STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEILSON PLACE	1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601

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E 0041 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Implement emergency and standby power systems.** Based on interview and document review the facility failed to provide inspection documentation in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 the Standard for Emergency and Standby Power Systems. In addition, the facility failed to form a policy for emergency generator maintenance. This deficient practice had the potential to affect all 78 residents residing in the facility along with staff and visitors. Findings include: During the facility tour on 8/18/20, between 9:00 am to 12:00 p.m. the generator weekly inspection log was reviewed. The inspection log identified there was no record of a generator inspection for the week of 5/25/20. The assistant administrator and director of maintenance confirmed the generator was not tested the week of 5/25/20. The facility Emergency Operations Plan reviewed 1/23/20, failed to identify a policy for emergency generators. A policy on emergency generators was requested and was not provided. During interview on 8/20/20, at 1:10 p.m. the supervisor of power plant (SPP) stated the facility did not have a policy on emergency generators. SPP was not aware why there was not a specific policy for maintaining and testing the emergency generators, however, the facility followed the bi-monthly testing log and weekly inspections logs.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to report to the stated agency (SA) neglect of care for 1 of 2 residents (R18) reviewed for abuse. Findings include: R18's annual Minimum Data Set ((MDS) dated [DATE], indicated she had intact cognition and required total assistance for locomotion on and off the unit. R18's care plan dated 6/5/20, identified a risk for a decline in wheel chair mobility and a self care deficit related to bilateral amputations, pain and [DIAGNOSES REDACTED]. A review of R18's Resident Progress Note dated 5/9/20, indicated R18 came out for breakfast and requested Tylenol for face pain, R18 had been outside previously and got a sun burn to the right side of her face. R18's skin was peeling and her lip was slightly swollen. Staff had been applying lotion to R18's face. During interview on 8/17/20, at 7:21 p.m. R18 stated she had gotten a sunburn while outside a few months prior. R18 stated, I think I fell asleep and I got terribly burned on my face and said, oh god did I ever blister. During an interview on 8/19/20, the administrator stated when determining whether an incident is reportable to the SA he reviewed the facility policy. The administrator stated he was not aware of the incident in which R18 had a blistering sun burn and stated if it truly was a blistering sun burn that would have been a major event and the nurse manager should have filled out an incident report. The administrator confirmed and incident report had not been completed. On 8/20/20, at 10:10 a.m. family member (FM)-A stated staff had not been letting R18 face time with her and she could not understand why. FM-A stated she went and saw R18 through the window and stated when R18 turned her face she saw the sun burn. FM-A stated R18's face was swollen and stated it looked awful. FM-A stated she asked R18 who popped the blister on her face but R18 did not know. FM-A stated she had a photo of the burn and said around the corner of R18's right lip there were blisters and a line going along her cheek and the bottom half was red and indented. FM-A stated the burn was on the right side of R18's face, ear and cheek and down by her neck. FM-A stated she called and asked about the burn and was told that staff brought R18 outside and forgot about her. During a subsequent interview on 8/20/20, at approximately 1:00 p.m. the administrator stated a report had not been made to the SA and stated he did not feel the incident was reported because there was no proof R18 had blistered. A facility policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property dated 9/5/19, identified neglect as the failure of the facility to provide services that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The policy indicated reports of neglect would be reported to the SA no later than two hours if the events that cause the allegation involve abuse.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to investigate a burn for 1 of 1 resident (R18) reviewed for neglect of care who had sustained a sunburn which blistered. Findings include: R18's annual Minimum (MDS) data set [DATE] indicated she had intact cognition and required total assistance for locomotion on and off the unit. R18's care plan dated 6/5/20, identified a risk for a decline in wheel chair mobility and a self care deficit related to bilateral amputations, pain and [DIAGNOSES REDACTED]. R18 stated, I think I fell asleep and I got terribly burned on my face and said, oh god did I ever blister. A review of R18's Resident Progress Note dated 5/9/20, indicated R18 came out for breakfast and requested Tylenol for face pain, R18 had been outside previously and got a sun burn to the right side of her face. R18's skin was peeling and her lip was slightly swollen. Staff had been applying lotion to R18's face. During interview on 8/19/20, at 9:57 a.m. nursing assistant (NA)-J stated she was