R1 still goes out to the dining room and activities, but, "She is being treated differently in her room." SW-N stated staff feel "threatened" because of the video camera and the facility needed to respect the staff rights to not be videotaped while providing cares.

When interviewed on 2/16/16, at 10:40 a.m. the administrator stated administration directed staff to alert the resident she was on camera and possible audio and staff would be turning the video camera towards the wall. However, the administrator stated the previous day staff were

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F 490	Continued From page 33	F 490		

directed to turn the video camera off when providing cares instead of asking the resident. The administrator stated this change was made because she was not aware until the previous day the residents life was being affected by staff constantly asking the resident about the camera. The administrator stated staff were originally directed to ask the resident if they could turn the camera when doing cares because they were uncomfortable being on camera. The administrator stated she was aware R1 had signed a notarized consent to the video camera, however, that was currently being reviewed by the facility's legal team because the residents cognition varied at times and they wanted to ensure the resident understood the consent and that it was an actual legal document. The administrator stated a few weeks ago staff had discussed the consent to electronic monitoring with the resident and she understood at that time. The administrator stated the situation with the video camera had been assessed on a daily basis by multiple staff, however, she was unsure why no one had brought to her attention the effect staff treatment was having on the resident until the previous day, 2/15/17, approximately three weeks after the video camera had been in place.

The facility policy titled, Photography and Video Imagining, Patient, Visitor, Workforce Member-Enterprise, revised on 2/3/17, indicated Video monitoring by family/ friends in a patients room must be approved by the bedside nurse. Family/ friends should be informed that the camera or monitor must be focused only on the patient and cannot be placed in a position that captures staff or other patients or activities in the room. Staff may ask the individual to stop taking pictures or recording at any time. The facility policy does not

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F 490	Continued From page 34 state how the resident's rights will be protected.	F 490		

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5039013. As a result, the following correction orders are issued.	2 000		
2 130	MN Rule 4658.0050 Subp. 1 Licensee;General duties	2 130		3/17/17

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/05/17

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2 130	Continued From page 1 Subpart 1. General duties. The licensee of a nursing home is responsible for its management, control, and operation. A nursing home must be managed, controlled, and operated in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility administration directed all staff to treat 1 of 3 residents reviewed, R1, in such a manner that caused mental anguish to R1. This treatment of the resident started after the resident installed a video camera in her room to feel safe. Findings include: R1's care plan dated 2/4/17, indicated R1 required total staff assistance with all activities of daily living (ADL's) and assist of one staff with eating. R1 required a total body mechanical lift for all transfers. During observation on 2/14/16, at 6:30 p.m. R1 was in her room laying in bed. On the wall there was a notarized document signed by R1 and family member (FM)-D titled, Consent To Electronic Monitoring. The consent indicated R1 had given consent to placement of the video camera in her room, and indicated, "I ask that staff members respect my consent to placement of the device and not talk to me about the device, tamper with the device, remove the device, or pressure me to turn off the device. The device is being used to better understand my care and to	2 130		

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2 130	Continued From page 2 prevent maltreatment of me by staff and others." During observation of R1's room, there was a small plastic daisy sitting on a small end table in front of the residents bed which contained a video camera in the center of the flower. R1's Progress Notes indicated on 2/1/17, at 3:50 p.m. staff had spoken with FM-D who stated a video camera was put into R1's room to protect the resident. R1 had signed a notarized consent for the video camera and the paper was hanging in R1's room. R1's Progress Note dated 2/4/17, at 10:30 a.m. indicated R1, "Was very tearful. RN [registered nurse] wiped tears with cool cloth and asked why she was so upset. Resident stated that she felt staff were upset with her because of the camera. RN assured her this was not the case. Staff are concerned for her and feel uncomfortable performing cares with a video recording. No one is angry with the resident. Resident feels interactions have lessened because of the video camera." The progress note also indicated the resident, "Said this is her home and the camera has changed how it feels here. She began to cry again. RN explained that if the time comes that she is too distressed about the camera, staff RN may ask permission, on camera, to permanently disable it. Unplug it, remove batteries." R1's Progress Note dated 2/7/17, at 11:12 a.m. indicated the nurse was completing a mood and mental evaluation on R1 and the resident started crying and stated, "People treat her differently because of the camera in her room." R1's Progress Note dated 2/8/17, at 1:30 p.m. indicated FM-D called the facility and requested staff put a tissue over the video camera instead	2 130		

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2 130	Continued From page 3 of turning the camera because when staff turn the camera it is not always turned back in the right position. The Progress Note indicated the nurse called the director of nursing (DON) regarding FM-D's request to put a tissue over the camera, and the DON instructed, "The lawyer said to turn the camera so we need to stick to what they say." R1's Progress Note dated 2/14/17, at 8:31 p.m. indicated, "Prior to HS [hour of sleep] cares and assessment, staff asked resident if she wanted the camera covered and she stated yes 'no peeking.' Camera covered with red hanky while resident was exposed." R1's current Nursing Assistant care sheet (what the nursing assistants use to know specific cares on residents) dated 2/10/17, indicated R1 "Loves to visit with staff." During observation on 2/14/17, at 7:00 p.m. four handwritten pieces of paper were hung up behind the nurses station on R1's unit. The handwritten paper directed staff when going into R1's room to ask the following questions. "May I turn the camera off while I work with you as it makes me uncomfortable?" If the resident said yes staff were directed to turn the camera off. If the resident responded no, staff were directed to respond, "Then I would like to do your cares in another area." Staff were directed to, "Document EVERY time you ask this question and what you get for a response." The other papers were titled R1's data collection for the camera, and contained boxes which were titled, quote what you asked R1, time, what was R1's response to what you ask, and action taken. Some of the data collection included: 2/1/17, at 4:45 p.m.- Staff stated to R1, "I don't consent to the camera you might have consented	2 130		

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2 130	Continued From page 4 to the camera but I don't. I stated I can't turn it off [the camera] because of the papers in her room [the consent]." The resident response was documented as, "She stated then turn it off." 2/2/17, at 3:30 p.m.- "Asked to turn off camera. Refused and said we were the first people to ask to turn it off." The next entry was made at 4:12 p.m. on 2/2/17, which indicated, "Resident didn't want the camera off or to go to another room but agreed to turn the camera." The resident response was, "Agreed to have RN [registered nurse] in the room and could turn camera around." 2/6/17, at 5:55 p.m.- Staff asked the resident if they could cover the camera up. R1's response was documented as, "You're the only one who asks that you know. If you don't like it open your own place. That's what they tell you to say." The action taken was staff responding to R1, "Well, it makes me uncomfortable." Staff proceeded to do cares with the camera covered. 2/9/17, at 4:30 p.m.- "Is it okay if I turn the camera, I feel uncomfortable." The resident requested staff use the red handkerchief to cover the camera. A hospital progress note dated 2/6/17, indicated R1 was ill in November 2016, December 2016, and early January 2017, with a chronic infection. At that time she was unable to make any medical or legal decisions, however, she was now alert and orientated and it appeared the confusion and delirium had resolved. When interviewed on 2/14/17, at 6:45 p.m. FM-D stated since R1 had the video camera in her room, staff treated the resident differently. FM-D stated R1 liked to joke and laugh with the staff, however, since placement of the video camera staff only focused on the camera in the room, and	2 130		

