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	02/25/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569 Based on interview and document review the facility failed to develop and implement care planned interventions to address refusal of cares for 1 of 3 residents (R1) reviewed for deteriorating skin condition. Findings include: R1's Resident Face Sheet indicated he admitted to the facility on [DATE], with diagnosis that included congestive heart failure, hypertension, cellulitis of right lower limb, Esysipelis and mild cognitive impairment. R1's Skin Risk Assessment with Braden Scale dated 11/2/24, indicated he required assistance of a mechanical lift and was frequently incontinent. The assessment identified open lesions on the foot, edema and reduced urinary output. R1's Braden evaluation for risk of skin breakdown indicate he was at risk. R1's care plan dated 11/18/24, identified a self-care deficit due to weakness. The care plan directed staff to encourage participation in grooming and indicated he required substantial assistance for grooming and toileting. The care plan identified incontinence and directed staff to keep skin dry and intact. The toileting plan indicated before and after meals and at bedtime and directed staff to check for incontinence at night with repositioning. The care plan was updated 2/5/25, to include an alteration in behavioral state as evidenced by refusal of cares, choosing to stay in soiled brief, chucks. The care plan directed staff to document refusals of care and re-approach R1 when refused care. R1's Resident Progress Note dated 12/15/24, indicated power of attorney (POA) in this evening. POA reported that R1 would refuse care and sit for days in feces. POA reported if R1 refused care, staff should call and POA would get on phone to have him wash up. R1's Physician Progress Note dated 2/5/25, indicated pubic area rash, appears resident had been incontinent for an extended period. See attached photos. Abrasions, multiple, scattered. Erythema and rash present. Significant maceration to genitals and bilateral posterior upper thighs. The note indicated R1 was started on Amoxicillin 500 milligrams three times daily for seven days with extension if needed. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's discharge Minimum Data Set (MDS) dated [DATE], identified intact cognition and indicated he displayed rejection of care behaviors 1-3 days during the assessment period. The MDS indicated R1 required substantial to maximal assistance for transfers and was dependent on staff for toileting and bathing. During interview on 2/21/25 at 10:50 a.m., POA-A said one time while R1 was at the facility he sat in the same soiled incontinent brief for at least 48 hours. POA-A said she had told staff to call if R1 was non-compliant, but no one ever called. POA-A stated a few days before they took R1 home the smell was so bad coming down the hall they decided to take R2 home out of the facility. POA-A stated there was a concern for bed sores and said R1's buttocks was purple, like leather and had multiple wounds on it. During interview on 2/21/25 at 2:18 p.m., registered nurse (RN)-B stated R1 did not like to use a urinal and would urinate in a cup. RN-B said it was hit or miss whether he would allow treatments to be done or not. RN-B said when R1 was incontinent, staff tried to change him, but he would say no. RN-B said staff should have re-approached R1 or let a nurse know if he refused and said, part of the time they did. Regarding calling the POA for assistance, RN-B stated, I honestly can't say we did, but was not sure why. RN-B stated the care plan was updated on 2/5/25, because she had not realized the refusal of cares were not on the care plan. During interview on 2/21/25 at 3:52 p.m., Nursing assistant (NA)-A stated she would offer cares to R1 but said he did not want her to provide care. NA-A stated she helped with R1's care here and there. NA-A said almost every time she arrived to work her shift, R1 was wet and/or soiled and said there was a very strong odor in the hall that bothered other residents. NA-A stated staff never received any interventions related to refusals until R1 was scheduled to discharge. During interview on 2/21/24 at 4:00 p.m. RN-A stated R1 had been very hard to deal with at times and stated he had behaviors in which he would yell and scream and kick staff out of his room. RN-A stated she had only worked with R1 a couple times and said he could be very nice. RN-A said only certain staff were able to get R1 to stand up and get cleaned up. RN-A said if R1 had been refusing cares staff would get her but said it did not work. RN-A stated she was unaware R1's POA's could be called if he refused cares. During interview on 2/25/25 at approximately 2:00 p.m. the interim director of nursing (as of 2/25/25) stated the facility tried to acknowledge resident preferences but said if refusals put a resident at risk, interventions should have been implemented along with physician notification. Facility policy Care Plan dated 12/2/24, indicated each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident ' s optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Any problems, needs and concerns identified will be addressed through use of departmental assessments, the Resident Assessment Instrument (RAI) and review of the physician ' s orders.