not working the day R18 was sun burned but thought staff had brought R18 outside and forgot to put sun block on her. At 10:02 a.m. NA-I stated she was not working the day R18 got burned but stated she heard R18 had been left outside for a few hours. NA-I stated R18 was pretty burnt and it was painful. NA-I stated R18 could not physically get in or out of the building on her own. At 10:09 a.m. NA-K stated she was not working the day R18 got burned but stated she thought the umbrella may have moved. NA-K stated all I know is it was really red for a few days. At 10:11 a.m. registered nurse (RN)-D stated she was not aware of the incident, had not looked into, and did not know who brought R18 outside that day however, if R18 had sustained a burn, an incident report should have been made out. RN-D reviewed R18's medical record and verified a Progress Note written by licensed practical nurse (LPN)-A was the only documentation related to the incident. At 10:18 a.m. LPN-A stated she had worked a day or two after R18 sustained the burn and verified R18 had pain related to the burn. LPN-A verified she was the nurse who documented R18's pain and swollen lip. At 12:39 p.m. the administrator stated any incident that comes up including falls, skin tears, skin injury or security events should have been investigated and stated he was not aware of the incident. The administrator stated if R18 truly had a blistering sunburn that would have been a major event and RN-D should have been aware of it and completed an incident report. On 8/20/20, at 10:10 a.m. family member (FM)-A stated staff had not been letting R18 face time with her and she could not understand why. FM-A stated she went and saw R18 through the window and stated when R18 turned her face she saw the sun burn. FM-A stated R18's face was swollen and stated it looked Awful. FM-A stated she asked R18 who popped the blister on her face but R18 did not know. FM-A stated she had a photo of the burn and said around the corner of R18's right lip there were blisters and a line going along her cheek and the bottom half was red and indented. FM-A stated the burn was on the right side of R18's face, ear and cheek and down by her neck. FM-A stated she called and asked about the burn and was told that staff brought R18 outside and forgot about her. A facility policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property dated 9/5/19, identified neglect as the failure of the facility to

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) provide services that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The policy indicated repots of neglect would be promptly and thoroughly investigated.
F 0679 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide meaningful activities for 3 of 5 residents (R56, R46 and R420) reviewed for activities. Findings include: R56's quarterly Minimum Data Set ((MDS) dated [DATE], identified R56 had severe cognitive impairment and required extensive assistance with cares. R56's Activity Care Area Assessment (CAA) dated 1/23/20, identified R56 was shy and uneasy around others and declined to participate in large group activities. The CAA further identified R56 preferred to listen to music in her room, being around animals and doing things with groups of people. On 8/17/20, at 6:57 p.m. R56 was observed in the common room, seated in her wheelchair watching television. On 8/19/20, at 8:25 a.m. R56 was observed in the common room, seated in her wheelchair in front of the television. On 8/19/20, at 9:52 a.m. R56 was observed in bed on her back. The lights were off, there was no television or music on in the room. When interviewed on 8/19/20, at 10:06 a.m. nursing assistant (NA)-B she had attempted to do nail care for the female residents last week including R56. NA-B stated after meals she would position R56 in front of the television. NA-B also stated R56 liked having music on when she was in her room. During interview on 8/20/20, at 8:48 a.m. NA-G stated she relied on the activity aide to do 1:1 activities with the residents including R56. NA-G indicated R56 liked music and would scoot around the unit in her wheelchair. NA-G confirmed she had not turned on any music for R56 that day. During interview on 8/20/20, at 8:58 a.m. registered nurse (RN)-A stated there had been more 1:1 activities, some distance bingo and church was put on the television on Sundays if there was staff available to turn it on. When interviewed on 8/20/20, at 1:35 p.m. activity aide (AA)-A stated R56 liked music and that more 1:1's visits were being done with her, but probably were not documented. AA-A stated R56 scooted around the unit in her wheelchair and indicated R56 did not like television. R56's Activity (Group and independent Leisure) Participation Documentation dated August 2020, revealed August 1st though the 18th R56 was offered to participate in TV/Movie/Sports/News ten out of eighteen days, Radio and music was offered two out of eighteen days, had one family visit in eighteen days and had three staff 1:1 activities in eighteen days. According the the documentation, other independent activities such as reading/writing/newspaper, crafts, helping others and games/puzzles, had not been offered to R56. R46's undated face sheet included [DIAGNOSES REDACTED]. R46's admission MDS dated [DATE], indicated impaired cognition and the need for extensive assist with transfer, bed mobility, dressing and grooming. The activities