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2 130	Continued From page 5 avoid conversation and entering R1's room. FM-D stated R1 was upset about being treated differently and did not like being questioned about the camera every time staff came into her room. FM-D stated R1 had signed a notarized consent and talked to multiple staff and told them she agrees with the video camera in her room but staff would not stop asking. FM-D stated she had requested the facility not turn the camera to the side, or shut it off, because it is not put back in the correct position after cares are complete. FM-D brought in a red handkerchief to cover the camera when staff are providing cares to R1 to ensure the residents privacy, however, most of the time staff just turn the camera and will not use the handkerchief. When interviewed on 2/14/17, at 7:05 p.m. licensed practical nurse (LPN)-M stated the video camera was discovered hidden in R1's room about a month ago. About a week after the camera was found, the daisy video camera was placed by family on R1's end table in her room. LPN-M stated staff were initially instructed to turn the video camera off while in R1's room, and then a few weeks ago it changed to just turning the camera away from the resident and point it towards the wall. LPN-D stated FM-D had requested staff to just cover the camera instead of moving it or turning it off, but staff were directed by administration to turn the camera or shut if off. LPN-M stated she was aware R1 was upset and the resident had cried about the video camera. LPN-M stated R1, "Was in a difficult spot; we [staff] want it off; [FM-D] wants it on- the resident is in between." Administration told staff they had a right not to be videotaped, and LPN-M stated staff were confused because they didn't know if they should be turning the camera, shutting it off, or covering it up.	2 130		

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2 130	Continued From page 6 When interviewed on 2/14/17, at 7:30 p.m. Nursing assistant (NA)-E stated she was directed about two weeks ago to cover the camera when providing cares to R1. NA-E stated R1 gets "annoyed" with staff when they ask about the camera and often responds, "Yes! You know you can cover it!" NA-E stated when she goes into R1's room she says to the resident, "Can I cover it [video camera] because we don't want to be taped during cares." NA-E stated this was the instruction provided by administration to staff. During interview on 2/14/17, at 7:45 a.m. NA-F stated the video camera in R1's room was, "Causing a lot of commotion." NA-F stated there were NA's in the facility who did not want to provide cares to R1 and "steer clear" of R1's room. NA-F stated she tells R1 she is uncomfortable doing cares with the video camera and turns it towards the wall as she had been directed by administration. NA-F stated R1 was cognitively intact and, "This is too hard on the resident; we tell her every time we do cares we are uncomfortable with the camera." During interview on 2/15/17, at 8:50 a.m. director of nursing stated the facility policy did not allow any videotaping and staff had the right not to be videotaped. DON stated for staff protection they had been instructed to ask the resident about turning off the video camera every time they do cares. DON stated she was aware R1 felt staff didn't come around as much to talk with her since the video camera was in place. DON stated staff were directed to ask the resident to turn the video camera off, and if resident refused, they would take the resident to another room to provide cares. DON stated administration was aware of the notarized consent for the video camera	2 130		

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2 130	Continued From page 7 signed by R1, however, the facility is currently having it reviewed to ensure it is a legal document. DON stated R1 was "Caught in the middle," between having the video camera in her room, and staff not wanting the video camera in the room. During interview on 2/15/17, at 9:50 a.m. R1 stated she has told "everyone" she is fine with the video camera in her room. R1 stated when staff ask her about the video camera she tells them to do what they want, "I am sick of it- I don't want to keep being asked!" R1 stated staff treat her differently because of the video camera and they are, "Cold; staff ignore me; they don't like the camera." R1 stated staff don't stay in her room and joke and talk with her anymore, and before staff were even all the way in her room and knew what she wanted, they were asking to turn the video camera off. R1 stated the video camera made her feel safe. R1 stated a couple weeks ago one of the nurses was, "In my face all morning long about the damn camera." R1 stated she finally responded to the nurse to either turn the camera off or get rid of it. R1 stated she talks and talks about the camera and says it is okay, however, staff continue to ask about it all day, everyday. R1 stated, "It pisses me off," when staff constantly talked about the camera because, "They [staff] know the routine!" During a follow up interview on 2/15/17, at 10:40 a.m. DON stated she had just spoke with R1 and the resident wanted the video camera in her room, and staff would now just tell R1 they would be turning the camera off when doing cares instead of asking the resident every time. DON stated they were going to make this change so staff don't have to ask R1 about the camera constantly, but she will still have a chance to give	2 130		

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2 130	Continued From page 8 input. During interview on 2/15/17, at 11:00 a.m. NA-G stated she had been directed by administration to ask R1 to turn the camera off because she was uncomfortable with it on, and if the resident refused staff should take her to another room and provide cares. NA-G stated R1 was teary and told her she was sad because she felt staff treat her differently when they go into her room. NA-G stated she was aware some of the newer staff were nervous about going into R1's room with the video camera. When interviewed on 2/15/17, at 11:15 a.m. NA-H stated when she goes into R1's room she asks the resident to turn the camera and, "Turns it no matter what." When interviewed on 2/15/17, at 11:30 a.m. NA-I stated when she provided cares to R1 she tells the resident she is not comfortable providing cares with the video camera on and she turns the camera towards the wall. NA-I stated when R1 asked her to cover the camera with the handkerchief instead of turning it towards the wall she told the resident she was directed by administration to turn the camera and not cover it. NA-I stated R1 told her in the past she didn't want to deal with talking about the camera everyday. When interviewed on 2/15/17, at 11:50 a.m. LPN-J stated staff were directed by administration that staff had a right to not be videotaped and were directed to tell the resident staff were uncomfortable with the camera on and they would be turning it towards the wall. LPN-J stated R1 told her she feels she was treated differently by staff because of the video camera in her room as staff does not joke and play around with her like	2 130		

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2 130	Continued From page 9	2 130		

they used to. LPN-J stated she can see staff treating the resident differently because they all have to watch what they say when the video camera is on. LPN-J stated she asked the DON if staff could cover the video camera with the handkerchief but was directed administration wanted the video camera turned towards the wall.

When interviewed on 2/15/17, at 12:15 p.m. unit manager (UM)-K stated staff were directed to ask R1 if they could turn the camera for their privacy, and if R1 said no staff would tell the resident they will do cares in another room. UM-K stated she felt the issues with the video camera made R1 more confused and guarded, and, "We have lost our joking relationship." UM-K stated staff get nervous with the camera in the room so they do treat the resident different. UM-K stated the video camera made staff uncomfortable, and she was aware she didn't go into R1's room as much as she did prior to the video camera. UM-K stated all the direction staff had been given regarding the camera was directed by administration.

When interviewed on 2/15/17, at 1:00 p.m. RN-L stated administration had directed staff to tell R1 they would be turning the video camera while doing cares, and if the resident did not want the video camera turned, staff would need to take the resident to another room to do cares privately. RN-L stated a few weeks ago R1 had refused to have the camera turned and would not go to another room to have cares provided. RN-L stated she spoke with R1 and the resident agreed to allow the camera to be turned if RN-L would stay in the room when the aides were providing cares.

