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	03/05/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure food service equipment used in 3 of 4 facility kitchenettes ([NAME], Strawberry and Elderberry) were kept in a clean and sanitary condition to prevent potential food-borne illness. This had the potential to affect 86 of 87 residents, visitors and staff who consumed food prepared in the kitchenettes. In addition, the facility failed to ensure frozen food items were stored in a manner to reduce the risk of cross contamination in 1 of 4 freezers (Strawberry Unit) used in the facility's kitchenettes. This had the potential to affect all 19 residents who resided on the Strawberry unit and could potentially consume the items. Findings include: On 3/3/26, at 11:28 a.m. lunch food service was observed on [NAME] wing. Dietary aide (DA)-A was serving residents their lunch meal. DA-A stated the unit currently had 13 residents as one resident was in the hospital. The stove and attached griddle in the unit appeared dirty. There was greasy appearance with charred food bits scattered around the burners and base of stove. A thick, dark, substance was built up on the sides of the splash guard of the griddle that separated the griddle and stove/burners. The griddle base appeared to have a thin layer of used greasy substance built up over the surface of the griddle. DA-A stated the stove, and griddle were used for breakfast, as each unit prepared the resident breakfast as well as needed per resident request for different food items. A tour of the facility's kitchenettes located in each of the four wings of the facility was conducted on 3/5/26, at 2:25 p.m. with the dietary manager (DM)-B.-On Strawberry unit, a gas cooking stove with an attached griddle was observed in the unit's kitchenette. The stove and griddle were used in the mornings when the dietary staff prepared resident breakfasts and as needed with individual resident requests. The stove top and between each of the four burners, had black thick and greasy appearance. The griddle area had greasy black buildup spattered over the splash guard. Lumps of dark black substances were visible in the grates of the stove between the burner areas. Grease and dark, thick, buildup was noted on all surfaces around the burners. The back splash of the stove had visible black and spattered greasy substance scattered over the surface. The sides of stove had drip marks and buildup visible. An upright freezer, located on Strawberry unit had a half full opened bag of cooked frozen pasta. Many of the pasta noodles in the open bag were coated with a thick layer of ice and the pasta bag was lying on the bottom shelf of the upright freezer with the top of the bag gaping open. The bag was clear and free of markings with nothing to indicate what was in the bag, expiration date or date it had been opened. Another clear bag was on the bottom shelf of the freezer with half used, open meat links, The bag lacked identifying information of what was in the bag, expiration date or date it had been opened. DM-B stated she thought it contained breakfast sausage links. -On [NAME] unit, a gas cooking stove with an attached griddle was observed in the unit's kitchenette. The stove and griddle were used in the mornings when the dietary staff prepared resident breakfasts and as needed with individual resident requests. The stove top and between each of the four burners, had black, thick and greasy appearing buildup. The griddle area had greasy buildup spattered over the splash guard. The back splash of the stove had visible spattered greasy substance scattered over the surface.-On Elderberry unit, a gas cooking stove with an attached griddle was observed in the unit's (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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	kitchenette. The stove and griddle were used in the mornings when the dietary staff prepared resident breakfasts and as needed with individual resident requests. The stove top and between each of the four burners had black, greasy appearing buildup. The griddle area had greasy buildup spattered over the splash guard. The back splash of the stove had visible spattered greasy substance scattered over the surface. Lumps of dark black substances were visible in the grates of the stove between the burner areas. Grease and dark, thick, buildup was noted on all surfaces around the burners. The back splash of the stove had visible black and spattered greasy substance scattered over the surface. When interviewed on 3/5/26, at 2:40 p.m. DM-B stated there was currently no cleaning schedule set up for maintenance cleaning of the equipment such as the stove. The facility currently used a daily cleaning schedule; however, it did not include to clean the stove top, griddle and splash guards. The stoves in the three units did need to be cleaned and was on her list of things to get completed. Food could be potentially contaminated when cooking on the unclean equipment. The grates on the stove could be removed and deep cleaned, and she would see the stoves in the kitchenettes were cleaned. DM-B stated it was important for staff to label and date the food in the freezer to know what the food was and when it could no longer be used and needed to be thrown out. DM-B removed both bags of food from the freezer on Strawberry unit and threw them into the garbage. DM-B stated there would be no way to tell how old the food was, when the suggested expiration date was or when it had been opened. The facility policy General Sanitation-Food and Nutrition dated 6/27/25, identified cleaning and sanitizing equipment surfaces was a two-step process. Surfaces were to be cleaned and rinsed before being sanitized. All food contact surfaces would be washed, rinsed and sanitized:a. After each use.b. When working with one kind of food to another.c. Any time there is an interruption during a task with the tools or items being used or with any that may have been contaminated.When cleaning fixed/immobile equipment such as mixers and slicers, removable parts would be washed and sanitized. Non-removable parts were to be cleaned with detergent and hot water, rinsed, air dried and sprayed with sanitizing solution at effective concentration, If any foodcontact surfaces were contaminated during reassembly, staff were to re-sanitize. The facility policy Food Supply Storage-Food and Nutrition dated 3/7/25, identified foods that had been opened or prepared were to be placed in an enclosed container, dated, labeled and stored