section of the MDS indicated R46 enjoyed the outdoors, music and participating in favorite activities. R46's Communication CAA dated 7/14/20, indicated R46 had hearing loss and problem understanding others and being understood. The CAA also indicated R46 had cognitive deficit and was not able to read. R46's Activity CAA dated 7/15/20, indicated the care plan was developed for 1:1's and independent leisure activities because of COVID-19 restrictions and R46's dementia. R46's Care plan, with revision date of 7/14/20, indicated R46 had impaired activity participation due to covid restrictions. The care plan directed staff to adapt activity equipment to meet R46's needs such as sitting with R46 when she colored and visiting about living on her farm in Oklahoma. R46's care plan directed staff to assess environmental factors that may hinder activity involvement such as being in her room more and to provide R46 with 1:1 interventions as needed or desired so socialization and stimulation decreases any decline. R46's activity log for the month of August 2020, indicated R46 was in the hospital from 8/13/20, through 8/17/20. The log indicated R46 had participated with independent television and music on 8/18/20 and 8/19/20. With the exception of three days, the log lacked any 1:1 visits with R46 for the remaining 14 days of August 2020. On 8/18/20, at 1:46 p.m. R46's room was observed laying in her bed with the door closed. The room was dark and there was no television or music playing. On 8/19/20 at 8:53 a.m. R46 was observed lying in bed, sleeping. The room was dark and no television or music was playing. R46 had refused to get out of bed. -At 9:28 a.m. R46 was observed lying in bed, sleeping. The room was dark and no television or music was playing. NA-A entered the room to assist R46 into her wheelchair for breakfast, however. R46 refused to get out of bed despite several verbal attempts and stated she just wanted to remain in bed. -At 2:07 p.m. R46 was observed lying in her bed. The room was dark and no television or music was playing. The door to the room remained closed due to on isolation precautions. NA-A stated R46 had refused to get out of bed for the entire shift. On 8/20/20, at 9:57 a.m. NA-A stated anyone who was going to enter R46's room needed to sign in on the log by her door. On review of the sign in logs for entry to R46's room, NA-A verified the activity aides signature was not on the sign in logs indicating they had not entered her room to provide activities, since her hospital return on 8/18/20. NA-A stated there was just one activity aide for the facility and she was on vacation today. At 10:00 a. m. NA-N stated R46 refused to get out of bed at all the day before, but they were going to try to get her up now. NA-N stated in the past, she used to take R46 out on the balcony on nice days and R46 used to come to dining area for her meals and other stuff, but now she was quarantined. NA-N stated she wished they had more time to sit with residents and read to them. On 8/20/20 at 1:00 p.m. R46 was observed in her room, seated in the wheelchair, awake. R46's television was on, however R46's head hung down with her chin resting on her chest. R46 was dressed and groomed. R46 began moving a glass about her bedside table. R46 stated she did not know what was playing on the television and that she did not have any favorite television shows. R46 again put her head down with her chin resting on her chest and appeared to fidget with her blanket. R46 did not appear to be actively watching the television. R420's admission MDS dated [DATE], indicated R420 had moderate cognitive impairment, was able to make own decisions and enjoyed leisure activities. The MDS identified R420 had activity preference which included: music, news, group activities and being outside. Activity preferences included on the MDS music, news, group activities and being outside. R420's baseline care plan dated 8/6/20, identified an area to complete activity interventions and preferences; however, the section was blank. R420's Activity assessment dated [DATE], identified leisure interests which included games, crafts, music, being outside, talking and conversing. On 8/18/20, at 2:06 p.m. R420 was observed in his room, seated in his recliner, awake and watching the television. R420's room was noted to not have any type of reading material or a radio to play music. On 8/19/20, at 10:06 a.m. R420 was observed in his room, seated in his recliner awake, actively watching television. R420's room remained void of any reading material or radio to play music. R420 stated no one had been to his room to offer activities. When interviewed on 8/17/20, at 4:43 p.m. R420 stated there was nothing to do in his room except watch television. R420 stated he sat in his room most of the day except for therapy, because he was in quarantine. R420 stated he wished there was more to do than be in his room and watch TV. When interviewed on 8/18/20, at 4:17 p.m. NA-H stated residents that were in quarantine were provided 1:1 visits by staff while providing personal cares and that there were no group activities except for Bingo. NA-H indicated she was not aware of a therapeutic recreation schedule and stated she did not know who assessed or reassessed residents' activity preferences. When interviewed on 8/20/20, at 9:20 a.m. activity coordinator (A)-B stated the blue binder was for floor staff to document residents' independent leisure