When interviewed on 2/16/17, at 9:30 a.m. social worker (SW)-N stated staff were directed to tell

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2 130	Continued From page 10 R1 they were not comfortable providing cares with the video camera on and ask if they may turn it towards the wall. If the resident refused, staff would bring the resident to another room to provide R1's cares. SW-N stated after the video camera was discovered, the resident had a change in behavior. SW-N was not sure if the change was because of the actual video camera or because of the effects of the camera. SW-N stated recently R1 had refused to talk with her, so the DON was assessing the resident and changes in behavior. SW-N stated the resident had agreed to the camera since the camera had been installed, and she felt the resident was, "Unfairly put in the middle." SW-N stated the R1 still goes out to the dining room and activities, but, "She is being treated differently in her room." SW-N stated staff feel "threatened" because of the video camera and the facility needed to respect the staff rights to not be videotaped while providing cares. When interviewed on 2/16/16, at 10:40 a.m. the administrator stated administration directed staff to alert the resident she was on camera and possible audio and staff would be turning the video camera towards the wall. However, the administrator stated the previous day staff were directed to turn the video camera off when providing cares instead of asking the resident. The administrator stated this change was made because she was not aware until the previous day the residents life was being affected by staff constantly asking the resident about the camera. The administrator stated staff were originally directed to ask the resident if they could turn the camera when doing cares because they were uncomfortable being on camera. The administrator stated she was aware R1 had signed a notarized consent to the video camera,	2 130		

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2 130	Continued From page 11 however, that was currently being reviewed by the facility's legal team because the residents cognition varied at times and they wanted to ensure the resident understood the consent and that it was an actual legal document. The administrator stated a few weeks ago staff had discussed the consent to electronic monitoring with the resident and she understood at that time. The administrator stated the situation with the video camera had been assessed on a daily basis by multiple staff, however, she was unsure why no one had brought to her attention the effect staff treatment was having on the resident until the previous day, 2/15/17, approximately three weeks after the video camera had been in place. The facility policy titled, Photography and Video Imagining, Patient, Visitor, Workforce Member-Enterprise, revised on 2/3/17, indicated Video monitoring by family/ friends in a patients room must be approved by the bedside nurse. Family/ friends should be informed that the camera or monitor must be focused only on the patient and cannot be placed in a position that captures staff or other patients or activities in the room. Staff may ask the individual to stop taking pictures or recording at any time. The facility policy does not state how the resident's rights will be protected. SUGGESTED METHOD OF CORRECTION: The facility must ensure all staff treat residents in such a manner that does not cause mental anguish. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 130		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights	21850		3/17/17

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21850	Continued From page 12 Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents reviewed, R1, was free from maltreatment after R1 had a video camera installed in her room to feel safe. The facility staff was directed by administration to state the following every time they entered the resident's room to provide care or before all interactions with the resident, "May I turn the camera off while I work with you as it makes me feel uncomfortable." The staff were also directed to tell the resident that if they were not able to turn the camera off they would take the resident to another room to provide care. The use of this constant repeated oral language which would be considered by a reasonable person to be harassing resulted in R1 experiencing emotional distress. R1 was tearful on multiple occasions due to staff constantly asking the resident about turning off the camera. The resident stated she wanted the camera as it	21850		

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21850	Continued From page 13 made her feel safe. R1 stated that the staff significantly decreased their interactions with her. This resulted in actual harm for R1 who experienced emotional distress. Findings include: R1's care plan dated 2/4/17, indicated R1 required total staff assistance with all activities of daily living (ADL's) and assist of one staff with eating. R1 required a total body mechanical lift for all transfers. During observation on 2/14/16, at 6:30 p.m. R1 was in her room laying in bed. On the wall there was a notarized document signed by R1 and family member (FM)-D titled, Consent To Electronic Monitoring. The consent indicated R1 had given consent to placement of the video camera in her room, and indicated, "I ask that staff members respect my consent to placement of the device and not talk to me about the device, tamper with the device, remove the device, or pressure me to turn off the device. The device is being used to better understand my care and to prevent maltreatment of me by staff and others." During observation of R1's room, there was a small plastic daisy sitting on a small end table in front of the residents bed which contained a video camera in the center of the flower. R1's Progress Notes indicated on 2/1/17, at 3:50 p.m. staff had spoken with FM-D who stated a video camera was put into R1's room to protect the resident. R1 had signed a notarized consent for the video camera and the paper was hanging in R1's room. R1's Progress Note dated 2/4/17, at 10:30 a.m. indicated R1, "Was very tearful. RN [registered	21850		

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21850	Continued From page 14 nurse] wiped tears with cool cloth and asked why she was so upset. Resident stated that she felt staff were upset with her because of the camera. RN assured her this was not the case. Staff are concerned for her and feel uncomfortable performing cares with a video recording. No one is angry with the resident. Resident feels interactions have lessened because of the video camera." The progress note also indicated the resident, "Said this is her home and the camera has changed how it feels here. She began to cry again. RN explained that if the time comes that she is too distressed about the camera, staff RN may ask permission, on camera, to permanently disable it. Unplug it, remove batteries." R1's Progress Note dated 2/7/17, at 11:12 a.m. indicated the nurse was completing a mood and mental evaluation on R1 and the resident started crying and stated, "People treat her differently because of the camera in her room." R1's Progress Note dated 2/8/17, at 1:30 p.m. indicated FM-D called the facility and requested staff put a tissue over the video camera instead of turning the camera because when staff turn the camera it is not always turned back in the right position. The Progress Note indicated the nurse called the director of nursing (DON) regarding FM-D's request to put a tissue over the camera, and the DON instructed, "The lawyer said to turn the camera so we need to stick to what they say." R1's Progress Note dated 2/14/17, at 8:31 p.m. indicated, "Prior to HS [hour of sleep] cares and assessment, staff asked resident if she wanted the camera covered and she stated yes 'no peeking.' Camera covered with red hanky while resident was exposed."	21850		

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21850	Continued From page 15 R1's current Nursing Assistant care sheet (what the nursing assistants use to know specific cares on residents) dated 2/10/17, indicated R1 "Loves to visit with staff." During observation on 2/14/17, at 7:00 p.m. four handwritten pieces of paper were hung up behind the nurses station on R1's unit. The handwritten paper directed staff when going into R1's room to ask the following questions. "May I turn the camera off while I work with you as it makes me uncomfortable?" If the resident said yes staff were directed to turn the camera off. If the resident responded no, staff were directed to respond, "Then I would like to do your cares in another area." Staff were directed to, "Document EVERY time you ask this question and what you get for a response." The other papers were titled R1's data collection for the camera, and contained boxes which were titled, quote what you asked R1, time, what was R1's response to what you ask, and action taken. Some of the data collection included: 2/1/17, at 4:45 p.m.- Staff stated to R1, "I don't consent to the camera you might have consented to the camera but I don't. I stated I can't turn it off [the camera] because of the papers in her room [the consent]." The resident response was documented as, "She stated then turn it off." 2/2/17, at 3:30 p.m.- "Asked to turn off camera. Refused and said we were the first people to ask to turn it off." The next entry was made at 4:12 p.m. on 2/2/17, which indicated, "Resident didn't want the camera off or to go to another room but agreed to turn the camera." The resident response was, "Agreed to have RN [registered nurse] in the room and could turn camera around." 2/6/17, at 5:55 p.m.- Staff asked the resident if they could cover the camera up. R1's response	21850		

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21850	Continued From page 16	21850		

was documented as, "You're the only one who asks that you know. If you don't like it open your own place. That's what they tell you to say." The action taken was staff responding to R1, "Well, it makes me uncomfortable." Staff proceeded to do cares with the camera covered.
2/9/17, at 4:30 p.m.- "Is it okay if I turn the camera, I feel uncomfortable." The resident requested staff use the red handkerchief to cover the camera.

A hospital progress note dated 2/6/17, indicated R1 was ill in November 2016, December 2016, and early January 2017, with a chronic infection. At that time she was unable to make any medical or legal decisions, however, she was now alert and orientated and it appeared the confusion and delirium had resolved.