properly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure staff utilized the appropriate personal protective equipment (PPE) during high contact cares for 3 of 4 residents (R66, R67, R49) reviewed for enhanced barrier precautions. In addition, the facility failed to implement timely airborne precautions for 1 of 2 residents (R16) reviewed for transmission-based precautions.ENHANCED BARRIER PRECAUTIONS: R66 R66's comprehensive MDS dated [DATE], identified R66 had severe cognitive impairment and diagnoses included traumatic brain dysfunction, quadriplegia and seizure disorder. R66 used a feeding tube. R66's care plan revised 1/7/26, identified R66 needed enhanced barrier precautions (EBP) (an infection control strategy in nursing homes requiring staff to wear gowns and gloves during high-contact resident care, such as bathing, dressing, or device care) due to gastrotomy (G-tube) (a medical device inserted through the abdomen directly into the stomach to deliver nutrition, fluids, and medication when oral intake is unsafe or insufficient.) Personal protective equipment (PPE) was available immediately outside of R66's room. Staff were to wash their hands upon entering and leaving R66's room. PPE was to be removed prior to leaving R66's room. During an observation on 3/2/26 at 7:38 p.m., an EBP sign hung outside R66's door and a plastic 3-tiered cart contained gowns, gloves and surgical masks. RN-D entered R66's room to administer G-tube medications. registered nurse (RN)-D did not put on a gown but did wear gloves while touching R66 and R66's bed and belongings. During an interview on 3/2/26 at 7:48 p.m., RN-D stated staff used gowns and gloves during personal cares, like bedtime cares. Upon review of the EBP sign outside R66's room, RN-D stated she should have worn a gown during G-tube medication administration. During an interview on 3/3/26 at 2:30 p.m., RN-C stated staff were expected to wear a gown and gloves for any resident care planned for EBP when staff were doing anything where they were touching the resident and that included G-tube medication administration. R66 was on EBP because R66 had a G-tube specifically so that was the only reason R66 needed EBP. Staff were protecting R66 and that's why they were expected to wear a gown. During an interview on 3/5/26 at 4:34 p.m., licensed practical nurse (LPN)-A, the infection preventionist (IP), stated EBP was used for indwelling medical device, surgical wound, targeted MDRO, or a healed surgical wound. On top of standard precautions – gown and glove w/ high contact cares including anytime you come in contact with the resident or their belongings ie: combing hair, repositioning, cleaning, and/or transferring. R67 R67's annual MDS dated [DATE], identified R67 was cognitively aware and diagnoses included heart failure, chronic obstructive pulmonary disease (COPD), morbid obesity and had a fall with major injury. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The untitled care sheet dated 3/4/26, failed to identify R67 needed EBP. R67's C diff NAAT with Reflex to Toxin A/B dated 8/26/25, identified C diff tcdB [NAME] NAAT was detected but the toxins were not detected. (If the initial NAAT is positive, it indicates the potential for infection. The reflex to toxin test confirms if the bacteria are actively producing toxins, which is essential for diagnosing active colitis) R67's care plan revised 7/4/25, identified R67 required assist of two staff for bed mobility but did not identify R67 required EBP. During an observation on 3/4/26 at 8:26 a.m., there was an EBP sign outside R67's door with a 3-tiered plastic cart with gowns, surgical masks and gloves. Nursing assistant (NA)-B and NA-C, without putting on gowns or gloves, transferred R67 from her recliner to her bed and provided morning cares before taking R67 to breakfast. During an interview on 3/4/26 at 8:50 a.m., NA-B stated R67 no longer required EBP because R67 previously had a wound that was healed. R67 reviewed R67's care sheet and stated EBP was not care planned and staff must have forgotten to remove the sign. During an interview on 3/4/26 at 9:39 a.m., LPN-B stated R67 was on EBP due to a history of C. diff and R67 used nebulizers. Staff were expected to wear gowns, gloves and a mask if needed during any personal care. Any time staff were touching R67. During an interview on 3/4/26 at 1:45 p.m., NA-C stated she did not remove the soiled gloves after providing BM care to R67 and should have because you didn't want to get that stuff all over everything. NA-C stated she and NA-B should have followed the EBP and wore gowns and gloves as well. NA-C stated she didn't know R67 was on EBP and did not work in the unit often. During an interview on 3/5/26 at 4:34 p.m., LPN-A stated staff should have been wearing gowns and gloves. We might need to make that clearer, probably on the care sheet. R49: R49's quarterly MDS dated [DATE], identified R49 was cognitively impaired and had diagnoses including Alzheimer's disease, diabetes, urine retention, and indwelling foley catheter. R49 required staff assistance for catheter care. R49's care plan dated 11/17/25, identified R49 had an indwelling foley catheter and required staff assistance for transfers. Staff were required to wear personal protective equipment (PPE) including gowns and gloves for high contact resident care including transferring and urinary catheter care. On 3/3/26 at 2:59 p.m., NA-A was assisting R49 into the resident's room and stated she was going to help R49 into bed. NA-A placed R49's wheelchair parallel to the bed and put on a pair of gloves. NA-A was used hands on assistance to transfers R49 onto the bed. NA-A moved the wheelchair away from the bed and reached under R49's legs and lifted them onto R49's bed. NA-A gathered supplies and proceeded to empty R49's catheter bag. NA-A failed to wear a gown while transferring R49 to bed and while emptying R49's catheter. NA-A stated R49 was on enhanced barrier precautions (EBP) because the resident had a catheter, and staff were supposed to wear gowns and gloves during direct cares including while transferring the resident to/from bed and while emptying the resident's catheter. NA-A (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the gown, and gloves were to protect the residents from my germs and me/staff from spreading any of her germs to other residents. NA-A stated she failed to wear a gown during transferring and emptying R49's catheter. On 3/3/26 at 4:15 p.m., RN-A stated residents with wounds and/or catheters were placed on enhanced barrier precautions and staff were to wear