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	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neilson Place	1000 Anne Street Northwest Bemidji, MN 56601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan with person centered interventions for food seeking behaviors for 1 of 3 residents (R1) reviewed for behavioral health needs. Findings include: R1's annual Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included dementia, and type 2 diabetes mellitus with hyperglycemia. Further, MDS revealed R1 had moderately impaired cognition and did not exhibit any behaviors. R1's Progress Notes revealed the following: -On 6/25/24, R1 was seen by staff taking half gallon of milk from the kitchen. Staff spoke with R1 and R1 returned the gallon while saying this is bullshit. -On 6/21/24, R1 had been restless all night and had been out to nursing station numerous times looking for and requesting food. R1 had also made attempts to enter kitchen to sneak food. R1 was offered snacks and redirected when attempts were made to enter kitchen. -On 6/19/24, R1's care plan was reviewed and updated with completed of the MDS. -On 6/17/24, R1 was walking from his room to the kitchen area in his briefs, staff declined to give him snacks. R1 got mad at staff. -On 6/16/24 at 10:17 p.m., R1 went inside the kitchen for the 3rd time, took 2 Boosts, staff spoke with resident and reminded R1 he was not allowed in the kitchen area. R1 ignored staff. -On 6/16/24 at 8:23 p.m., R1 was seen walking out of the kitchen door with 2 chocolate Boosts. -On 6/15/24 at 10:25 p.m., R1 was awake and kept asking staff for snacks. -On 6/14/24 at 9:07 p.m., R1 was observed by staff walk inside the kitchen door and took 3 cups of ice cream. When staff approached R1 he stated he was hungry and needed some snacks. (continued on next page)

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

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	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neilson Place	1000 Anne Street Northwest Bemidji, MN 56601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's care plan dated 6/27/24, indicated R1 had diabetes mellitus and the goal was identified as R1 will have blood glucose ranging between 80-180 and absence of signs of hypoglycemia and hyperglycemia. Interventions included to monitor blood glucose as ordered and monitor for signs of hyperglycemia which included increased appetite. Further, R1's care plan indicated R1 had an alteration in behavioral state which was exhibited by yelling at staff or other residents and making comments about wanting to die. R1's care plan lacked evidence of identifying R1 had behaviors related to food which included eating and drinking excessive amounts, and lacked interventions directing staff what to implement to minimize these behaviors as R1 was at risk due to diagnosis of diabetes. R1's Emergency Department (ED) Provider Notes dated 6/21/24, indicated R1 was evaluated due to hyperkalemia and has had potassium of around 5.8 for a few weeks and was now up to 6.2 and glucose was elevated on morning labs also. R1 was given insulin prior to arrival at the ED. Further, labs revealed normal renal functioning and was noted R1's elevated potassium was almost certainly due to Spironolactone, which R1 takes for history of congestive heart failure. R1 was also noted to be drinking several cans of Boost, which does have a small amount of potassium. Further, history provided by patient and family, who reported R1 had taken 6 protein shakes that morning. Family would take steps to see that R1 does not have access to Boost. On 6/27/24 at 12:08 p.m., family member (FM)-A stated R1 had short term memory deficits and no safety awareness. FM-A stated R1 would break into the cabinets and drink Boosts, syrup, or whatever he could get his hands on. Further, FM-A stated she has spoke with registered nurse (RN)-A multiple times regarding this concern and the impact this behavior had on R1's blood sugars and potassium levels, the concerns were brought up a couple weeks ago at R1's care conference and family requested another care conference on that day, 6/27/24. On 6/27/24 at 12:43 p.m., during an observation an unidentified female nursing staff uses a key to unlock a cabinet in the dining room area, grabs a Boost shake from the cabinet, closes and locks the door again. The unidentified staff then grabs a cup and pours the Boost into the cup with a straw for another resident in the dining room. On 6/27/24 at 3:37p.m, during an observation of the dining room, there was a large metal pull down door to close off the kitchen and all the cabinets appeared to have a lock already installed on the outside of them. There was no visible food, beverages, or fridge visible. On 6/27/24 at 3:42 p.m., nursing assistant (NA)-A stated R1 had impaired cognition and was able to independently ambulate through out the unit without any assistive devices. NA-A stated R1 had exhibited behaviors of stealing food or beverages from the kitchen when staff were not around, and for approximately two months the cabinets had been locked and the kitchen door had just had a keypad installed on that day, 6/27/24, due to R1's behaviors. NA-A stated staff would redirect R1 if they observed R1 in the kitchen but there were no other interventions for R1's behavior at that time. On 6/27/24 at 4:15 p.m., FM-B stated there was a Rice Krispy Treat wrapper and an empty Boost container in his garbage can just a little while ago. FM-B was frustrated and stated she was not sure where R1 was getting the extra snacks. (continued on next page)