When interviewed on 2/14/17, at 6:45 p.m. FM-D stated since R1 had the video camera in her room, staff treated the resident differently. FM-D stated R1 liked to joke and laugh with the staff, however, since placement of the video camera staff only focused on the camera in the room, and avoid conversation and entering R1's room.
FM-D stated R1 was upset about being treated differently and did not like being questioned about the camera every time staff came into her room.
FM-D stated R1 had signed a notarized consent and talked to multiple staff and told them she agrees with the video camera in her room but staff would not stop asking. FM-D stated she had requested the facility not turn the camera to the side, or shut it off, because it is not put back in the correct position after cares are complete.
FM-D brought in a red handkerchief to cover the camera when staff are providing cares to R1 to ensure the residents privacy, however, most of the time staff just turn the camera and will not use

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21850	Continued From page 17 the handkerchief. When interviewed on 2/14/17, at 7:05 p.m. licensed practical nurse (LPN)-M stated the video camera was discovered hidden in R1's room about a month ago. About a week after the camera was found, the daisy video camera was placed by family on R1's end table in her room. LPN-M stated staff were initially instructed to turn the video camera off while in R1's room, and then a few weeks ago it changed to just turning the camera away from the resident and point it towards the wall. LPN-D stated FM-D had requested staff to just cover the camera instead of moving it or turning it off, but staff were directed by administration to turn the camera or shut if off. LPN-M stated she was aware R1 was upset and the resident had cried about the video camera. LPN-M stated R1, "Was in a difficult spot; we [staff] want it off; [FM-D] wants it on- the resident is in between." Administration told staff they had a right not to be videotaped, and LPN-M stated staff were confused because they didn't know if they should be turning the camera, shutting it off, or covering it up. When interviewed on 2/14/17, at 7:30 p.m. Nursing assistant (NA)-E stated she was directed about two weeks ago to cover the camera when providing cares to R1. NA-E stated R1 gets "annoyed" with staff when they ask about the camera and often responds, "Yes! You know you can cover it!" NA-E stated when she goes into R1's room she says to the resident, "Can I cover it [video camera] because we don't want to be taped during cares." NA-E stated this was the instruction provided by administration to staff. During interview on 2/14/17, at 7:45 a.m. NA-F stated the video camera in R1's room was,	21850		

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21850	Continued From page 18 "Causing a lot of commotion." NA-F stated there were NA's in the facility who did not want to provide cares to R1 and "steer clear" of R1's room. NA-F stated she tells R1 she is uncomfortable doing cares with the video camera and turns it towards the wall as she had been directed by administration. NA-F stated R1 was cognitively intact and, "This is too hard on the resident; we tell her every time we do cares we are uncomfortable with the camera." During interview on 2/15/17, at 8:50 a.m. director of nursing stated the facility policy did not allow any videotaping and staff had the right not to be videotaped. DON stated for staff protection they had been instructed to ask the resident about turning off the video camera every time they do cares. DON stated she was aware R1 felt staff didn't come around as much to talk with her since the video camera was in place. DON stated staff were directed to ask the resident to turn the video camera off, and if resident refused, they would take the resident to another room to provide cares. DON stated administration was aware of the notarized consent for the video camera signed by R1, however, the facility is currently having it reviewed to ensure it is a legal document. DON stated R1 was "Caught in the middle," between having the video camera in her room, and staff not wanting the video camera in the room. During interview on 2/15/17, at 9:50 a.m. R1 stated she has told "everyone" she is fine with the video camera in her room. R1 stated when staff ask her about the video camera she tells them to do what they want, "I am sick of it- I don't want to keep being asked!" R1 stated staff treat her differently because of the video camera and they are, "Cold; staff ignore me; they don't like the	21850		

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21850	Continued From page 19 camera." R1 stated staff don't stay in her room and joke and talk with her anymore, and before staff were even all the way in her room and knew what she wanted, they were asking to turn the video camera off. R1 stated the video camera made her feel safe. R1 stated a couple weeks ago one of the nurses was, "In my face all morning long about the damn camera." R1 stated she finally responded to the nurse to either turn the camera off or get rid of it. R1 stated she talks and talks about the camera and says it is okay, however, staff continue to ask about it all day, everyday. R1 stated, "It pisses me off," when staff constantly talked about the camera because, "They [staff] know the routine!" During a follow up interview on 2/15/17, at 10:40 a.m. DON stated she had just spoke with R1 and the resident wanted the video camera in her room, and staff would now just tell R1 they would be turning the camera off when doing cares instead of asking the resident every time. DON stated they were going to make this change so staff don't have to ask R1 about the camera constantly, but she will still have a chance to give input. During interview on 2/15/17, at 11:00 a.m. NA-G stated she had been directed by administration to ask R1 to turn the camera off because she was uncomfortable with it on, and if the resident refused staff should take her to another room and provide cares. NA-G stated R1 was teary and told her she was sad because she felt staff treat her differently when they go into her room. NA-G stated she was aware some of the newer staff were nervous about going into R1's room with the video camera. When interviewed on 2/15/17, at 11:15 a.m. NA-H	21850		

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21850	Continued From page 20 stated when she goes into R1's room she asks the resident to turn the camera and, "Turns it no matter what." When interviewed on 2/15/17, at 11:30 a.m. NA-I stated when she provided cares to R1 she tells the resident she is not comfortable providing cares with the video camera on and she turns the camera towards the wall. NA-I stated when R1 asked her to cover the camera with the handkerchief instead of turning it towards the wall she told the resident she was directed by administration to turn the camera and not cover it. NA-I stated R1 told her in the past she didn't want to deal with talking about the camera everyday. When interviewed on 2/15/17, at 11:50 a.m. LPN-J stated staff were directed by administration that staff had a right to not be videotaped and were directed to tell the resident staff were uncomfortable with the camera on and they would be turning it towards the wall. LPN-J stated R1 told her she feels she was treated differently by staff because of the video camera in her room as staff does not joke and play around with her like they used to. LPN-J stated she can see staff treating the resident differently because they all have to watch what they say when the video camera is on. LPN-J stated she asked the DON if staff could cover the video camera with the handkerchief but was directed administration wanted the video camera turned towards the wall. When interviewed on 2/15/17, at 12:15 p.m. unit manager (UM)-K stated staff were directed to ask R1 if they could turn the camera for their privacy, and if R1 said no staff would tell the resident they will do cares in another room. UM-K stated she felt the issues with the video camera made R1 more confused and guarded, and, "We have lost	21850		

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21850	Continued From page 21 our joking relationship." UM-K stated staff get nervous with the camera in the room so they do treat the resident different. UM-K stated the video camera made staff uncomfortable, and she was aware she didn't go into R1's room as much as she did prior to the video camera. UM-K stated all the direction staff had been given regarding the camera was directed by administration. When interviewed on 2/15/17, at 1:00 p.m. RN-L stated administration had directed staff to tell R1 they would be turning the video camera while doing cares, and if the resident did not want the video camera turned, staff would need to take the resident to another room to do cares privately. RN-L stated a few weeks ago R1 had refused to have the camera turned and would not go to another room to have cares provided. RN-L stated she spoke with R1 and the resident agreed to allow the camera to be turned if RN-L would stay in the room when the aides were providing cares. When interviewed on 2/16/17, at 9:30 a.m. social worker (SW)-N stated staff were directed to tell R1 they were not comfortable providing cares with the video camera on and ask if they may turn it towards the wall. If the resident refused, staff would bring the resident to another room to provide R1's cares. SW-N stated after the video camera was discovered, the resident had a change in behavior. SW-N was not sure if the change was because of the actual video camera or because of the effects of the camera. SW-N stated recently R1 had refused to talk with her, so the DON was assessing the resident and changes in behavior. SW-N stated the resident had agreed to the camera since the camera had been installed, and she felt the resident was, "Unfairly put in the middle." SW-N stated the R1	21850		