gowns and gloves when completing high contact cares with the residents. The PPE was to help prevent the spread of infections to/from the residents/staff. On 3/4/26 at 4:34 p.m., LPN-A stated EBP was used when residents had an indwelling medical device, surgical wound, targeted multidrug-resistant organism (MDRO), or a healed surgical wound. On top of standard precautions staff were required to wear gowns and gloves when performing high contact cares including anytime staff encountered the resident or their belongings. High contact cares included combing hair, repositioning, cleaning, and transferring the resident. Staff knew when and why a resident was on EBP by seeing a sign on their door, a PPE cart outside their room, through shift-to-shift report and by reviewing the residents' care plan. The information should also be on the NA care sheets. LPN-A stated staff should have worn a gown and gloves when transferring R49 from the wheelchair to the bed and when completing catheter cares. On 3/5/26 at 2:40 p.m., the director of nursing (DON) stated EBP was used when a resident had an open wound, an indwelling medical device or a surgical wound. Staff were instructed to wear a gown and gloves with high contact care including transferring residents and catheter care. Staff should have worn a gown during R49's transfer and catheter care and staff should wash their hands and/or use hand sanitizer anytime they go from dirty to clean. TRANSMISSION BASED PRECAUTIONS: R16's quarterly MDS dated [DATE], identified R16 had moderate cognition and diagnoses included chronic kidney disease, adult failure to thrive, and dementia. R16's care plan updated 3/3/26, identified R16 tested positive for COVID-19 and was on airborne with contact precautions and staff were to wear gown, gloves, N95 respirator and eye protection when entering R16's room. R16's physician orders dated 3/3/26 at 5:00 p.m., identified a one-time lab order for a QUAD respiratory panel (a test to detect the most common pathogens for COVID-19, Influenza A, Influenza B and Respiratory Syncytial Virus (RSV)) due to nasal congestion. R16's progress note dated 3/3/06, at 6:09 p.m., identified staff were to monitor R16 for symptoms of nasal congestion. A QUAD respiratory panel had been ordered and was pending. Airborne/contact precautions initiated. R16's physician orders dated 3/13/26, identified R16 was to be on airborne with contact precautions due to COVID-19 infection. A time was not listed on the order. On 3/4/26 at 7:06 a.m., a sign was observed at the facility entrance identifying [NAME] unit was positive for COVID-19 (a contagious respiratory illness that can attack body systems including the lungs and respiratory system) and all visitors were to wear face masks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/4/26 at 8:18 a.m., LPN-B stated R16 tested positive for COVID-19 when the provider was rounding at the facility in the afternoon on 3/3/26. LPN-B was uncertain of the exact time R16 was tested although thought it was before the evening meal. LPN-B stated she told staff she was going to place R16 in isolation but had not immediately done so. Later that evening, LPN-B observed R16 seated at a dining room table, along with two other residents, eating the evening meal. LPN-B stated ideally R16 should have been placed in airborne and contact precautions immediately after staff identified symptoms including nasal congestion. The facility failed to immediately place R16 on isolation precautions resulting in two other residents being exposed to COVID-19. On 3/5/26 at 2:29 p.m., RN-B stated he worked the evening shift on 3/3/26 and was notified R16 had stomach discomfort and was not feeling well. RN-B couldn't remember the exact time, but stated sometime after the evening meal, LPN-A told him R16 tested positive for COVID-19 and would be placed on airborne/contact precautions. RN-B stated he had not seen R16 the rest of the evening and was uncertain if or what time LPN-B had placed R16 in precautions. The facility Standard, Enhanced Barrier, and Transmission-Based Precautions policy dated 7/7/25, identified EBP expanded the use of personal protective equipment beyond situations in which exposure to blood and body fluids was anticipated and referred to the use of gown and gloves during high-contact resident care activities that provided opportunities for transfer of MDROs to staff hands and clothing. EBP was also used for residents with indwelling medical devices (i.e., indwelling urinary catheters), even if the resident was not known to be infected or colonized with an MDRO. High-contact resident care activities included transfers and indwelling medical device care. The policy further identified airborne isolation/precautions was used for illnesses including COVID-19 and staff were to wear PPE including N95, gown, gloves and eye protection when providing direct care to resident's positive for COVID-19.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure clinical justification and ensure non-pharmacological interventions were utilized prior to initiation of an antipsychotic for 1 of 6 (R6) residents reviewed for psychotropic medications. Findings include: R6's significant change Minimum Data Set (MDS) dated [DATE], identified R6 had severe cognitive impairment and was dependent on staff for all activities of daily living (ADLs). R6 had not exhibited any behavioral symptoms. Diagnoses included Alzheimer's disease, failure to thrive, pneumonia, diabetes and congestive heart failure. R6's Psychotropic Medication Use Care Area Summary (CAA) dated 1/27/26, identified R6 was taking antipsychotic medication. Staff monitored for adverse effect sides and effectiveness and target behaviors. R6's care plan with last review date 3/3/26, identified a potential problem related to psychotropic drug use with a goal for reduction of targe behaviors of wandering, exit seeking and inappropriate comments. A problem start date was listed as 1/24/26. Interventions included to administer the medication as ordered and monitor for side effects. Another problem dated 12/2/25 listed behavioral symptoms of making inappropriate comments to staff, attempts to leave facility and dementia and confusion to what was going on. Staff were directed to identify self when approaching, administer medications as ordered, re-orientate to three spheres as needed and monitor for side effects of medication. R6's most recent Physician Order Report dated 3/4/26, identified Seroquel (an antipsychotic medication to treat schizophrenia and bipolar) 25 milligrams (mg) to be given