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569 Based on interview and document review the facility failed to ensure toileting and hygiene tasks were performed for 1 of 3 (R1) residents reviewed resulting in worsening skin condition that required physician ordered treatment. Findings include: R1's Resident Face Sheet indicated he admitted to the facility on [DATE], with diagnosis that included congestive heart failure, hypertension, cellulitis of right lower limb, Esysipelis and mild cognitive impairment. R1's Skin Risk Assessment with Braden Scale dated 11/2/24, indicated he required assistance of a mechanical lift and was frequently incontinent. The assessment identified open lesions on the foot, edema and reduced urinary output. R1's Braden evaluation for risk of skin breakdown indicate he was at risk. R1's care plan dated 11/18/24, identified a self-care deficit due to weakness. the care plan directed staff to encourage participation in grooming and indicated he required substantial assistance for grooming and toileting. The care plan identified incontinence and directed staff to keep skin dry and intact. The toileting plan indicated before and after meals and at bedtime and directed staff to check for incontinence at night with repositioning. Alteration in behavioral state as evidenced by refusal of cares and choosing to stay in soiled brief, chucks was added 2/5/25. R1's Point of Care History dated 1/5/25 through 2/5/25, identified rejection of care behavior four times over a period of 30 days/ 90 shifts: 1/27/25, 1/29/25, 2/1/25 and 2/5/25. R1's Physician Progress Note dated 2/5/25, indicated pubic area rash, appears resident had been incontinent for an extended period. See attached photos. Abrasions, multiple, scattered. Erythema and rash present. Significant maceration to genitals and bilateral posterior upper thighs. The note indicated R1 was started on Amoxicillin 500 milligrams three times daily for seven days with extension if needed. R1's discharge Minimum Data Set (MDS) dated [DATE], identified intact cognition and indicated he displayed rejection of care behaviors 1-3 days during the assessment period. The MDS indicated R1 required substantial to maximal assistance for transfers and was dependent on staff for toileting and bathing. During interview on 2/21/25 at 10:50 a.m., power of attorney (POA)-A stated R1 had a number of visitors, and a few times had received complaints from his friends. POA-A said one-time R1 sat in the same soiled incontinent brief for at least 48 hours. POA-A said she had told staff to call if R1 was non-compliant, but no one ever called. POA-A stated a few days before they took R1 home the smell was so bad coming down the hall they decided to take home out of the facility. POA-A stated there was a concern for bed sores and said R1's buttocks was purple, like leather and had multiple wounds on it. POA-A stated she brought R1 a planner to write things down every day because staff contradicted everything, he told them and was getting paranoid. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During Interview on 2/21/25 at 11:17 a.m., POA-B stated R1 was known to be non-complaint with care but said I do believe some staff didn't care. POA-B stated R1's room stunk like body odor and yeast and said R1 would urinate in a plastic cup and put it into a urinal. POA-B said R1 was not always the most helpful patient. POA-B said when R1 discharged , most of his groin and thighs were a red, irritated mess, really red and irritated. POA-B said when R1 was at the facility, if the door to his room was open, he could smell him coming down the hall and said it was not out of the ordinary to find R1 sitting in an incontinent brief in his own feces. POA-B further said he told staff if R1 was not compliant to call. During interview on 2/21/25 at 1:36 p.m., an anonymous staff member stated had never had a problem with R1 refusing cares and stated had a hard time believing R1 would adamantly refuse care. Anonymous staff member stated instead of completing cares and treatment staff would just mark that he refused. The staff member stated there were nursing assistant (NA)'s that would not go check on R1 and said one day R1 sat in a wet brief and chair until approximately 10:00 p.m. and a second time R1 was still sitting in a urine soaked brief at 3:30 p.m., even though staff had been asked to provide care at 1:30 p.m. During interview on 2/21/25 at 2:18 p.m., registered nurse (RN)-B stated R1 did not like to use a urinal and would urinate in a cup. RN-B said it was hit or miss whether he would allow treatments to be done or not. RN-B said when R1 was incontinent, staff tried to change him, but he would say no. RN-B said staff should have re-approached R1 or let a nurse know if he refused and said, part of the time they did. Regarding calling the POA for assistance, RN-B stated, I honestly can't say we did, but was not sure why. RN-B stated she had observed the odor coming from R1's room when the door was open but said, he was okay with the door being closed. RN-B stated on 2/5/25, the provider told her she need to come to R1's room and after getting him up, the provider took photos and left the room. RN-B stated R1 had redness in his groin and on his upper thighs and had stool between his butt cheeks. RN-B said the brief was definitely wet along with the chucks and the chair underneath. RN- B stated she had not seen R1's skin prior to that. RN-B further stated the provider seemed upset. During interview on 2/21/25 at 3:08 p.m., nursing assistant (NA)-C stated she had never had any trouble getting R1 to wash up. NA-C stated R1 would holler and was cantankerous but said she would re-approach him and explain she needed to provide cares he would allow it. NA-C stated frequently when she started her shift, she would find R1 saturated and said you could wring