

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 07/02/2025
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)		
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. (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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure respect and dignity for 1 of 3 residents (R1) reviewed when her personal power chair was removed from her room and use without her consent. Findings include: R1's admission Record indicated she admitted to the facility on [DATE]. Diagnosis included diabetes, arthritis, right above the knee amputation, post-traumatic stress disorder, depression and anxiety. R1's significant change Minimum Data Set (MDS) dated [DATE], identified intact cognition and indicated she displayed no behaviors during the assessment period. The MDS indicated R1 was independent with dressing, personal hygiene and transfers and did not ambulate. R1's care plan dated 5/9/25, indicated she had a history of utilizing her motorized wheelchair off campus. The care plan identified the following approaches: 1. R1 will notify staff when leaving facility and expected return time. 2. R1 will utilize safety features when using wheelchair: Flag, seat belt, horn , reflectors. 3. Staff to assist R1 to get in wheelchair. 4. Staff to assist R1 in charging wheelchair. 5. R1 will not leave facility without battery fully charged. 6. If Resident had a change in condition facility would reevaluate R1's ability to safely operate wheelchair. 7. R1 will operate wheelchair in low speed only. 8. If R1 utilized wheelchair in an unsafe or reckless manor or under the influence of any alcohol or non-prescription drugs the facility had ability to prohibit the use of the wheelchair in facility and campus.R1's Progress Notes indicated the following:-5/8/25, R1 told staff that she had a dentist appointment and she was planning on taking her wheelchair over so staff could cancel Medivan. Staff did not have appointment on the calendar for R1 and therefore no medivan had been set up. R1 was informed of this and that she had not been assessed to take her wheelchair outside of the facility. R1 went to therapy to ask about it and administrator, therapy staff and writer attempted to talk to R1 about concerns and safety of crossing a busy highway with a new chair. R1 stated that she didn't have battery issues and it was a new wheelchair so there should be no issues. She was informed that there still could be issues. Staff also brought up concerns about the lack of shoulder on the road and how she would deal with it if she got herself in a position where she tipped the wheel chair. Resident again stated she didn't think that would happen as she wasn't stupid and would not get herself in that situation. Staff attempted to explain to R1 that we had concerns for safety. She stated she had taken it to the store the previous day and didn't have issues. When asked what store she just stated, the store. R1 felt that staff was just trying to be controlling. R1 did relent to taking medivan to appointment but staff received a call from Medivan that she had not stayed for pickup. R1 was already back at the facility at that time. Therapy has now said that R1 was safe outside of building on facility grounds.5/13/25, Writer received a call from unit nurse at 7:00 p.m. reporting that R1 had not returned from 1:00 p.m. appointment. Nurse reported R1 took medivan to appointment with her electric wheelchair and stated there was no indication or communication that she was going elsewhere after her appointment. Directed staff to attempt to reach R1 via number listed on her face sheet. Writer arrived at facility, confirmed R1 was not on the campus, confirmed location of her appointment, and called police department. A different staff member called to report resident was spotted in town south of facility and that resident reported to staff she was headed back to facility. 5/14/25, While R1 was out of the building for a procedure, management team discussed issues they were having with R1. Since receiving her electric scooter, R1 had been leaving the facility without letting staff know and had left appointment before transportation arrived to pick her up. The previous day R1 had not returned after an appointment. Staff had located her and she did return. After review it was decided to remove R1's electric scooter. During interview on 7/1/25 at 10:44 a.m., the interim DON stated he had only been at the facility for three weeks and said he was familiar with the situation. The DON said R1 was appropriate for independent living with services and the facility was actively working on it. In regard to the removal of R1's power chair, the DON said he would rather have a rights violation than have her out over dosing or getting hit by a bus. During observation and interview on 7/1/25 at 11:08 a.m., R1 was lying in bed watching television. There was a manual wheelchair next to her bed. R1 said the facility had taken her scooter away on May 15th while she was out of the facility for a medical procedure. R1 said she had gone to visit her kids and had taken the bus there and took her wheelchair back to the facility. R1 said she used the cross walks, pushed the buttons and did everything safe the way she should have. R1 said the facility told her they took her chair away because she hadn't signed out. R1 said she had not had any accidents with the scooter and said she had passed the facility driving test. During interview on 7/1/25 at 2:38 p.m. RN-R stated the previous DON, administrator and corporate staff</p>		

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F 0603 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). (continued on next page)		