at bedtime related to dementia, psychotic disturbance, mood disturbance and anxiety with a start date of 1/6/26. R6's Point of Care monitored for behaviors of wandering, physical behavioral symptoms toward others, verbal behavioral symptoms toward others and rejection of care. Review of behavioral symptom documentation 12/1/25 to 2/28/26, identified two incidents of wandering, two incidents of physical behavioral symptoms toward others, three incidents of verbal behavioral symptoms toward others and one incident of rejection of care for the three-month period. On 3/3/26, at 9:37 a.m. R6 was observed lying in bed, dressed in hospital gown. Nursing assistants (NA)-B and NA-I entered R6's room with two unidentified nursing students and a mechanical lift. NA-B obtained a wash basin with warm water, and both aides assisted resident to wash and dress. R6 mumbled nonsensical words out loud but did not attempt to physically resist care and was unable to participate with dressing at all. The aides assisted R6 from bed to his wheelchair with the use of a mechanical lift. R6 made no attempt to participate or to resist care. NA-I stated R6 was always a mechanical lift as he was unable to stand. Staff assisted R6 out to the dining room. R6 was unable and made no attempt to propel his wheelchair. R6's Nursing Progress notes were reviewed 1/1/26 through 3/4/26. On 1/1/26 and 1/3/26 made attempts to leave facility which were easily redirected by staff. And on 1/2/26 and 1/3/26 R6 rejected care. R6's medical record was reviewed and lacked evidence a comprehensive assessment, to include medical justification, for the use of Seroquel was completed prior to the initiation of the medication. When interviewed on 3/3/26, at 4:54 p.m. NA-J stated she had worked with R6 and had never seen him restless or agitated but had heard he could be. R6 did not like to be changed so could be a little resistive with that but NA-J had never seen R6 wander or attempt to leave the facility. During interview on 3/3/26, at 4:59 p.m. registered nurse (RN)-C stated when R6 was first admitted to the facility in October, he would exit seek occasionally, but R6 was not wandering now. R6 had a decline in condition and was unable to wander. The medication Seroquel had been started about the same time of his decline in condition. RN-C stated she did not think the medication was helping with R6's lethargy and decline in condition. During interview on 3/4/26, at 10:45 a.m. NA-B stated R6 may have wandered a little when he first was admitted but did not do so now. R6 was unable to walk and had not been able to walk since a little before Christmas. R6 could be a little resistive with cares and had tried to hit out at staff but nothing that could not be handled. NA-B (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not think R6 had bad behaviors at all. When interviewed on 3/4/26, at 10:50 a.m. licensed practical nurse (LPN)-B stated R6 had a hospitalization in early January and had not been able to walk after that. R6 had no wandering or behaviors after the hospitalization and LPN-B could not remember R6 ever having any hard to deal with behavior. LPN-B was not sure why Seroquel had been ordered for R6, but he did have some sundowning and would have exhibited more behaviors in the evenings or at night. During interview on 3/4/26, at 12:33 p.m. RN-C stated she could not remember why Seroquel had been started. R6 may have been a case where he came back from the hospital with the medication ordered and they had missed it or it may have been physician initiated. R6 was definitely someone they would be looking at to try to discontinue the medication. Right before R6 got sick and ended up in the hospital, he did exhibit significant behaviors of wandering and RN-C felt staff had not done a good job of documenting R6's behaviors when they had occurred. The medication Seroquel was definitely not appropriate for R6 now and they should be looking at that. Review of the physician progress notes identified the physician had dictated R6 was often up late at night, had difficulty getting to sleep and then sleeping during the day. RN-C stated there would be other options to try before prescribing an antipsychotic medication. RN-C did not believe any other options were attempted other than just starting the Seroquel. During interview on 3/5/26, at 4:45 p.m. the director of nursing (DON) stated a psychotropic medication would be added if there would be a danger to self or others or could be for an emotional outcome as well. R6 had been admitted to the facility in October 2025, and the Seroquel had been started on 1/6/26. The Seroquel was at a pretty low dose. Review of the physician note did identify the medication had been started for sleep. The provider would have been aware nothing else had been tried previously. Targeted behaviors and other things for sleep should have been implemented prior to starting the antipsychotic. The facility policy Psychotropic Medications dated 12/9/25, identified residents would be free from any chemical restraint imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used psychotropic drugs were not given those drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record. Before administration of non-emergency psychotropic medications, the following must be competed: a. documentation in the plan of care observations of mood, symptoms or behaviors that caused the resident distress and/or endangered the resident or others and response to interventions used. b. the behavior committee and or care plan team would ensure the care plan was updated and would reflect non-pharmacological interventions to be used and the physician and family would be notified of the change in condition. After reviewing the mood and behavior documentation, if the behavior committee and/or care plan team determined psychotropic medications necessary, the reduction committee must be notified. If the reduction committed determined initiating the medication was warranted, the committee nurse would ensure the physician was contacted with description of the behavior, attempted interventions and committee recommendations. Obtain an order for an appropriate medication, in an appropriate dose and corresponding diagnosis, as well as medical symptoms from the physician.