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	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neilson Place	1000 Anne Street Northwest Bemidji, MN 56601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 4:58 p.m., RN-B stated R1 was alert and exhibited behaviors of sneaking into the kitchen and taking all the snacks such as a half-gallon of chocolate milk or 6 bottles of Boosts. Further, RN-B stated she would educate R1 related to his blood sugars and potassium levels, visual checks on R1 frequently, as well as staff locked the cabinets and the pull-down kitchen door to help decrease R1 from sneaking snacks. However, RN-B stated R1 will forcefully open the cabinets, and go through the back door of the kitchen, and still have access to the snacks and boosts. Further, RN-B stated RN-A and the director of nursing were aware of R1's behaviors. RN-B stated as of 6/27/24, the back door to the kitchen was now locked with a keypad. On 6/28/24 at 9:55 a.m., licensed practical nurse (LPN)-A stated she noticed R1 does not eat much of his meals but prefers to have snacks and will often ask staff multiple times for different snacks such as chocolate milk or Rice Krispy Treats. LPN-A stated she was not sure what the kitchen has for healthy snack choices for residents who are diabetic and stated as of the last two days the kitchen had been locked in attempt to prevent R1 from obtaining snacks. On 6/28/24 at 10:04 a.m, NA-B stated R1 was independent with activities of daily living (ADLs) and was often forgetful. NA-B stated since admission, R1 had a history of going into the kitchen and taking multiple snacks, and NA-B stated recently R1's behaviors have got worse. NA-B stated staff would attempt to redirect R1 back to his room and staff had moved the snacks and closed the big pulldown door to the kitchen, but R1 figured out to use the back door to obtain the snacks now. Further, NA-B stated depending on the dietary staff working there are different healthier snack options to offer R1. On 6/28/24 at 10:23 a.m., NA-C stated R1 was independent and would often be up in the middle of the night wanting snacks and would go into the kitchen without staff's knowledge and grab cookies Boosts, pop, and unlimited coffee. NA-C stated staff started locking some of the cabinets in the kitchen but now R1 was going through the back kitchen door to obtain the snacks. Further, NA-C stated as of 6/27/24, the back kitchen door was now locked. NA-C stated R1's family was upset regarding R1's behaviors and being able to obtain the snacks without staff's knowledge and have now brought it healthier snack options for R1 to keep in his room. On 6/28/24 at 11:12 a.m., RN-C stated R1 had impaired cognition and was often forgetful. RN-C stated R1 had been going into the kitchen and taking Boosts and was taking a ton of them and his blood sugars were ridiculous. RN-C stated R1 had a history of alcoholism and now was bit into eating sweets. RN-C stated R1 has had these behaviors since admission but over the last three months had increased and staff were directed to lock the main pull-down door to the kitchen but R1 now had been using the back door to the kitchen to obtain the snacks. On 6/28/24 at 11:45 a.m., nurse practitioner (NP)-A stated R1 had cognitive impairments and would exhibit behaviors such as the certain food he was choosing to eat as well as the quantity. Further, NP stated the facility staff were lacking monitoring or restricting R1 to those types of food, especially Boosts, and had been an ongoing issue for 6 or more months. NP-A stated these concerns have been brought to administration multiple times and had not been addressed. NP-A expressed frustration and puts a wrench in treating some of R1's medical concerns he had been experiencing when R1 had access to Boosts and would consume 6 bottles in a quick manner. NP-A stated conversations related to R1's behaviors had been an ongoing discussing with facility management every time NP-A was onsite and had been aware of R1's behaviors months ago and were discussed at interdisciplinary team (IDT) meetings. (continued on next page)

