

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER Neilson Place		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569</p> <p>Based on interview and document review the facility failed to follow care planned intervention for the use of a gait belt for 1 of 3 residents (R1) reviewed. This resulted in actual harm when R1 fell while ambulating with staff assistance and sustained bilateral sacral fractures (a break in the bone at the back of the pelvis). The deficient practice was corrected prior to the start of the survey therefore, was issued at past non-compliance.</p> <p>Findings include:</p> <p>R1's Resident Face Sheet identified an admitted [DATE] and a latest return date of 12/16/24. R1's diagnosis included osteoarthritis, age related osteoporosis and impaired mobility.</p> <p>R1's care plan dated 10/25/22, identified a self care deficit due to morbid obesity and pain in right knee. The care plan indicated R1 was not ambulating and chose not to get out of bed and indicated a history of sitting in chair at home and not walking much.</p> <p>R1's annual Minimum Data Set (MDS) dated [DATE], identified intact cognition. The MDS indicated R1 had upper and lower extremity impairments, required substantial to maximal assistance to stand, supervision or touching assistance for transfers and did not ambulate.</p> <p>An untitled care guide dated 12/12/24, indicated R1 required assistance from one staff using a gait belt and walker, following with wheelchair to ambulate.</p> <p>A facility Live Event report dated 12/20/24, indicated on 12/15/24 at 1:40 p.m., R1 fell while ambulating with staff assistance and was sent to the emergency department (ED). Injuries indicated fracture/dislocation. The report indicated R1 was ambulating with a nursing assistant (NA) to her left side and was using a walker. A licensed nurse was behind her with a wheelchair. R1 got to the nurses station desk and reached for a pen, the walker fell forward to the ground and the resident landed on top of it. R1 complained of pain rated 8/10 and was sent to the ED.</p> <p>R1's Resident Progress Notes identified the following:</p> <p>12/15/24, R1 was walking next to the nurses station with NA. R1 reached for a pen on the desk and the walker went forward. R1 fell on top of the walker. The walker was removed from beneath her. R1 complained of hip pain rated 8/10 and was sent to the ED for assessment.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>12/15/24, R1's family member called and updated facility R1 remained in the hospital with a right sacrum fracture and possible left sacrum fracture.</p> <p>R1's hospital Discharge Summary dated 12/16/24, indicated R1 presented to the ED after a fall. fell at facility when her walker got placed away from her and when trying to reach her walker she fell down. Found to have bilateral sacral insufficiency fractures. Orthopedics recommended conservative management, partial weight bearing to her right lower extremity and weight as tolerated as she progresses and pain tolerates.</p> <p>During observation on 12/20/24 at 8:54 a.m., R1 was lying in bed in her room with the lights off.</p> <p>During interview on 12/20/24 at 9:01 a.m., R1 was asked about her fall and said I let go of the walker and then I went. R1 stated at the time of the fall staff had not used a gait belt when assisting her to walk. R1 stated her bottom was sore and she was unable to get up and walk. R1 stated, it hurts and said even turning to the side hurt the one leg.</p> <p>During interview on 12/20/24 at 9:13 a.m., physical therapist (PT)-A stated the purpose of a gait belt was to help with stability and reduce the risk for falls. PT-A stated when using a gait belt, staff were able to support or correct moments of instability or loss of balance and said if a resident leaned too far forward or to the left or right the belt could help prevent a fall.</p> <p>During interview on 12/20/24 at 10:54 a.m., NA-A stated prior to the fall R1 was able to transfer with supervision and was care planned to walk with assistance using a transfer belt and the wheelchair following behind her. NA-A stated since the fall R1 was wanting to stay in bed and not getting up. NA-A was unsure but said it was due to either the pain or the fear of falling. NA-A stated staff had received education on the care plan and use of the gait belts after the incident.</p> <p>During interview on 12/20/24 at 12:19 p.m. NA-B stated she had been walking with R1 in the hallway and had seen two pens on the floor so she had picked them up. NA-B stated R1 reached for one of the pens and fell and landed on top of the walker. NA-B stated she had not used a gait belt when ambulating with R1 and said, I don't know why. NA-B stated she had received education related to use of the gait belt, reviewing the care plan daily and following the care plan.</p> <p>During interview on 12/20/24 at 1:17 p.m., registered nurse (RN)-A stated the day R1 fell , she received a call from staff who reported staff were walking with R1 who reached to grab a pen off the desk and fell forward onto the walker. RN-A stated staff had not been following the care plan intervention to use the gait belt. RN-A stated if the gait belt had been used staff would have been able to grab onto the belt and prevent the fall. RN-A stated care planned interventions were listed on the care plan and stated staff should have been aware. RN-A stated any resident who required and kind of touching assistance required the use of a gait belt.</p> <p>During interview on 12/20/24 at 11:35 a.m. RN-B stated on the day R1 fell she had seen NA-B walking with her in the hall and assisted with pushing the wheelchair behind. RN-A stated she had noticed R1 was wearing a robe and had been shuffling her feet. RN-B stated she did not see R1 reach over for the pen and said all she had seen was the walker. RN-A said R1 flipped over the walker and landed on her back with the walker underneath her. RN-B stated she had not noticed if a gait belt had been used but said unless a resident was independent the staff should know to always use a gait belt.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Facility policy Mobility Support and Positioning dated 5/6/24, indicated unless contraindicated, a gait belt should be used for all residents who require assistance with ambulation. The caregiver should walk in step with the resident holding onto the gait belt with palm up. The purpose of the gait belt is to ensure the caregiver can control the residents center mass if he or she loses their balance.</p> <p>Prior to the start of the survey the facility initiated education related to the transfer belt policy and use of gait belts and completed an audit of care guides to ensure accuracy. The education was verified through interview and document review.</p>		