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a significant change in status assessment (SCSA) was completed within required timeframe to help facilitate timely person-centered care planning for 1 of 3 residents (R21) reviewed for Minimum Data Set (MDS) accuracy.Findings include:R21's quarterly Minimum Data Set (MDS) dated [DATE], identified R21 required setup or supervision with dressing and grooming and ambulation was not attempted due to safety. R21's Interdisciplinary Assessment form dated 9/12/25, identified walking was not attempted due to safety concerns. R21's progress note dated 9/21/25, quarterly MDS review, identified R21 was coded as not applicable on her quarterly MDS as R21 was non ambulatory at the time. R21's annual MDS dated [DATE], identified R21 was independent with upper and lower extremity dressing and grooming and ambulation was listed as not applicable. Diagnoses included Alzheimer's disease, and heart disease. R21's Interdisciplinary Assessment form dated 12/2/25, identified walking was not attempted. R21's care plan dated 12/17/25, identified a problem of self-care deficit related to Alzheimer's disease. A goal was listed to maintain ambulation ability. R21 was to ambulate with nursing staff to and from meals and bathroom with a full wheeled walker and assist with one. R21 was to maintain her current independence with dressing and staff were directed to provide assist of one with dressing morning and evening. R21's quarterly MDS dated [DATE], identified R21 required moderate assistance with upper extremity dressing and grooming, was dependent with lower extremity dressing and ambulation was listed as not applicable. Diagnoses included Alzheimer's disease, and heart disease. During interview on 3/5/26, at 11:05 a.m. registered nurse (RN)-F stated if a resident had a significant change she would be notified by the nurse managers as well as staff working with the resident. The facility required a significant change MDS if a resident had declined in two areas such as with ADL's or weight loss. RN-F reviewed R21's MDS and felt the February quarterly should have been a significant change MDS due to the new dependence with dressing and toileting. RN-F thought it had just gotten missed that the dependencies were new decline for R21.During interview on 3/5/26, at 4:30 p.m. the director of nursing (DON) stated a significant change MDS should have been completed if there was a decline in ADL abilities with a resident. The facility policy MDS 3.0 RAI (Resident Assessment Instrument)- Rehab/Skilled & Therapy and Rehab dated 10/27/25, identified the following procedures: Procedure: Significant Change MDS1. When a significant change is identified, the professional employee identifying the change would notify the social worker, RN coordinator or designated employee so that a timeline may be established and communicated to team members. The team member who identified the change would document in the progress notes - MDS that a significant change had occurred and would identify whether the change was an improvement or a decline and in what areas. The MDS/Care Plan Notification (GSS #278) would be routed to interdisciplinary team members to inform them of the significant change.The Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) 3.0 User's Manual, dated October 2025, indicated a significant change in status assessment (SCSA) was required when various criteria were met. The manual directed a significant change is a major decline or improvement in a resident's status that: would not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline was not considered self-limiting; Any decline in an ADL physical functioning area (e.g., self-care or mobility) (at least 1) where a resident is newly coded as partial/moderate assistance, substantial/maximal assistance, dependent, resident refused, or the activity was not attempted since last assessment and did not reflect normal fluctuations in that individual's functioning; - Resident's incontinence pattern changes or there was placement of an indwelling catheter; - Emergence of unplanned weight loss problem - Emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status; - Resident begins to use (continued on next page)

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	245039	A. Building B. Wing	03/05/2026

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a restraint of any type when it was not used before; and/or - Emergence of a condition/disease in which a resident is judged to be unstable

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure foot pedals were removed from the wheelchair as directed by the care plan for 2 of 3 residents (R21, R6) reviewed for falls. Findings include:R63's admission Minimum Data Set (MDS) dated [DATE], identified R63 had a severe cognitive impairment and diagnoses that included dementia. R63 was at risk for falls.R63's care plan revised 3/2/26, identified R63 was at risk for falls due to weakness, cognition and history of falls. Interventions included footrest on wheelchair when transporting only. The untitled nurse aide care sheet undated, identified R67's footrests on wheelchair when transporting.During an observation on 3/3/26 at 9:03 a.m., nursing assistant (NA)-G assisted R63 with R63's morning cares.At 9:18 a.m., NA-G wheeled R63 to the dining room table. NA-G did not remove R63's footrests and walked away.At 11:14 a.m., R63 was seated in her wheelchair at the dining room table. R63 continued to have the footrests on and her feet were up against the table pedestal. During an interview on 3/3/26 at 11:47 a.m., NA-G stated she always left R63's footrests on and only takes the footrests off when R63 was transferred out of her wheelchair. NA-G stated she did this because staff would just take off with R63 and not put on the footrests. During an interview on 3/3/26 at 2:01 p.m., registered nurse (RN)-C stated R63's footrests should have been removed and placed into the bag on the back of R63's wheelchair. R63 was more likely to try to climb over the footrests and potentially fall.During an observation on 3/4/26 at 9:50 a.m., NA-H assisted R63 to the dining room. R63 was sitting in her wheelchair at the dining table with the footrests on and her feet up against the table pedestal. NA-H did not remove R63's footrests and left the dining room. There was no bag on the back of R63's wheelchair for the footrests.During an interview on 3/4/26 at 9:51 a.m., NA-H stated she did not know R63 well but did get R63 up that morning. NA-H stated she was unaware R63 should have the footrests only for transportation. NA-H then placed R63's feet on the floor and turned the footrests away from the front of R63 but left the footrests connected to the wheelchair. During an interview on 3/5/26 at 1:40 p.m., the director of nursing (DON) stated staff were expected to follow the resident care plans for the safety of all residents.A care plan policy was requested but not received.