and small group activities. A-B stated there was an independent leisure activity cart that was offered to the residents' once a week and as needed, in order to provide activities in the residents' rooms. A-B she would offer activities on each unit, once a week. A-B stated there was no schedule for providing 1:1 resident visits as those visits were provided during the provision of personal cares. A-B indicated she completed the 1:1 resident assessments. When interviewed on 8/20/20, at 10:32 a.m. A-A stated A-B was the therapeutic recreation coordinator and was responsible to complete all resident activity assessments, care plans and created the schedule for resident activities. A-A reviewed R420's baseline care plan and verified the activities section was blank. A-A stated the baseline care plan was to be completed within 48 hours after admission to the facility. The facility provided activities calendar dated 8/16/20 - 8/22/20 revealed the following scheduled activities: -1:1 activities would be provided throughout the day, everyday. -Bingo was scheduled for 8/17/20, 8/18/20, 8/19/20, and was also held on select units, daily. -Outdoor visits were scheduled for 8/16/20, 8/17/20, 8/19/20, 8/20/20, 8/21/20. -Church services scheduled 8/16/20. -Ice cream treats scheduled on 8/21/20. The facility provided an Activity (Group and independent Leisure) Participation Documentation dated August 2020, which revealed R420 participated in TV/Movie/Sports/News. Other listed independent activities such as reading/writing/newspaper, crafts, radio/music, company, helping others, games/puzzles and 1:1's were blank which indicated not offered/provided. The Activities Participation policy dated October 2018, specified an ongoing program to support residents in their choice of activities all nursing and activity staff are required to review the resident's care plan and residents preferences listed on their activity documentation sheet. Finally, the Activities Participation policy stated staff were to communicate resident/family leisure

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F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) request to an activities staff member.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure clinical justification for the use of an indwelling catheter and failed to provide education related to the effects of catheter use for 1 of 1 resident (R18) reviewed with a catheter. Findings include: R18's annual Minimum Data Set (MDS) 6/1/20, indicated intact cognition. The MDS indicated R18 required extensive to total assistance with activities of daily living and identified the use of an indwelling catheter. R18's care plan dated 6/5/20, identified the use of an indwelling urinary catheter related to skin breakdown and family request. R18's physician's orders [REDACTED]. No [DIAGNOSES REDACTED]. A wound care visit note dated 3/19/19, indicated R18 was evaluated for wounds to her bilateral ischial areas (sit bones). The wound care orders included treatment and directed staff to encourage offloading. The wound care orders did not address the use of the indwelling catheter. R18's clinical record lacked evidence of an assessment, patient education or clinical justification for use of the indwelling catheter. During observation and interview on 8/17/20, at 7:08 p.m. R18 was seated in a reclining wheel chair in her room. R18 stated she had a urinary catheter. R18 stated the doctor said I didn't need it but I said I wanted it. On 8/20/20, at 9:11 a.m. registered nurse (RN)-D stated R18 had the catheter placed because she was incontinent and it was causing pain in her wounds. RN-D stated R18's family member had called and requested the catheter due to R18's incontinence and the physician ordered the catheter to be placed until wound care evaluated R18 in March of 2019. RN-D further stated there was no diagnosis listed for the catheter. At 2:00 p.m. the director of nursing (DON) stated the facility tried to avoid using catheters. The DON stated R18's catheter had been placed due to her sores and said there had been multiple conversations about R18's catheter amongst the staff. The DON stated R18 did not want the catheter removed. In regard to discussion of the risk of long term catheter use or clinical justification for use of the catheter, the DON stated she would look however, no further information was provided. A policy related to catheter use was requested but not received.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to follow up on pharmacy recommendations for 2 of 5 residents (R9, R18) reviewed for unnecessary medications. Findings include: R9's quarterly Minimum Data Set ((MDS) dated [DATE], indicated she required extensive assistance from two staff for all activities of daily living. R9's care plan dated 6/3/20, identified a [DIAGNOSES REDACTED]. R9's Physician order [REDACTED]. The order had a start date of 11/12/19. A Consultant Pharmacist's Medication Review dated April 2020, indicated the following: Medication: atorvastatin 40 mg. Irregularity or comments: According to the treatment of [REDACTED]. Suggested course of action: Could this statin be discontinued? Follow-up or action taken: Physician circled rejected and indicated will review at next appt. (appointment) A physician progress notes [REDACTED]. The Progress Note lacked evidence the use of atorvastatin was reviewed. R18's Annual MDS dated [DATE], indicated she had intact cognition