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21850	Continued From page 22 still goes out to the dining room and activities, but, "She is being treated differently in her room." SW-N stated staff feel "threatened" because of the video camera and the facility needed to respect the staff rights to not be videotaped while providing cares. When interviewed on 2/16/16, at 10:40 a.m. the administrator stated administration directed staff to alert the resident she was on camera and possible audio and staff would be turning the video camera towards the wall. However, the administrator stated the previous day staff were directed to turn the video camera off when providing cares instead of asking the resident. The administrator stated this change was made because she was not aware until the previous day the residents life was being affected by staff constantly asking the resident about the camera. The administrator stated staff were originally directed to ask the resident if they could turn the camera when doing cares because they were uncomfortable being on camera. The administrator stated she was aware R1 had signed a notarized consent to the video camera, however, that was currently being reviewed by the facility's legal team because the residents cognition varied at times and they wanted to ensure the resident understood the consent and that it was an actual legal document. The administrator stated a few weeks ago staff had discussed the consent to electronic monitoring with the resident and she understood at that time. The administrator stated the situation with the video camera had been assessed on a daily basis by multiple staff, however, she was unsure why no one had brought to her attention the effect staff treatment was having on the resident until the previous day, 2/15/17, approximately three weeks after the video camera had been in place.	21850		

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21850	Continued From page 23 The facility policy titled, Photography and Video Imagining, Patient, Visitor, Workforce Member-Enterprise, revised on 2/3/17, indicated Video monitoring by family/ friends in a patients room must be approved by the bedside nurse. Family/ friends should be informed that the camera or monitor must be focused only on the patient and cannot be placed in a position that captures staff or other patients or activities in the room. Staff may ask the individual to stop taking pictures or recording at any time. The facility policy does not state how the resident's rights will be protected. SUGGESTED METHOD OF CORRECTION: The facility must ensure the resident is not maltreated during the provision of care. TIME PERIOD FOR CORRECTION: Ten (10) days	21850		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older	21880		3/17/17

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21880	Continued From page 24 Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that 1 of 3 residents reviewed, R1, could exercise her rights as a resident of the facility when she installed a video camera in her private room on 2/1/2017 in order to feel safe. R1 stated after the facility found out about the camera she felt staff treated her differently. As a result of the camera the facility administration directed all staff upon	21880		

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21880	Continued From page 25 entering the resident's room to state, "May I turn the camera off while I work with you as it makes me feel uncomfortable." The staff were also directed to tell the resident that if they were not able to turn the camera off they would take the resident to another room to provide care. This resulted in actual harm for R1 who experienced psychosocial harm related to staff constantly questioning the resident about her right to have a camera in her room. Findings include: R1's care plan dated 2/4/17, indicated R1 required total staff assistance with all activities of daily living (ADL's) and assist of one staff with eating. R1 required a total body mechanical lift for all transfers. During observation on 2/14/16, at 6:30 p.m. R1 was in her room laying in bed. On the wall there was a notarized document signed by R1 and family member (FM)-D titled, Consent To Electronic Monitoring. The consent indicated R1 had given consent to placement of the video camera in her room, and indicated, "I ask that staff members respect my consent to placement of the device and not talk to me about the device, tamper with the device, remove the device, or pressure me to turn off the device. The device is being used to better understand my care and to prevent maltreatment of me by staff and others." During observation of R1's room, there was a small plastic daisy sitting on a small end table in front of the residents bed which contained a video camera in the center of the flower. R1's Progress Notes indicated on 2/1/17, at 3:50 p.m. staff had spoken with FM-D who stated a video camera was put into R1's room to protect	21880		

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21880	Continued From page 26 the resident. R1 had signed a notarized consent for the video camera and the paper was hanging in R1's room. R1's Progress Note dated 2/4/17, at 10:30 a.m. indicated R1, "Was very tearful. RN [registered nurse] wiped tears with cool cloth and asked why she was so upset. Resident stated that she felt staff were upset with her because of the camera. RN assured her this was not the case. Staff are concerned for her and feel uncomfortable performing cares with a video recording. No one is angry with the resident. Resident feels interactions have lessened because of the video camera." The progress note also indicated the resident, "Said this is her home and the camera has changed how it feels here. She began to cry again. RN explained that if the time comes that she is too distressed about the camera, staff RN may ask permission, on camera, to permanently disable it. Unplug it, remove batteries." R1's Progress Note dated 2/7/17, at 11:12 a.m. indicated the nurse was completing a mood and mental evaluation on R1 and the resident started crying and stated, "People treat her differently because of the camera in her room." R1's Progress Note dated 2/8/17, at 1:30 p.m. indicated FM-D called the facility and requested staff put a tissue over the video camera instead of turning the camera because when staff turn the camera it is not always turned back in the right position. The Progress Note indicated the nurse called the director of nursing (DON) regarding FM-D's request to put a tissue over the camera, and the DON instructed, "The lawyer said to turn the camera so we need to stick to what they say." R1's Progress Note dated 2/14/17, at 8:31 p.m.	21880		

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21880	Continued From page 27 indicated, "Prior to HS [hour of sleep] cares and assessment, staff asked resident if she wanted the camera covered and she stated yes 'no peeking.' Camera covered with red hanky while resident was exposed." R1's current Nursing Assistant care sheet (what the nursing assistants use to know specific cares on residents) dated 2/10/17, indicated R1 "Loves to visit with staff." During observation on 2/14/17, at 7:00 p.m. four handwritten pieces of paper were hung up behind the nurses station on R1's unit. The handwritten paper directed staff when going into R1's room to ask the following questions. "May I turn the camera off while I work with you as it makes me uncomfortable?" If the resident said yes staff were directed to turn the camera off. If the resident responded no, staff were directed to respond, "Then I would like to do your cares in another area." Staff were directed to, "Document EVERY time you ask this question and what you get for a response." The other papers were titled R1's data collection for the camera, and contained boxes which were titled, quote what you asked R1, time, what was R1's response to what you ask, and action taken. Some of the data collection included: 2/1/17, at 4:45 p.m.- Staff stated to R1, "I don't consent to the camera you might have consented to the camera but I don't. I stated I can't turn it off [the camera] because of the papers in her room [the consent]." The resident response was documented as, "She stated then turn it off." 2/2/17, at 3:30 p.m.- "Asked to turn off camera. Refused and said we were the first people to ask to turn it off." The next entry was made at 4:12 p.m. on 2/2/17, which indicated, "Resident didn't want the camera off or to go to another room but	21880		