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene cares (i.e.,toileting assistance and/or nail care) were offered and/or completed for 2 of 3 residents (R63, R46) reviewed for activities of daily living (ADLs) and whom were dependent on staff for such cares. Findings include: R63's admission Minimum Data Set (MDS) dated [DATE], identified R63 had a severe cognitive impairment and diagnoses that included dementia. R63 required supervision with eating, substantial assistance with oral hygiene, upper body dressing, and personal hygiene, and was dependent on staff for all other cares areas. R63's care plan revised 3/2/26, identified R63 had an alteration in urinary elimination due to incontinence. R63's toileting plan included: Toilet before/after meals and at bedtime. R63 was to bed checked for incontinence at night during repositioning. R63's goal was to have 1 or less episodes of urinary incontinence per day and 3 or less episodes of bowel incontinence per week. The untitled nurse aide care sheet undated, directed staff to toilet R63 when R63 gets up, after meals, and before bed. During an observation on 3/3/26 at 9:03 a.m., nursing assistant (NA)-G assisted R63 with her morning cares. R63 was incontinent of urine. NA-G did not offer toileting nor toileted R63. R63 was wheeled to the dining room for breakfast. At 11:26 a.m., R63 continued to sit at the dining room table. R63 had not been offered toileting. At 11:34 a.m., registered nurse (RN)-G assisted R63 into R63's room and stated NA-G would take R63 to the bathroom before lunch and left the room. At 11:36 a.m., NA-G brought R63 into the bathroom and transferred R63 onto the toilet using the sit-to-stand aid. R63 incontinence brief was wet with urine and R63 immediately voided when R63 sat down on the toilet. During an interview on 3/3/26 at 11:47 a.m., NA-G stated she did not toilet R63 when NA-G assisted R63 with morning cares and should have. During an interview on 3/3/26 at 1:52 p.m., RN-G stated residents were expected to be at least checked and changed every 2 hours or whatever was care planned. R63 was supposed to be toileted every 2-3 hours. During an interview on 3/3/26 at 2:01 p.m., RN-C stated R63 was more of a check and change and, if R63 was alert, R63 may sit on the toilet. Staff were expected to follow R63's care plan. During an interview on 3/5/26 at 1:40 p.m., the director of nursing (DON) stated staff were expected to follow the care plan for toileting. During an interview on 3/5/26 at 2:50 p.m., the administrator stated staff were expected to follow the care plan for toileting. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R46: R46's annual MDS dated [DATE], identified R46 had moderate cognitive impairment and was dependent with dressing and toileting and required setup and supervision with grooming. Diagnoses included dementia, diabetes, and neurogenic bladder. R46's care plan dated 2/12/26, identified R46 had a self-care deficit related to weakness, history of cerebral vascular accident. Staff were directed to assist R46 with bathing. The care plan lacked any guidance or direction on fingernail care including what, if any, preference for length R10 had or how often they should be checked or clipped. On 3/4/26, at 1:58 p.m. R46 was observed seated in his wheelchair in his room with NA-F also present. R46's fingernails were long on both his hands extending a centimeter or more beyond his fingertips. R46 stated he knew his fingernails were very long and he preferred to keep his fingernails short. R46 stated he asked a staff member a few days previously if they would trim his fingernails for him. The staff had agreed to assist him with the task but never returned. NA-F stated he thought R46 was diabetic and so a nurse would have to trim his nails. It was the facility policy the aides were not allowed to trim finger or toenails of diabetic residents. NA-F stated he would find out and if able would make sure he came back later to trim R46's nails or ask the nurse to do so. On 3/5/26, at 5:28 p.m. R46 was again observed seated in his wheelchair in the dining room. R46 again stated his fingernails were very long. R46 stated no one had come to trim them for him. The staff member he had asked to trim them told him she would but then said she did not have time. During interview on 3/5/36, at 5:30 p.m. licensed practical nurse (LPN)-E stated diabetic residents nails were done by the nurses. LPN-E was not aware R46 had wanted his fingernails trimmed. Staff should have trimmed his nails when he had requested it or as soon as reasonably possible. LPN-E would check with R46 and try to trim his nails that evening. During interview on 3/5/26, at 5:33 p.m. the director of nursing (DON) stated staff should trim resident nails when it was requested. An activities of daily living (ADL) policy was requested but not received.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ambulate residents as directed for 1 of 1 resident (R21) reviewed for mobility decline.Findings include:R21's progress note dated 9/21/25, quarterly MDS review, identified R21 was coded as not applicable on her quarterly MDS as R21 was non ambulatory at the time. R21's Interdisciplinary Assessment form(s) identified:9/12/25, identified walking was not attempted due to safety concerns.12/2/25, identified walking was not attempted. R21's medical record lacked a comprehensive assessment to determine potential safety concerns or new interventions were needed.R21's care plan with revision date 12/17/25, identified a problem of self-care deficit related to Alzheimer's disease. A goal was listed to maintain ambulation ability. R21 was to ambulate with nursing staff to and from meals and bathroom with a full wheeled walker and assist of one. R21's quarterly Minimum Data Set (MDS) dated [DATE], identified R21 had severe cognitive impairment and required moderate assistance with upper extremity dressing and grooming, was dependent with lower extremity dressing and ambulation was listed as not applicable. Diagnoses included Alzheimer's disease, and heart disease. R21's undated nurse aide care plan sheet directed staff to assist R21 to ambulate to meals and bathroom each day.R21's point of care task completion sheet for February and March 2026, did not identify an ambulation task for R21 and ambulation had not been recorded as attempted or completed. On 3/4/26, at 7:25 a.m. R21 was observed wheeling herself in her wheelchair from her room to the dining room for the