and required total to extensive assistance for all activities of daily living. R18's care plan dated 6/5/20, identified a [DIAGNOSES REDACTED]. The care plan indicated R18 received insulin. R18's physician's orders [REDACTED]. Irregularity or comments: Long-term use of sliding scale insulin is not recommended due to lack of evidence for efficacy. Suggested course of action: Consider discontinuing use of sliding scale insulin and manage blood glucose with basal/bolus insulin based on daily sliding scale requirements Follow-up or action taken: Physician circled rejected with no clinical rationale for the continued use of sliding scale insulin was documented by the physician. During interview on 8/20/20, at 8:45 a.m. the director of nursing (DON) stated the pharmacist reviewed medications monthly and made recommendations. The DON stated the recommendations were given to the clinical managers and the clinical manager was responsible to reach out to the physician. At 1:31 p.m. the DON stated she was not aware the physician had to document a clinical rational for a rejection of the pharmacy recommendation. A policy related to follow up on the consultant pharmacists recommendations was requested but not received.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide clinical justification for the ongoing use of [MEDICAL CONDITION] medications for 1 of 5 residents (R9) reviewed for unnecessary medications. Findings include: R9's annual Minimum Data Set ((MDS) dated [DATE], indicated she was severely cognitively impaired, had minimal symptoms of depression and suffered from delusions. The MDS indicated R9 displayed behaviors 1-3 days during the assessment period. R9's quarterly MDS dated [DATE], and 5/21/19. indicated she did not display any physical, verbal or other behaviors nor did she display any delusions. R9's Behavioral Symptom Care Area Assessment (CAA) dated 11/20/19, indicated she displayed other behavioral symptoms directed toward others and indicated she had delusions. The CAA also indicated R9's nurses notes reflected calling out especially at night and/or when alone and R9 was very confused and forgetful. The CAA indicated R9 required a care plan for the behavior of calling out. The CAA did not describe R9's delusions. R9's Patient Health Questionnaire-9 (PHQ-9) (assesses degree of depression severity via questionnaire) assessment dated [DATE], indicated a score of 3 out of 27 indicating minimal depression. R9's PHQ-9 assessment dated [DATE], indicated R9 reported no signs or symptoms of depression. R9's physician's orders [REDACTED]. Target behaviors: statements about dying, crying and yelling out. -[MEDICATION NAME] (antidepressant medication) order date 6/30/20, 20 mg oral once daily for target behaviors: yelling out and crying. A facility document titled Yearly Data Summary dated 2020, indicated the following: Target behaviors and data: yelling out, fear of being alone, statements of sadness, crying: January 2020, number of behaviors indicated 0. February 2020, number of behaviors indicated 0. March 2020, number of behaviors indicated 0. April 2020, number of behaviors indicated 0. May 2020, number of behaviors indicated 0. June 2020, number of behaviors indicated 0. July 2020, number of behaviors indicated 0. A review of R9's certified nurse practitioner (CNP) Progress Notes indicated the following: -2/18/20, Staff had expressed that R9 seemed unhappy and was difficult to please. R9 was trying to adjust to her move within the long term care facility. This was further complicated by probable pain related to a fracture of her left arm. A trial of [MEDICATION NAME] 10 mg daily and time will help her through this adjustment period. The Progress Note referred to a PHQ-9 score of 10 dated 7/11/18. -4/7/20, Nursing reported R9 had settled into her new environment - had a rocky start and was quite unhappy and verbally disruptive. R9 was now taking her medications, eating well, stated she was able to talk to her children on the phone and watch television and appears to be quite content. R9 had been started on [MEDICATION NAME] 10 mg daily for yelling out,crying and making statements about dying which have all improved. Will increase [MEDICATION NAME] to 20 mg and continue [MEDICATION NAME] 25 mg. -4/21/20, R9 up in wheel chair at time of visit, smiling, calm, interactive. Stated she was getting settled in and liked it at the facility. R9 appeared to be understanding and accepting of visitor restrictions and was able to tell stories about her boys from when they were kids. Continue anti-depressant for the time being. During an interview with R9 on 7/17/20, at 3:09 p.m. she stated she had been in the facility since fall. R9 stated all of the staff were very nice to her. R9 stated her three sons had visited her the previous day and she played bingo, watched television and went for a walk every day. During the interview, three male visitors appeared outside her window to wave to her. On 8/19/20, at 2:00 p.m. nursing assistant (NA)-I was asked about documentation of behaviors and stated that the nurses documented all of the resident behaviors not the NAs. During interview on 8/20/20, at 8:45 a.m. the director of nursing (DON) indicated she was not familiar with the regulations. On