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21880	Continued From page 28 agreed to turn the camera." The resident response was, "Agreed to have RN [registered nurse] in the room and could turn camera around." 2/6/17, at 5:55 p.m.- Staff asked the resident if they could cover the camera up. R1's response was documented as, "You're the only one who asks that you know. If you don't like it open your own place. That's what they tell you to say." The action taken was staff responding to R1, "Well, it makes me uncomfortable." Staff proceeded to do cares with the camera covered. 2/9/17, at 4:30 p.m.- "Is it okay if I turn the camera, I feel uncomfortable." The resident requested staff use the red handkerchief to cover the camera. A hospital progress note dated 2/6/17, indicated R1 was ill in November 2016, December 2016, and early January 2017, with a chronic infection. At that time she was unable to make any medical or legal decisions, however, she was now alert and orientated and it appeared the confusion and delirium had resolved. When interviewed on 2/14/17, at 6:45 p.m. FM-D stated since R1 had the video camera in her room, staff treated the resident differently. FM-D stated R1 liked to joke and laugh with the staff, however, since placement of the video camera staff only focused on the camera in the room, and avoid conversation and entering R1's room. FM-D stated R1 was upset about being treated differently and did not like being questioned about the camera every time staff came into her room. FM-D stated R1 had signed a notarized consent and talked to multiple staff and told them she agrees with the video camera in her room but staff would not stop asking. FM-D stated she had requested the facility not turn the camera to the	21880		

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21880	Continued From page 29	21880		

side, or shut it off, because it is not put back in the correct position after cares are complete. FM-D brought in a red handkerchief to cover the camera when staff are providing cares to R1 to ensure the residents privacy, however, most of the time staff just turn the camera and will not use the handkerchief.

When interviewed on 2/14/17, at 7:05 p.m. licensed practical nurse (LPN)-M stated the video camera was discovered hidden in R1's room about a month ago. About a week after the camera was found, the daisy video camera was placed by family on R1's end table in her room. LPN-M stated staff were initially instructed to turn the video camera off while in R1's room, and then a few weeks ago it changed to just turning the camera away from the resident and point it towards the wall. LPN-D stated FM-D had requested staff to just cover the camera instead of moving it or turning it off, but staff were directed by administration to turn the camera or shut if off. LPN-M stated she was aware R1 was upset and the resident had cried about the video camera. LPN-M stated R1, "Was in a difficult spot; we [staff] want it off; [FM-D] wants it on- the resident is in between." Administration told staff they had a right not to be videotaped, and LPN-M stated staff were confused because they didn't know if they should be turning the camera, shutting it off, or covering it up.

When interviewed on 2/14/17, at 7:30 p.m. Nursing assistant (NA)-E stated she was directed about two weeks ago to cover the camera when providing cares to R1. NA-E stated R1 gets "annoyed" with staff when they ask about the camera and often responds, "Yes! You know you can cover it!" NA-E stated when she goes into R1's room she says to the resident, "Can I cover

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21880	Continued From page 30 it [video camera] because we don't want to be taped during cares." NA-E stated this was the instruction provided by administration to staff. During interview on 2/14/17, at 7:45 a.m. NA-F stated the video camera in R1's room was, "Causing a lot of commotion." NA-F stated there were NA's in the facility who did not want to provide cares to R1 and "steer clear" of R1's room. NA-F stated she tells R1 she is uncomfortable doing cares with the video camera and turns it towards the wall as she had been directed by administration. NA-F stated R1 was cognitively intact and, "This is too hard on the resident; we tell her every time we do cares we are uncomfortable with the camera." During interview on 2/15/17, at 8:50 a.m. director of nursing stated the facility policy did not allow any videotaping and staff had the right not to be videotaped. DON stated for staff protection they had been instructed to ask the resident about turning off the video camera every time they do cares. DON stated she was aware R1 felt staff didn't come around as much to talk with her since the video camera was in place. DON stated staff were directed to ask the resident to turn the video camera off, and if resident refused, they would take the resident to another room to provide cares. DON stated administration was aware of the notarized consent for the video camera signed by R1, however, the facility is currently having it reviewed to ensure it is a legal document. DON stated R1 was "Caught in the middle," between having the video camera in her room, and staff not wanting the video camera in the room. During interview on 2/15/17, at 9:50 a.m. R1 stated she has told "everyone" she is fine with the	21880		

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21880	Continued From page 31 video camera in her room. R1 stated when staff ask her about the video camera she tells them to do what they want, "I am sick of it- I don't want to keep being asked!" R1 stated staff treat her differently because of the video camera and they are, "Cold; staff ignore me; they don't like the camera." R1 stated staff don't stay in her room and joke and talk with her anymore, and before staff were even all the way in her room and knew what she wanted, they were asking to turn the video camera off. R1 stated the video camera made her feel safe. R1 stated a couple weeks ago one of the nurses was, "In my face all morning long about the damn camera." R1 stated she finally responded to the nurse to either turn the camera off or get rid of it. R1 stated she talks and talks about the camera and says it is okay, however, staff continue to ask about it all day, everyday. R1 stated, "It pisses me off," when staff constantly talked about the camera because, "They [staff] know the routine!" During a follow up interview on 2/15/17, at 10:40 a.m. DON stated she had just spoke with R1 and the resident wanted the video camera in her room, and staff would now just tell R1 they would be turning the camera off when doing cares instead of asking the resident every time. DON stated they were going to make this change so staff don't have to ask R1 about the camera constantly, but she will still have a chance to give input. During interview on 2/15/17, at 11:00 a.m. NA-G stated she had been directed by administration to ask R1 to turn the camera off because she was uncomfortable with it on, and if the resident refused staff should take her to another room and provide cares. NA-G stated R1 was teary and told her she was sad because she felt staff treat	21880		

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21880	Continued From page 32 her differently when they go into her room. NA-G stated she was aware some of the newer staff were nervous about going into R1's room with the video camera. When interviewed on 2/15/17, at 11:15 a.m. NA-H stated when she goes into R1's room she asks the resident to turn the camera and, "Turns it no matter what." When interviewed on 2/15/17, at 11:30 a.m. NA-I stated when she provided cares to R1 she tells the resident she is not comfortable providing cares with the video camera on and she turns the camera towards the wall. NA-I stated when R1 asked her to cover the camera with the handkerchief instead of turning it towards the wall she told the resident she was directed by administration to turn the camera and not cover it. NA-I stated R1 told her in the past she didn't want to deal with talking about the camera everyday. When interviewed on 2/15/17, at 11:50 a.m. LPN-J stated staff were directed by administration that staff had a right to not be videotaped and were directed to tell the resident staff were uncomfortable with the camera on and they would be turning it towards the wall. LPN-J stated R1 told her she feels she was treated differently by staff because of the video camera in her room as staff does not joke and play around with her like they used to. LPN-J stated she can see staff treating the resident differently because they all have to watch what they say when the video camera is on. LPN-J stated she asked the DON if staff could cover the video camera with the handkerchief but was directed administration wanted the video camera turned towards the wall. When interviewed on 2/15/17, at 12:15 p.m. unit	21880		

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21880	Continued From page 33 manager (UM)-K stated staff were directed to ask R1 if they could turn the camera for their privacy, and if R1 said no staff would tell the resident they will do cares in another room. UM-K stated she felt the issues with the video camera made R1 more confused and guarded, and, "We have lost our joking relationship." UM-K stated staff get nervous with the camera in the room so they do treat the resident different. UM-K stated the video camera made staff uncomfortable, and she was aware she didn't go into R1's room as much as she did prior to the video camera. UM-K stated all the direction staff had been given regarding the camera was directed by administration. When interviewed on 2/15/17, at 1:00 p.m. RN-L stated administration had directed staff to tell R1 they would be turning the video camera while doing cares, and if the resident did not want the video camera turned, staff would need to take the resident to another room to do cares privately. RN-L stated a few weeks ago R1 had refused to have the camera turned and would not go to another room to have cares provided. RN-L stated she spoke with R1 and the resident agreed to allow the camera to be turned if RN-L would stay in the room when the aides were providing cares. When interviewed on 2/16/17, at 9:30 a.m. social worker (SW)-N stated staff were directed to tell R1 they were not comfortable providing cares with the video camera on and ask if they may turn it towards the wall. If the resident refused, staff would bring the resident to another room to provide R1's cares. SW-N stated after the video camera was discovered, the resident had a change in behavior. SW-N was not sure if the change was because of the actual video camera or because of the effects of the camera. SW-N	21880		