out his brief. NA-C stated some of the staff just did not go in an offer to help him because they did not want to deal with him. NA-C stated before R1 discharged she saw his skin and said, oh my word. During interview on 2/21/25 at 3:52 p.m., NA-A stated R1 required a stand lift to do cares and never wanted to get up and go to the dining room. NA-A stated she would offer cares to R1 but said he was not a fan of her. NA-A said she stayed away from R1 after an incident when she brought him disposable cups because he would urinate in them and R1 grabbed onto her shirt and yelled at her. NA-A stated she helped with R1's care here and there and said R1 was kind of icky. NA-A said R1 hardly ever kept a brief on and sat with a sheet over him. NA-A said staff would come in and find R1 wet and soiled and while cleaning him, he would start urinating. NA-A said she fully believed R1 had some control and thought maybe it was done on purpose. NA-A said almost every time she arrived to work her shift, R1 was wet and/or soiled and said there was a very strong odor in the hall that bothered other residents. NA-A stated staff never received any interventions related to refusals until R1 was scheduled to discharge. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/21/24 at 4:00 p.m. RN-A stated R1 had been very hard to deal with at times and stated he had behaviors in which he would yell and scream and kick staff out of his room. RN-A said R1 had been sexually inappropriate and said NAs told her he was looking at their butts and down their shirts and would masturbate while they were in the room. RN-A stated she had only worked with R1 a couple times and said he could be very nice. RN-A said only certain staff were able to get R1 to stand up and get cleaned up. RN-A said if R1 had been refusing cares staff would get her but said it did not work. RN-A stated she was unaware R1's POA's could be called if needed. RN-A further stated other residents were complaining of the smell in the hallway and said it was horrendous. During interview on 2/25/25 at 11:19 a.m., R1 stated he felt his care at the facility had been satisfactory but said when it came to keeping him clean, he did not get the help he needed. R1 said he needed the assistance of a machine to stand and when he asked staff for assistance, by the time they came back he had already soiled himself. R1 stated he did not refuse care and said when staff came to assist him, he said yes, but said they took 2-3 hours to come back. R1 said regarding bathing, staff would ask him after supper and he would agree, then no one would return until around 10:00 p.m. R1 said staff did not offer or provide cares every two hours as directed by the plan of care. During interview on 2/25/25 at 11:52 a.m., anonymous resident (AR)- A stated oof-[NAME], the smell coming down the hallway. AR- A stated it went on for weeks and said it smelled like R1 was rotting. AR said staff told him R1 was the cause of the smell and told him R1 did not shower. AR-A sated the smell was offensive. During interview on 2/25/25 at 11:57 a.m., AR-B stated there used to be a resident at the end of the hall who lived in his recliner, pooped in it, and said the stink coming out of the room was unbearable. AR-B said his room was next door. AR-B stated he told R1 to keep his door shut and said the smell was so bad he would almost gag. AR-B said the NA's told him what had been happening. During interview on 2/25/25 at 1:10 p.m., NA-B said R1 never asked for anything other than breakfast and lunch. NA-B stated right before R1 discharged she took care of him and said she asked two other staff to assist her and said that was the only time she had ever seen staff change R1. NA-B said she had never heard R1 tell staff no and said staff just had not gone in and checked on him. During interview on 2/25/25 at 1:17 p.m., photos of R1's skin dated 2/25/25, were observed with RN-B. RN-B described R1's skin as follows: Lower abdomen, groin and inner thigh were red from moisture. Buttocks impacted stool in rectum, redness from moisture and pressure of sitting covering both buttocks from upper thighs to just above his knees. RN-B stated staff had not reported the condition of R1's skin to her. During interview on 2/25/25 at approximately 2:00 p.m. the interim director of nursing (as of 2/25/25) stated the facility tried to acknowledge resident preferences but said if refusals put a resident at risk, interventions should have been implemented along with physician notification. Facility policy Refusal of Treatment, Right to Choose dated 10/15/24, indicated refusal of treatment will be documented consistently in the medical record and will be countered by discussion with the resident regarding the health and safety consequences of the refusal and the availability of any therapeutic alternatives that may exist. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When a resident chooses not to follow treatment which is prescribed by the physician or a member of the healthcare team, appropriate employees should attempt to determine why the resident is making this choice. Inform the resident about the health risk/benefit and safety consequences, as well as the availability of other existing therapeutic alternatives. Inform the resident ' s physician of the resident ' s choice. If the physician changes an order to align with the resident ' s desire, employees are to comply with the new order. However, if the physician is not able to change the order to align with the resident ' s wishes, employees should continue to offer the treatment as ordered and document all attempts.