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F 0603 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure 1 of 3 residents (R1) reviewed for use of electric wheelchairs in the community was free from involuntary seclusion. This resulted in actual psychosocial harm for R1 when the facility took away her personal mobile equipment (power wheelchair), which restricted R1's access to her community (including family), causing increased depressive symptoms, isolation and withdrawal from usual activities. Findings include: R1's admission Record indicated she admitted to the facility on [DATE]. Diagnosis included diabetes, arthritis, right above the knee amputation, post-traumatic stress disorder, depression and anxiety. R1's significant change Minimum Data Set (MDS) dated [DATE], identified intact cognition and indicated she displayed no behaviors during the assessment period. The MDS indicated R1 was independent with transfers. 4/8/25, PHQ-9 (patient health questionnaire) assessment (a self-report tool used to assess the severity of depression) score was 11 which indicated moderate depression. 6/27/25, PHQ-9 score was 16 which indicated moderate to moderately severe depression. R1's care plan dated 5/9/25, indicated she had a history of utilizing her motorized wheelchair off campus. The care plan identified the following approaches:1. R1 will notify staff when leaving facility and expected return time.2. R1 will utilize safety features when using wheelchair: Flag, seat belt, horn, reflectors. 3. Staff to assist R1 to get in wheelchair.4. Staff to assist R1 in charging wheelchair.5. R1 will not leave facility without battery fully charged.6. If Resident had a change in condition facility would reevaluate R1's ability to safely operate wheelchair.7. R1 will operate wheelchair in low speed only.8. If R1 utilized wheelchair in an unsafe or reckless manor or under the influence of any alcohol or non-prescription drugs the facility had ability to prohibit the use of the wheelchair in facility and campus. R1's Progress Notes indicated the following:-4/30/25, Occupation therapy note: R1 received her power wheelchair this date and demonstrated ability to transfer from manual chair to power chair, power chair to toilet and power chair to bed. R1 demonstrated appropriate use of controls. At this time R1 was instructed to keep the speed set at level one. R1 demonstrated ability to maneuver the wheelchair in her room, bathroom, up to table, in hallway, on/off elevator and with use of elevator controls. R1 used dressing stick to aid with getting the leg rest out of the way. R1 had a sensor system on the wheelchair which alerted her if she came too close to an object (due her limited neck range of motion). Plan to further assess R1 outdoors, R1 was instructed to only use the power wheelchair indoors at this time, until outdoor assessment and recommendations could be completed. -5/8/25. R1 told staff that she had a dentist appointment and she was planning on taking her wheelchair over so staff could cancel Medivan. Staff did not have appointment on the calendar for R1 and therefore no Medivan was set up. R1 was informed of this and that she had not been assessed to take her wheelchair outside of the facility. Resident then went down to therapy to ask about this. Administrator, therapy staff and writer attempted to talk to R1 about concerns and safety of crossing a busy highway with a new chair. R1 stated that she didn't have battery issues, and it was a new wheelchair so there should be no issues. She was informed that there still could be issues. Staff also brought up concerns about the lack of shoulder on the road and how she would deal with it if she got herself in a position where she tipped the wheelchair. Resident again stated she didn't think that would happen as she wasn't stupid and would not get herself in that situation. Staff attempted to explain to resident that we had concerns for safety. She stated she had taken it to the store the previous day and didn't have issues. When asked what store she just stated, the store. R1 felt the facility was just trying to be controlling. Resident did relent to taking Medivan to appointment, but later facility received a call from Medivan that she had not stayed for pickup. R1 was already back at the facility at that time. Therapy has now said that R1 was safe outside of building on facility grounds. -5/9/24, Writer and registered nurse (RN)-A reviewed R1's care plan with her regarding use of electric chair. It was read to her, she signed care plan and stated she understood what was read to her. -5/13/25, R1 left at 1:00 p.m. for appointment via Medivan to go to behavior health and had not returned. Attempted to call personal cell phone. R1 did not answer and voicemail was full. -5/13/25, Writer received call from unit nurse at 7:00 p.m. reporting that R1 had not returned from 1:00 p.m. appointment. Nurse reported R1 took Medivan to her appointment with her electric wheelchair and stated there was no indication or communication that R1 was going elsewhere after her appointment. Directed staff to attempt to reach R1 via number listed on her face sheet. Arrived at facility, confirmed R1 was not on the campus, confirmed location of her appointment, and called police department. A different staff member called to report R1 was</p>		