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	00823	A. BUILDING: _____ B. WING _____	C 02/23/2017

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21880	Continued From page 34 stated recently R1 had refused to talk with her, so the DON was assessing the resident and changes in behavior. SW-N stated the resident had agreed to the camera since the camera had been installed, and she felt the resident was, "Unfairly put in the middle." SW-N stated the R1 still goes out to the dining room and activities, but, "She is being treated differently in her room." SW-N stated staff feel "threatened" because of the video camera and the facility needed to respect the staff rights to not be videotaped while providing cares. When interviewed on 2/16/16, at 10:40 a.m. the administrator stated administration directed staff to alert the resident she was on camera and possible audio and staff would be turning the video camera towards the wall. However, the administrator stated the previous day staff were directed to turn the video camera off when providing cares instead of asking the resident. The administrator stated this change was made because she was not aware until the previous day the residents life was being affected by staff constantly asking the resident about the camera. The administrator stated staff were originally directed to ask the resident if they could turn the camera when doing cares because they were uncomfortable being on camera. The administrator stated she was aware R1 had signed a notarized consent to the video camera, however, that was currently being reviewed by the facility's legal team because the residents cognition varied at times and they wanted to ensure the resident understood the consent and that it was an actual legal document. The administrator stated a few weeks ago staff had discussed the consent to electronic monitoring with the resident and she understood at that time. The administrator stated the situation with the	21880		

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21880	Continued From page 35 video camera had been assessed on a daily basis by multiple staff, however, she was unsure why no one had brought to her attention the effect staff treatment was having on the resident until the previous day, 2/15/17, approximately three weeks after the video camera had been in place. The facility policy titled, Photography and Video Imagining, Patient, Visitor, Workforce Member-Enterprise, revised on 2/3/17, indicated Video monitoring by family/ friends in a patients room must be approved by the bedside nurse. Family/ friends should be informed that the camera or monitor must be focused only on the patient and cannot be placed in a position that captures staff or other patients or activities in the room. Staff may ask the individual to stop taking pictures or recording at any time. The facility policy does not state how the resident's rights will be protected. SUGGESTED METHOD OF CORRECTION: The facility must ensure the resident has the right to exercise their rights without reprisal. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21880		

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{F 000}	INITIAL COMMENTS A Post Certification revisit was conducted on 4/10/17 and 4/11/17, to follow up on deficiencies issued relate to complaint H5039013. Neilson Place is not in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities.	{F 000}		
F 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social	F 156		5/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/16/2017

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

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F 156	Continued From page 1 Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]	F 156		

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F 156	Continued From page 2 (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office	F 156		

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F 156	Continued From page 3 of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.	F 156		

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F 156	Continued From page 4 (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 156		

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F 156	Continued From page 5 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 1 residents reviewed, R1, who requested to have a video camera in her room, was fully informed of the rights and the rules of the facility regarding videotaping. Findings include: R1's quarterly Minimum Data Set (MDS) dated 2/28/17, indicated the resident had moderate cognitive impairment and required extensive	F 156		

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F 156	Continued From page 6 assistance with all activities of daily living. R1's care plan dated 3/2/17 indicated the resident required extensive assistance with all activities of daily living. R1's Progress Notes indicated the following: 2/23/17- Social services called R1's family member (FM)-C to inform her R1's video camera would be unplugged indefinitely per the facility's legal department. Social services notified the unit manager on R1's unit to unplug the camera and to notify staff to make sure the camera stayed unplugged. Staff were directed to stop telling the resident they were unplugging the camera since the camera would already be unplugged. 2/24/17- R1 was told today that the camera was being permanently unplugged. R1, "Smiled and stated okay." 3/9/17- R1's video camera was removed from resident's room and placed in the administrator's office for pick up by FM-C. FM-C had been asked to remove the camera last evening or it would be removed by 9:00 a.m. this morning. 3/10/17- FM-C picked up the video camera from the facility. 4/8/17- R1 had a new video camera in her room that appeared as a small alarm clock. The supervisor was alerted and staff were to continue providing care for the resident as they were before. When interviewed on 4/7/17, at 1:10 p.m. social worker (SW)-D stated she was directed by	F 156		

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F 156	Continued From page 7	F 156		

administration to notify FM-C the video camera was being removed from R1's room as it was against the facility policy. SW-D stated after the video camera was placed in R1's room in January 2017, the facility updated the admission agreement to include notifying residents videotaping was not allowed in the facility. SW-D stated when R1 was admitted the facility rules regarding videotaping was not provided to R1. SW-D was not aware if R1 had ever been provided the facility policy regarding videotaping.

When interviewed on 4/7/17, at 1:40 p.m. Registered nurse (RN)-E stated the admission agreement was updated at the end of February 2017, to include notifying residents the facility did not allow videotaping. RN-E verified R1's admission agreement did not include notifying the resident the facility did not allow videotaping. RN-E stated when R1 placed the video camera in her room in January 2017, the facility did not have a specific policy regarding residents videotaping so a policy was developed at that time.

When interviewed on 4/7/17, at 3:00 p.m. the director of risk management (DRM)-F stated prior to February 2017, there was no specific facility policy regarding videotaping. The current policy was a facility wide policy for the corporation and the nursing home did not have an individual, facility specific policy on videotaping.

When interviewed on 4/10/17, at 2:30 p.m. R1 stated in January 2017, she requested FM-C to put a video camera in her room because it made her feel safe. R1 stated when the video camera was in her room, staff were directed by administration to turn the camera off when providing cares. R1 stated the beginning of

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F 156	Continued From page 8 February 2017, administration told her it was against the facility policy to have video cameras in her resident room and administration unplugged the camera and requested FM-C to come and remove the camera. R1 stated she wanted a video camera in her room. On 4/7/17, FM-C brought the video camera back to the facility per R1's request and placed it on the nightstand in R1's room near the television. R1 stated the video camera was not hooked up to anything and was not actually videotaping. R1 stated she had never seen the facility policy regarding videotaping, she was only told by administration the facility policy did not allow videotaping. A small black box was observed on the resident's nightstand by the television. R1 stated this was the video camera but it was not hooked up. When interviewed on 4/10/17, at 3:00 p.m. the administrator stated the facility policy did not allow videotaping. The administrator was not aware if R1 had been provided the facility policy regarding videotaping. The administrator stated she was made aware R1 had placed a video camera in her room on 4/7/17, although the facility had told R1 video cameras were not allowed in the facility and removed the other video camera in February 2017. The facility had not spoken to R1 or FM-C about the video camera and had an upcoming meeting on 4/11/17. The administrator stated the facility policy regarding videotaping was a blanket policy for all of the corporations and not facility specific. The administrator stated there was no facility specific policy regarding videotaping. The administrator verified the policy, admission agreement, and information being given to R1 regarding videotaping is conflicting.	F 156		