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	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neilson Place	1000 Anne Street Northwest Bemidji, MN 56601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/28/24 at 12:59 p.m., RN-D stated she was furious with management related to R1's behaviors as staff have reported multiple times R1 was going into the kitchen and taking packs of oatmeal cookies, cartons of milk, 12 cups of ice crema at a time, and multiple Boosts. RN-D stated R1 has had a history of this since the day he admitted to the facility approximately a year ago and there had been no other interventions attempted until 6/27/24, when management locked the door to the kitchen. On 7/2/24 at 10:51 a.m., RN-A stated R1 was admitted to the facility following a hospitalization related to a stroke and R1 had cognitive impairment and complications with short term memory. Further, RN-A stated R1 had a history of helping himself to anything in the kitchen that he could find to eat or drink, and staff would close the pull-down kitchen door and lock the cabinets but R1 was still able to get access through the back door of the kitchen. RN-A stated R1's behavior had been occurring since admitting to the facility. Further, RN-A stated as of 7/2/24, registered dietician (RD)-A was now involved and assisting with interventions to manage R1's behaviors. RN-A stated staff would be aware of these behaviors by reviewing R1's care plan and interventions for staff to implement to reduce R1's behaviors would be listed in R1's care plan or the NA's care guide sheets. RN-A confirmed she had failed to update R1's care plan with these behaviors and could not recall interventions that had been attempted to reduce R1's behaviors, as well as the behaviors were not listed on the NA's care guide sheet. RN-A denied knowing of R1's ongoing behaviors despite multiple staff interviews reporting management was aware. At 1:30 p.m., RN-A confirmed she could not locate R1's behavior monitoring sheets for the last couple months. On 7/2/24 at 12:07 p.m., RD-A stated she has been working part time at the facility since December of 2023, and does not attend resident's care conferences. RD-A stated she was first made aware of R1's behaviors related to going into the kitchen and consuming large quantities of food on the morning of 7/2/24. Further, RD-A stated she was blindsided and was not aware of any active concerns and had been scrambling that morning to meet with the dietary team. RD-A then stated she did receive a report from staff related to R1 consuming 6 bottles of Boost last week and these behaviors had been an issue for a long time. In addition, RD-A stated now the kitchen was totally locked. On 7/2/24 at 12:32 p.m., director of nursing (DON) stated she has been the interim DON at the facility since May of 2024, and recently within the last two weeks, became aware of R1's food seeking behaviors. DON reported she was informed by a dietary staff member by email related to his concerns about R1 being able to access the kitchen and helping himself to the food and beverages. DON stated a keypad was implemented on the back door to the kitchen on 6/27/24, and staff were provided a key to be able to access the kitchen when needed. Further, DON stated concerns related to resident would be expected to be discussed in IDT meetings by staff, and DON stated she did not recall R1's name ever being brought up regarding any concerns. Review of facility policy titled Behavioral Causes and Interventions revised 2/22/24, revealed the purpose of the policy was to use an IDT approach to determine probable causes of the behavior and understand the meaning behind the behavior. Further, policy indicated when a nursing home accepts a resident for admission, the facility assumes the responsibility of ensuring the safety and well-being of the resident and it was the facility's responsibility to ensure that all staff were trained and knowledgeable in how to reach and respond appropriately to resident behavior. However, the facility lacked evidence and staff guidance as to how the resident's would be assessed and determining appropriate interventions to prevent or decrease the behaviors, as well as how the determined interventions would be communicated to staff to implement.

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	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neilson Place	1000 Anne Street Northwest Bemidji, MN 56601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on observation, interview, and document review, the facility failed to obtain blood sugar checks and administer insulin timely, as ordered by physician, for 3 of 3 residents (R1, R2,R3) who had a diagnosis of diabetes. Findings include: R1's annual Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included dementia, and type 2 diabetes mellitus with hyperglycemia. R1's Medication Administration History dated 6/1/24 through 6/27/24, indicated physician ordered blood glucose monitoring four times a day which was administered late 5 days. Further, physician order revealed insulin aspart once a morning which was administered late 8 days and Novolog FlexPen per sliding scale before meals and at bedtime which was administered late 9 days. R2's quarterly MDS dated [DATE], indicated R2 had diagnosis of diabetes mellitus. R2's Medication Administration History dated 6/1/24 through 6/27/24, indicated physician ordered blood glucose monitoring before meals and at bedtime which was administered late 11 days. Further, physician order revealed Humalog Insulin per sliding scale before meals which was administered late 18 days. R3's quarterly MDS dated [DATE], indicated R3 had diagnoses which included Alzheimer's disease and diabetes mellitus. R3's Medication Administration History dated 6/1/24 through 6/27/24, indicated physician ordered blood glucose monitoring before meals and at bedtime which was administered late 11 days. Further, physician order revealed Humalog solution per sliding scale before meals and at bedtime which was administered late 18 days. On 6/27/24 at 12:08 p.m., family member (FM)-A stated she requested R1's medical records and noticed from March 2024-until date there were several times where R1's insulin was administered late and not according to physician orders. On 6/27/24 at 4:15 p.m., registered nurse (RN)-B and licensed practical nurse (LPN)-A knock on R1's door and check his blood sugar level which was 192 and administers 8 units of insulin per physician orders. R1 was pleasant and compliant with interaction. On 6/27/24 at 4:58 p.m., RN-B stated insulin was expected to be administered before a resident would eat. (continued on next page)

