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	12/09/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure care planned fall interventions were implemented for 1 of 3 residents (R1) reviewed for falls. This resulted in actual harm for R1 who fell and sustained a fracture requiring surgical repair. The facility implemented corrective action prior to the start of survey, and this is issued in past noncompliance. R1's Resident Face Sheet indicated she was admitted to the facility on [DATE] and re-admitted , following hospitalization, on 11/13/25. R1's diagnosis included displaced fracture of right femur. Alzheimer's disease, dementia, history of sacral fracture and failure to thrive. R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated she was independent with bed mobility, sit to stand and required supervision for ambulation. R1's significant change MDS dated [DATE], indicated she was dependent for bed mobility, transfers, and indicated ambulation not attempted due to medical condition. R1's care plan dated 11/3/25, identified a risk for falls related to a history of falls, balance deficit and cognitive deficits. Care planned interventions dated 6/6/23, included bed at transfer height, hourly purposeful rounding, footrests for transportation and while at dining table. The care plan further identified cognitive loss/dementia as exhibited by confusion and forgetfulness. R1's Fall Risk Observation dated 11/5/25, indicated diminished safety awareness and indicated she required the use of assistive devices. The observation identified a high risk for falls. Fall Scene Huddle Worksheet dated 11/11/25, indicated at 7:30 a.m., R1 had an unwitnessed fall in the hallway. The worksheet indicated R1 had foot pedals on the chair and indicated possibly tripped on wheelchair or barrier from flood. R1's Hospital admission History and Physical dated 11/11/25, indicated fall with hip fracture. Will proceed with surgery. R1 had a fall at the nursing home. Obvious hip deformity noted. Found to have right femoral fracture. R1's Resident Progress Notes identified the following: 11/11/25, Writer came on shift and R1 was in her wheelchair sitting next to the storage cove. R1 had foot pedals on her wheelchair and a blanket wrapped around her that overnight staff had placed. R1 did not have hip protectors on. Writer was in the dining room administering medications and nursing assistants (NA)'s were in other resident rooms when writer heard a yell and a crash. Staff arrived to find R1 laying on the floor against a plastic barrier on her right side. Upon assessment R1 was very uncomfortable and would not allow writer to lift right leg. R1 was sent to the ED. 11/13/25, R1 was admitted to the hospital post fall and underwent a right hip nailing (a surgical procedure used to repair a broken hip by placing a metal rid or nail inside the center of the broken thigh bone (femur). During observation on 12/9/25 at 9:26 a.m., R1 was lying on her back in bed and appeared to be asleep. R1 did not respond to knock on her door. During interview on 12/5/25 at 3:59 p.m., licensed practical nurse (LPN)-A stated R1 had dementia and had a fall history. LPN- A stated prior to her fall, R1 was always attempting to walk independently but was not steady at all. LPN-A stated R1 was not directable and had recently been trying to get out of her chair again. During interview on 12/5/25 at 4:03 p.m., registered nurse (RN)-A stated R1 self-transferred a lot from her wheelchair, so staff frequently checked on her. RN-A stated prior to her recent fall, R1 was able to stand up and walked by herself but required staff supervision. During interview on 12/9/25 at 9:36 a.m., trained medication aide (TMA)-A stated R1 used to ambulate on her own, staff would assist R1 into a chair, then she would get antsy and would get up and start walking. TMA-A stated sometimes it meant R1 needed to use the bathroom and said if staff saw R1 ambulating they would walk with her then put her back in her wheelchair or in a recliner. When R1 fell, she had foot pedals on her wheelchair and should not have. The foot pedals should have been used only when transporting her in her wheelchair. TMA-A stated the pedals may have contributed to her fall. During interview on 12/9/25 at 10:46 a.m., nursing assistant (NA)-A stated the day R1 fell, she and another staff were in another resident room and heard the nurse call for help. NA-A said when she came out of the room, R1 was on the floor, leaning against a plastic barrier. NA-A said prior to the fall R1 had been seated in her wheelchair next to the plastic barrier because the overnight staff had gotten her out of bed and dressed for the day. NA-A stated because R1 would attempt to stand up out of her wheelchair, R1 should not have had the foot pedals on her chair. During interview on 12/9/25 at 10:15 a.m., RN-B stated the day R1 fell, she received a call from staff about the fall. When RN-B went to the unit, R1 had already been placed back into her wheelchair. RN-B said foot pedals should been removed when not transporting R1. During interview on 12/9/25 at 11:52 a.m., the director of nursing (DON) reviewed the care plan and acknowledged R1 should not have had foot pedals on the wheelchair when she was seated in a common area. Facility policy Care Plan dated 12/1/25, indicated