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F 156	Continued From page 9 The facility policy titled Photography and Video Imaging, Patient, Visitor, Workforce Member-Enterprise, dated 2/3/17, indicated video monitoring by family/ friends in a patient's room must be approved by the bedside nurse. Family/ friends should be informed that the camera or monitor must be focused only on the patient and cannot be placed in a position that captures staff or other patients or activities in the room. Staff may ask the individual to stop taking pictures or recording at any time. The facility undated admission agreement indicated, "Photographic, video, and/or audio monitoring is not permitted in this facility where resident personal cares such as activities of daily living are taking place." R1's admission agreement dated 8/31/16, did not include any information regarding facility rules of photographic, video, and/or audio monitoring.	F 156		

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5039013. Neilson Place was found not to be in compliance with state regulations.	{2 000}		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights	21800		

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(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
21800	Continued From page 1 Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 1 residents reviewed, R1, who requested to have a video camera in her room, was fully informed of the rights and the rules of the facility regarding	21800		

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 _____	R-C 04/11/2017

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

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21800	Continued From page 2 videotaping. Findings include: R1's quarterly Minimum Data Set (MDS) dated 2/28/17, indicated the resident had moderate cognitive impairment and required extensive assistance with all activities of daily living. R1's care plan dated 3/2/17 indicated the resident required extensive assistance with all activities of daily living. R1's Progress Notes indicated the following: 2/23/17- Social services called R1's family member (FM)-C to inform her R1's video camera would be unplugged indefinitely per the facility's legal department. Social services notified the unit manager on R1's unit to unplug the camera and to notify staff to make sure the camera stayed unplugged. Staff were directed to stop telling the resident they were unplugging the camera since the camera would already be unplugged. 2/24/17- R1 was told today that the camera was being permanently unplugged. R1, "Smiled and stated okay." 3/9/17- R1's video camera was removed from resident's room and placed in the administrator's office for pick up by FM-C. FM-C had been asked to remove the camera last evening or it would be removed by 9:00 a.m. this morning. 3/10/17- FM-C picked up the video camera from the facility. 4/8/17- R1 had a new video camera in her room that appeared as a small alarm clock. The	21800		

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21800	Continued From page 3 supervisor was alerted and staff were to continue providing care for the resident as they were before. When interviewed on 4/7/17, at 1:10 p.m. social worker (SW)-D stated she was directed by administration to notify FM-C the video camera was being removed from R1's room as it was against the facility policy. SW-D stated after the video camera was placed in R1's room in January 2017, the facility updated the admission agreement to include notifying residents videotaping was not allowed in the facility. SW-D stated when R1 was admitted the facility rules regarding videotaping was not provided to R1. SW-D was not aware if R1 had ever been provided the facility policy regarding videotaping. When interviewed on 4/7/17, at 1:40 p.m. Registered nurse (RN)-E stated the admission agreement was updated at the end of February 2017, to include notifying residents the facility did not allow videotaping. RN-E verified R1's admission agreement did not include notifying the resident the facility did not allow videotaping. RN-E stated when R1 placed the video camera in her room in January 2017, the facility did not have a specific policy regarding residents videotaping so a policy was developed at that time. When interviewed on 4/7/17, at 3:00 p.m. the director of risk management (DRM)-F stated prior to February 2017, there was no specific facility policy regarding videotaping. The current policy was a facility wide policy for the corporation and the nursing home did not have an individual, facility specific policy on videotaping. When interviewed on 4/10/17, at 2:30 p.m. R1 stated in January 2017, she requested FM-C to	21800		

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21800	Continued From page 4 put a video camera in her room because it made her feel safe. R1 stated when the video camera was in her room, staff were directed by administration to turn the camera off when providing cares. R1 stated the beginning of February 2017, administration told her it was against the facility policy to have video cameras in her resident room and administration unplugged the camera and requested FM-C to come and remove the camera. R1 stated she wanted a video camera in her room. On 4/7/17, FM-C brought the video camera back to the facility per R1's request and placed it on the nightstand in R1's room near the television. R1 stated the video camera was not hooked up to anything and was not actually videotaping. R1 stated she had never seen the facility policy regarding videotaping, she was only told by administration the facility policy did not allow videotaping. A small black box was observed on the resident's nightstand by the television. R1 stated this was the video camera but it was not hooked up. When interviewed on 4/10/17, at 3:00 p.m. the administrator stated the facility policy did not allow videotaping. The administrator was not aware if R1 had been provided the facility policy regarding videotaping. The administrator stated she was made aware R1 had placed a video camera in her room on 4/7/17, although the facility had told R1 video cameras were not allowed in the facility and removed the other video camera in February 2017. The facility had not spoken to R1 or FM-C about the video camera and had an upcoming meeting on 4/11/17. The administrator stated the facility policy regarding videotaping was a blanket policy for all of the corporations and not facility specific. The administrator stated there was no facility	21800		

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21800	Continued From page 5 specific policy regarding videotaping. The administrator verified the policy, admission agreement, and information being given to R1 regarding videotaping is conflicting. The facility policy titled Photography and Video Imaging, Patient, Visitor, Workforce Member-Enterprise, dated 2/3/17, indicated video monitoring by family/ friends in a patient's room must be approved by the bedside nurse. Family/ friends should be informed that the camera or monitor must be focused only on the patient and cannot be placed in a position that captures staff or other patients or activities in the room. Staff may ask the individual to stop taking pictures or recording at any time. The facility undated admission agreement indicated, "Photographic, video, and/or audio monitoring is not permitted in this facility where resident personal cares such as activities of daily living are taking place." R1's admission agreement dated 8/31/16, did not include any information regarding facility rules of photographic, video, and/or audio monitoring. SUGGESTED METHOD OF CORRECTION: The facility must ensure the resident is fully informed of their rights and rules of the facility. TIME PERIOD TO CORRECT: Twenty-one (21) days	21800		

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

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 _____	R-C 05/22/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A Post Certification revisit was conducted on 5/22/17, to follow up on deficiencies issued relate to complaint H5039013. Nielson Home is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities.	{F 000}		

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

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5039013. Nielson Place was found in compliance with state regulations.	{2 000}		

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 31, 2017

Mr. Adam Coe, Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

RE: Project Number H5039013

Dear Mr. Coe:

On February 24, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 1, 2017. (42 CFR 488.422)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 23, 2017. (42 CFR 488.417 (b))

Furthermore, this Department made a recommendation to the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Civil money penalty for the deficiency cited at F151 (S/S=G). (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F223 (S/S=G). (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F490 (S/S=G). (42 CFR 488.430 through 488.444)

As we notified you in our letter of February 24, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 23, 2017.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on February 23, 2017 pursuant to an investigation of complaint number H5039013. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 11, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on February 23, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 17,

2017. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on February 23, 2017. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

On May 22, 2017, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on April 11, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 19, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on April 11, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 19, 2017.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

May 22, 2017

Mr. Adam Coe, Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

Re: Complaint Number H5039013

Dear Mr. Coe:

A complaint investigation H5039013 was completed on May 22, 2017. At the time of the investigation, the investigator also assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, found no violations of these rules promulgated under Minnesota Statute section 144.653 and/or Minnesota Statute section 144A.10.

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

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,

Lindsey Krueger, RN
Office of Health Facility Complaints
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4135 Fax: (651) 281-9796

LK/ja

Enclosure(s)