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F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) 8/20/20, at 10:52 p.m. NA-I stated when R9 was first admitted to the facility. she was rude to staff but had seemed better since March. NA-I stated she felt R9 was a hundred percent perfect. On 8/20/20, at 10:55 a.m. licensed practical nurse (LPN)-A stated R9 was very crabby when she first admitted to the facility but had not displayed any behaviors since about a month after admission. A facility policy titled Antipsychotic Medication Reduction dated 12/21/18, indicated during the first year a resident is prescribed a psychopharmacological medication the facility should attempt to taper the medication unless clinically contraindicated.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**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 implement systems for the prevention, identification and control of infections, including potential infections not treated with an antibiotic, failed to implement recommended COVID-19 infection control procedures related to the use of gowns when in direct contact for 5 of 5 residents (R46, R24, R69, R370, R420) who were newly admitted to the facility and remained under the required 14 day new admission isolation period and for 1 of 1 resident (63) on transmission based precautions due to the colonization of extended spectrum beta-lactamases (ESBL) which required the staff to utilize gowns when in direct contact with the resident. Lastly, the facility failed to deep clean 1 of 1 resident (R69) room after isolation precautions were lifted. These practices had the potential to affect all 78 residents residing in the facility. Findings include: During an interview on [DATE], at 1:18 p.m. the director of nursing (DON) stated she had been helping with the infection control tracking in the facility. The DON stated the former infection control preventionist had left the facility however, had collected data related to antibiotics and reported the information at QAPI meetings. The DON stated she was still working on collecting the data for July and had not yet started August and had been using a report in the electronic record to determine which residents had received antibiotics each month and transferred the data onto a spreadsheet. The DON stated staff talked about infections and Covid-19 daily, during the interdisciplinary team meetings. When asked about tracking of infections not treated with an antibiotic, the DON stated she was not sure about that piece and was unable to provide evidence of ongoing tracking and trending for infections not treated with an antibiotic. A facility policy titled Infection Control Plan dated [DATE], indicated the policy established a facility wide system for the prevention, identification, investigation and control of infections of residents, staff and visitors. The policy indicated procedures for the infection control program included a system of surveillance designed to identify possible communicable diseases or infections before they could spread to other persons in the facility to include daily infections, urinary tract infections, [MEDICAL CONDITION], pneumonia and respiratory infections, skin and soft tissue infections and tracking of resident infections for patterns, trends and healthcare associated infections. R46's face sheet included [DIAGNOSES REDACTED]. R46's admission MDS dated [DATE] indicated impaired cognition and the need for extensive assist with ADL's. R46's Care plan revised [DATE], indicated R46 required Covid-19 isolation until [DATE]. The care plan directed any staff entering the room was to don a surgical mask, eye goggles or face shield and gloves and anyone upon entering and leaving the room must perform hand hygiene. Place an isolation sign on resident's door, use dedicated or disposable equipment and no visitors at this time The care plan also identified self care deficit and directed staff to assist R46 with her personal cares. On [DATE] at 1:46 p.m. R46's room door was observed to have laminated sign with picture indicators of personal protective equipment (PPE) to wear when in the room which included pictures of gloves, mask, face shield, and gowns however, the picture of gowns was crossed off with an X in bold black marker. The cart outside the room was supplied with gloves, visitor log, wipes and hand sanitizer. The cart did not have any isolation gowns. On [DATE] at 8:53 a.m. NA-L was observed to don a faceshield over her surgical mask. NA-L stated she was there to do a 30 minute fall risk check on R46 as R46 was at risk for falls. NA-L donned gloves, however did not don an isolation gown, knocked on R46's door and entered the room. NA-L stated she would check on R46 and also check her incontinent brief to see if she needed to be changed. NA-L confirmed R46's brief was wet with urine, and proceeded to assist R46 with peri care. NA-L removed R46's soiled brief, provided pericare with disposable wipes, and placed a clean brief under her and fastened it. NA-L's uniform pants was observed to touch R46's bed, bed linen, and soiled brief. NA-L offered to assist R46 up into her wheelchair at which time R46 indicated she preferred to remain in bed. NA-L placed R46's foot cushions on her feet, covered R46 with her blanket and placed the call light beside R46. NA-L uniform shirt was observed to touch R46's bare legs and bed linens. NA-L exited R46's room. On [DATE] at 9:28 a.m. NA-M was observed to put on a face shield and glove, sign in and entered R46's room for a 30 minute check. NA-M did not apply an isolation gown. Approximately one minute later, NA-M exited R46's