breakfast meal. Staff was observed in the dining room, however, made no attempt to stop R21 and offer to assist her to ambulate to the meal. During interview on 3/4/26, at 9:29 a.m. nursing assistant (NA)-F stated R21 was pretty independent and the staff just checked on her in the mornings to see that she was dressed appropriately and that she had toileted. NA-F just checked on her after breakfast and at end of his shift. Otherwise R21 was independent. When interviewed on 3/5/26, at 9:56 a.m. licensed practical nurse (LPN)-E stated R21 walked minimal distances. R21 was supposed to be walked to dine, and she knew the aides had tried a few days ago but by the time they had gotten around to R21, she was already at the dining room table waiting for her meal. LPN-E thought R21 was able to ambulate, but she had never seen her walk very far at all. LPN-A thought no one was asking R21 to walk and they should be asking her. LPN-A thought R21 was capable of walking though because she noticed when family took her out, they did not bring the wheelchair and only brought R21's walker with them. The last time LPN-A could remember seeing R21 ambulate was a few months ago. During interview on 3/5/26, at 10:16 a.m. NA-A stated she had checked with the charge nurse and staff were supposed to ask R21 to ambulate. NA-A had not asked R21 to walk for a long time, but she planned to try that after lunch.During interview on 3/5/26, at 11:05 a.m. registered nurse (RN)-F stated R21 must not have ambulated at all during the observation periods of the MDS when they were doing the look back. RN-F knew R21 did ambulate because when family took her out, they did so with the walker, but RN-F was not aware if R21 ambulated at the facility. The care plan directed staff to ambulate R21 to meals but was not an assigned task for the aides. The aides did not document ambulation at all for R21 as an error had been made and the task had not been assigned to them. On 3/5/26, at 11:18 a.m. NA-A approached R21 in her room and offered to assist R21 to ambulate to the dining room for lunch. R21 agreed and NA-A put a gait belt on R21 and assisted her to stand. R21 ambulated with wheeled walker, gait belt and assist of one with wheelchair following behind her to the dining room. R21 required frequent verbal prompts to direct ambulation for safety and moderate physical assistance but was able to ambulate to the dining room area with assistance. During interview on 3/5/26, at 4:30 p.m. the director of nursing (DON) stated if a task was care planned then it should be completed or at the minimum, offered to the resident. If staff were unable to get to an assigned task on their care sheet, they should let the charge nurse know. Anything on the aide care sheets needed to be (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed. If the aides missed the opportunity to walk R21 to the dining room at mealtimes they should have offered it at other times throughout the day. There should be something in the chart to document the task, so the aides could record if offered and refused or completed or not completed. The DON was not sure if that was something they had just missed for R21. The facility policy Restorative- Nursing Care Implementation and Screening dated 12/8/25, identified each resident would receive restorative nursing care to the extent possible, based on individual strengths, needs and problems as defined in nursing assessments. The restorative care would be outlined in the resident's nursing care plan. Residents would be provided appropriate treatment and services to attain/maintainfunctional abilities in activities of daily living. Any resident who was unable to carry out independent activities of daily living would receive necessary services to prevent further diminishing of independent abilities in bathing, dressing/undressing, grooming, transfer and ambulation, toileting, eating and use of speech, language or other functional communication systems.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure residents with side rails were comprehensively assessed prior to use/and or reassessed for appropriate continued use for 2 of 3 residents (R6, R63) reviewed who had side rails. Findings include: R6: R6's significant change Minimum Data Set (MDS) dated [DATE], identified R6 had severe cognitive impairment and was dependent on staff for all activities of daily living (ADLs). R6 had not exhibited any behavioral symptoms. Diagnoses included Alzheimer's disease, failure to thrive, pneumonia, diabetes and congestive heart failure. The MDS identified side rails or restraints were not in use. R6's care plan dated 3/3/26, identified R6 had a self-care deficit due to weakness. Staff were directed to assist R6 to turn and reposition and use of bilateral upper bed rails to assist. R6 required use of side rails to assist with mobility and repositioning with a goal R6 would remain free from injury associated with side rail use. Staff were directed to assess R6's need for side rails with changes in condition and annually, educate resident and family regarding risks and benefits of side rail use and ensure side rails were used only for medically necessary purposes such as positioning and bed mobility. R6's medical record lacked a consent for bed rails and an assessment to determine if R6 was able to use a side rail to assist with his mobility: including but not limited to what alternatives were provided before installing bed rails and ensure the assessment included medical diagnoses, conditions, symptoms, size and weight, sleep habits, medications, underlying medical conditions, cognition, communication, risk of falling and mobility along with risk versus benefits of use. On 3/3/26, at 9:37 a.m. R6 was observed lying in bed, dressed in hospital gown. 1/4 length side rails were located on each side of the bed. R6's bed was in low position to the floor, and a cushioned mat lie on the floor next to the bed. The bed was positioned against the wall. Nursing assistants (NA)-B and NA-I entered R6's room with two unidentified nursing students and a mechanical lift. NA-B obtained a wash basin with warm water, and both aides assisted resident to wash and dress. R6 was observed to mumble nonsensical words out loud but did not attempt to physically resist care and was unable to participate with dressing at all. The nursing assistants did not prompt R6 to grab the side rails on the bed or attempt to place his hands onto the side rails to encourage him to assist with rolling onto his side to wash and dress. NA-B stated R6 did not use the bed side rails to turn and often would push against the side rails when staff were rolling him to his side, interfering with cares. NA-I stated she thought the side rails were on each side of the bed for R6's safety and to keep him from falling out of the bed. The aides assisted R6 from bed to his wheelchair with the use of a mechanical lift and brought him out to the dining room. When interviewed on 3/4/26, at 2:30 p.m. licensed practical nurse (LPN)-F stated if a patient did not have, want or need side rails, a side rail assessment would not be completed. When residents did have or need side rails then an assessment would be done by nursing. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/4/26, at 4:55 p.m. registered nurse (RN)-C stated one of the past directors of nursing (DON) had the staff stop doing side rail assessments, claiming they were not needed, but they had started doing the consent forms again. Generally, RN-C printed out a consent for resident or family to sign, and the consent identified what the side rails were needed for, such as positioning and things like that. The facility did not use an actual assessment form to assess resident side rail use or to ensure they were not being used as a restraint. When R6 was first admitted to the facility he had been able to use the side rails to assist with positioning, but he would never be able to use the side rails now. R6 should have been re-evaluated for side rail use when a significant change MDS had been completed, but that had not been done. During interview on 3/5/26, at 4:45 p.m. the DON stated the use of side rails was to be addressed with annual, quarterly and significant change MDS assessments. R6's use of side rails on the bed should have been reassessed when his significant change MDS had been completed. Side rail assessments should be done on admission and with significant change in condition and only be used if benefitting the resident for independence. R63: R63's admission MDS dated [DATE], identified R63 had a severe cognitive impairment and diagnoses that included dementia. R63 required supervision with eating, substantial assistance with oral hygiene, upper body dressing, and personal hygiene, and was dependent on staff for all other cares areas. The MDS identified R63 did not use a restraint and did not use bed rails. R67's Side Rails Assessment and Consent 1 dated 2/14/26, identified R63 used side rails for boundary limitations and family request. R63 used the top half side rails on each side all the time. Benefits included: Aiding in turning/sitting/repositioning within the bed. *Providing a handhold for getting into or out of bed; Providing a feeling of comfort and security. *Reducing risk of a resident falling from bed when transported or when resting, Providing easy access to bed controls, call bells, light cords, and personal items. Potential Risks included: Strangling, suffocating, bodily injury or death when a resident or part of their body is caught between the spaces in the rail or between the bed or mattress and the rail; More serious injuries from falls when resident climbs over a rail or bar; Skin bruising, lacerations, tears, and abrasions when body parts bump against rail; and Feeling isolated or unnecessarily restricted. Preventing R63 from exiting a bed. The assessment failed to identify alternatives tried and failed before the installation of the bed rail and include resident specific information. R63's care plan revised 3/2/26, failed to identify R63's side rails. During an observation on 3/3/26 at 9:03 a.m., NA-G assisted R63 with morning cares. At 9:04 a.m., NA-G rolled R63 to her left side using R63's drawsheet, then removed R63's incontinent brief. NA-G did not tell R63 to use the side rails nor placed R63's hand on the side rails. R63 did not use the side rails nor participate in the task. At 9:06 a.m., NA-G rolled R63 to her back. R63 did not participate nor used the side rails At 9:08 a.m., NA-G rolled R63 to her right side. NA-G did not tell R63 to use the side rails nor placed R63's hand on the side rails. R63 did not use the side rails nor participate in the task. (continued on next page)

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/3/26 at 9:14 a.m., NA-G stated R63 used the side rails sometimes. Staff would just tell R63 to grab ahold of the side rails and R63 just did it. NA-G stated she didn't tell R63 to use the side rails because NA-G just rolled R63. NA-G stated sometimes R63 would understand and sometimes she wouldn't, but NA-G should have encouraged R63 to use the side rails. During an interview on 3/3/26 at 2:01 p.m., registered nurse (RN)-C stated when R63 was admitted , R63 was using the side rails to assist with bed mobility but needed to be reassessed due to declining since admission. Boundary limitations should never be used, and family requests still should show R63 was able to use the device. Staff were expected to report residents who required total dependence on staff and not using the side rails so it could be removed. During an interview on 3/4/26 at 9:51 a.m., NA-H stated she just took the drawsheet and just kind of turned R63. R63 didn't really participate, and NA-H did most of the work. R63 did understand verbal cues but just kind of laid there. During an interview on 3/4/26 at 10:39 a.m., RN-E stated R63 was admitted to the facility for physical therapy. R63 was very weak and lethargic. R63 did not use the side rails for bed mobility. It was a boundary limitation for R63 because R63 tried to get out of bed. RN-E spoke with R63's family and they were adamant R63 had side rails for safety. RN-E stated a device to keep a resident in bed was a restraint. RN-E stated she educated R63's family and they signed the consent for siderails for boundary limitations. That's what the facility did when a resident's family insisted on side rails. During an interview on 3/5/26 at 1:40 p.m., the director of nursing (DON) stated R63's side rail assessment should not say boundary limitations. Side rails were to be used only to assist with bed mobility. Family should be educated regarding the risks of using a side rail because that would be a restraint. R63's side rails were ¾ rails, so they were unable to keep R63 in bed. R63 should be reassessed to determine if side rails were a safe intervention for R63 because side rails were supposed to help keep R63's independence. During an interview on 3/5/26 at 2:50 p.m., the administrator stated staff were expected to comprehensively assess side rails to ensure resident safety. A side rail policy was requested but not received.