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	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neilson Place	1000 Anne Street Northwest Bemidji, MN 56601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/28/24 at 7:58 a.m., LPN-A knocked on R1's door and entered room. LPN-A stated she had obtained R1's blood sugar reading at 7:45 a.m., and it was 133 so R1 did not require the sliding scale insulin. LPN-A stated R1 ate his breakfast at 6:30 a.m. that morning. At 9:55 a.m., LPN-A stated blood sugars were expected to be obtained before meals however, she was a little late administering R1's insulin on that day due to computer issues. On 6/28/24 at 11:12 a.m., RN-C stated blood sugars were expected to be obtained 30 minutes prior to a resident eating and then administer the insulin once they are eating. On 6/28/24 at 11:45 a.m., nurse practitioner (NP)-A stated blood sugars were expected to be obtained prior to any oral consumption and if the blood sugars were not obtained prior to the resident eating then the nursing staff would not be treating them appropriate as the blood sugar would not be accurate, and the insulin would not be accurate. Further, NP-A stated staff had reported that R1's insulin was administered late in the mornings and NP-A would ask staff what was planned for the noon meal because R1's blood sugar reading was now inaccurate for the noon meal check due to the morning insulin being administered late. NP-A expressed frustration as now the inaccurate blood sugar reading falls on my plate and NP-A had to gauge how much R1 would eat for the noon meal to ensure enough insulin would be given to cover him because the staff unfortunately did not follow physician orders for timely administration of insulin. Further, NP-A stated RN-A approached her at the facility and stated, just so you know it looks like [R1]'s blood sugar was taken late and NP-A stated RN-A laughs about it. In addition, NP-A stated, we are failing him. On 6/28/24 at 12:59 p.m., RN-D stated she would check resident's blood sugars as soon as possible, first thing in the morning however, if an emergency occurs then RN-A may get to them later than usual. RN-A stated to be honest there had been times I don't get to the blood sugar and insulin administration until 10:00 a.m. Further when asked what the process was for late administration, RN-D stated she had never completed a medication error and was not sure if there was a process to follow. On 7/2/24 at 10:51 a.m., RN-A stated staff were expected to obtain blood sugar readings prior to the resident eating and administering the insulin shortly after. RN-A stated she was aware of times where the blood sugar readings slip through the cracks insulin was administered later than it should have been. RN-A stated staff had not been completing medication errors when that occurs but we should be as completing the medication error would assist the management with tracking and trending. RN-A confirmed she was not aware R1, R2, and R3 had late administrations of insulin per their administration records. On 7/2/24 at 12:32 p.m. director of nursing (DON) stated staff were expected to obtain a blood sugar reading prior to a resident eating and administer the insulin prior to the meal or within 15 minutes of starting to eat the meal. Further, DON stated staff were expected to complete a medication error if the insulin was administered late as well as notifying the resident's physician. DON stated completing a medication error was important for resident's safety especially for insulin as there was a risk for hypoglycemia and hyperglycemia, as well as obtaining guidance from the resident's physician and leadership would be able to identify patterns and trends. (continued on next page)

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	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neilson Place	1000 Anne Street Northwest Bemidji, MN 56601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Medication Errors revised 3/29/24, indicated if a medication error occurs it would be reported promptly to the attending physician, resident and or responsible party and documented. The policy defines medication error as the observed or identifier preparation or administration of medications which was not in accordance with the prescriber's order, manufactures specifications regarding the preparation and administration of the medication. Further, policy identifies wrong time, the failure to administer a medication to a resident within a predefined interval from its scheduled administration time (before meal or after meal), as a type of medication error.