room, utilized foaming hand sanitizer, removed her shield, wiped them with disinfectant wipes, put the shield into a paper bag, and signed time out on R46's log. On [DATE] at 12:49 p.m. clinical unit manager (CM)-A stated upon admission and hospital return, the residents were put under quarantine and isolated to their room for a 14 day period. CM-A verified the policy was for the staff to wear a face shield over their mask and to glove upon entering quarantined resident rooms and that the facility did not require staff to wear isolation gowns when the resident was under 14 day quarantine. CM-A stated the current policy had been in effect for about a month. CM-A stated she thought the facility had plenty of isolation gowns available and they were not in short supply. On ,[DATE]/ 20 at 2:06 p.m. The administrator stated the facility policy for use of PPE was the Long Term Toolkit sent out by the Minnesota Department of health. The administrator stated the policy did not direct staff to wear isolation gowns for new admission or hospital returns as the facility was in conservation mode. The administrator stated the facility policy directed staff to use the minimum of gloves, shield and mask for residents that are on 14 day quarantine but not COVID-19 positive. The administrator stated the facility was prioritizing gown use, but they did have backups in place, such as cloth gowns. R63's face sheet included [DIAGNOSES REDACTED]. R63's quarterly MDS dated [DATE], indicated the need for limited assist with transfers and supervision with dressing and toileting. R63's care plan with revision date of [DATE], indicated R63 was colonized with a multi-drug resistant organism of extended spectrum beta-lactamases (ESBL-a type of enzyme produced by some bacteria). The care plan directed staff to use enhanced barrier precautions and isolation during high touch procedures. The care plan indicated a gown and gloves were required for care activities such as dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting. On [DATE] at 1:09 p.m. R63 was observed in her room, seated in her wheelchair, attempting to lie down on her bed. NA-N entered R63's room to assist her and R63 requested to go to the bathroom. NA-N propelled R63 into the bathroom, positioned her wheelchair in front of the toilet and donned gloves. NA-N was wearing a surgical mask however, did not don an isolation gown. NA-N prompted R63 to stand. NA-N assisted R63 to pull down her pants, removed her urine soaked brief and assisted R63 to sit on the toilet. NA-N changed her gloves and assisted R63 to stand, cleansed her peri area and put on a clean brief. NA-N wheeled R63 to the bedside and assisted her into bed. NA-N removed her gloves, gathered up the garbage, washed her hands and exited the room. On [DATE] at 1:15 p.m. In a group interview, NA-N stated she was not aware R63 was on transmission based precautions. LPN-B stated staff were to wear isolation gowns when toileting R63 and indicated there was a sign on the outside of her door to notify staff of what to do. LPN-B verified there was no other signage located in R63's room to alert staff that she required transmission based precautions. At this time, LPN-B verified the precaution sign on R63's door was not visible when the door was open. LPN-B stated she did not know how NA-N would have known R63 was on transmission based precautions if she entered the room to assist R63 when the R63's door was open, as there were no other signs visible to indicate precautions were needed. On [DATE] at 10:26 a.m. RN-A stated R63 was on transmission based precautions because she was colonized with ESBL in her urine. RN-A verified she would expect the NA's to wear isolation gowns when providing cares or assisting R63 with toileting. RN-A stated the NA's would know that by the transmission based precaution sign on R63's door, and it was also documented on the NA's care sheet. R24's significant change of status MDS dated [DATE], indicated R24 had impaired cognition and required extensive assistance of one to two staff with activities of daily living (ADL's). R24's physician's orders [REDACTED]. R24's care plan dated [DATE], indicated R24 was to remain in Covid 19 isolation until [DATE], with the goal to prevent possible spread to others. The care plan directed staff to wear a surgical mask, eye goggles or face shield, and gloves when entering R24's room. The care plan indicated an isolation sign was placed on R24's door and to place surgical mask on the resident for transport, use dedicated and disposable equipment, and no visitors at this time. The care plan also indicated R24 had self care deficit due to stroke with right sided weakness, cognitive and communication deficits with goals to participate in ADL's. Approaches indicated R24 required assistance from staff with all ADL's. On [DATE], at 5:05 p.m. a droplet

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	245039	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) precautions (used for residents to prevent the spread of suspected disease through cough, sneeze or talking) sign was observed posted on R24's room door which included instructions to enter wearing gloves, and a mask with shield. A container hanging from the outside of the door contained small, medium, and large gloves, a garbage bag, and gold and purple topped disinfectant wipes. On [DATE], at 5:05 p.m. the surveyor asked to enter the room and was provided a shield to wear and was told a gown was not necessary. On [DATE], at 8:30 a.m. RN-A and an NA-J were observed to enter R24's room wearing surgical masks, gloves and a face shield. R24 was in bed. RN and NA-J proceeded to assist R24 to wash hands and face, change T-shirt, and don pants and socks. During this time, RN-A and NA-J assisted R24 from bed and onto the bathroom toilet followed by pericare at which time RN-A removed a soiled protective dressing from R24's coccyx. Upon completion of care, R24 was assisted back to wheelchair. Throughout the observation, both RN-A's and NA-J uniforms were observed to brush up against R24's bed linens, bare skin, and clothing. R69's MDS dated [DATE], indicated R69 had intact cognition and required extensive assistance with transfer. R69's care plan dated [DATE], indicated staff and visitors must don PPE which included a surgical mask, eye goggles/shield, and gloves. COVID-19 isolation precautions until [DATE]. COVID-19 precautions were in addition to standard precautions. On [DATE], at 7:10 p.m. a sign on R69's door read in black bold letters to sanitize hands prior to entering, A laminated picture of PPE was posted inside the room which included pictures of gloves, mask, and face shield. The picture of isolation gowns was crossed off indicating not needed. The cart positioned outside the room was noted to be supplied with gloves, a visitor log, wipes, and hand sanitizer. No gowns had been stocked in the cart. During interview on [DATE], at 7:10 p.m. R69 stated, Nobody wears gowns when they come in. During interview on [DATE], at 9:06 a.m. NA-A stated when a resident came off of isolation precautions, they usually moved to another resident room on the other side of the unit at which time the isolation room would be deep cleaned. NA-A stated someone should have cleaned R69's room after isolation precautions expired, since he stayed in the same room. NA-A stated if the individual was COVID-19 positive, they would use bleach wipes and thoroughly clean that room. NA-A was unsure who cleaned R69's room after isolation precautions were lifted on [DATE]. NA-A stated before entering isolation rooms, she would sanitize her hands and put on gloves. NA-A further stated she already had her mask and face shield on. Coming out of the room, she would take gloves off and sanitize hands. NA-A further stated gowns are not needed at this time with new admissions. She was unsure why they stopped wearing gowns, but managers advised that the State Agency does not require use of gowns any longer for new admissions. During interview on [DATE], at 9:46 a.m. RN-B stated when a resident came off of quarantine and had no symptoms of COVID the room was cleaned the same way as other days (swept, mopped and cleaned with disinfectant if needed or done on bath day). For COVID-19 positive residents they would obtain the bin from housekeeping, which has a checklist on how to disinfect the room with bleach products. RN-B stated there was a systematic guide in the bin to direct staff on proper procedure. Housekeeping was responsible for cleaning common areas of the facility and the railings in the hallway. RN-B stated housekeeping was helping with terminal cleaning of resident's rooms after discharge. NA's were responsible for the daily cleaning in resident's rooms along with the resident's laundry. RN-B stated when a residents isolation period was lifted she removed the isolation signs on the doors along with the sign in/out log sheets and then the staff would clean the room as they normally would. RN-B stated the NA's have a check off list to follow for bath days for cleaning reminders. During interview on [DATE], at 9:54 a.m. Housekeeper (H)-A stated housekeeping responsibility for cleaning common areas and help with terminal cleaning of residents rooms after discharge. H-A further stated nursing staff responsibilities include cleaning residents rooms. R370's care plan dated [DATE], identified R370 required COVID-19 isolation precautions until [DATE]. R370's care plan identified several interventions which included entering the room must don a surgical mask, eye goggles, or face shield and gloves. During interview on [DATE], at 5:30 p.m. RN-B stated the staff are to wear a face shield, mask and gloves in each room. If staff needed a gown, they could obtain these at the nurse's station. RN-B verified new admissions were placed on a 14 day quarantine period isolated to their rooms with isolation precautions, but if they had no Covid-19 symptoms, the staff should not be wearing gowns when entering the room. RN-B confirmed the isolation gown directive on the posted isolation precaution signs was crossed off as gowns were not required to be worn for new residents with no symptoms of Covid-19. On [DATE], at 2:25 p.m. NA-D was observed to walk out of the R370's room wearing a facemask and faceshield that did not cover the side of NA-D's eyes or face. During interview on [DATE], at 2:32 p.m. NA-D stated it was important to a wear face shield to protect herself from residents who could cough, sneezes, and protect from germs getting into her eyes. NA-D stated she was not sure why her face shield did not fully wrap around her glasses, but does not feel like germs would get into her eyes. She stated the face shield catches her glasses and does not wrap around them. NA-D stated she did not wear gowns due to a lack of supply. Further, NA-D stated the staff used to wear gowns when entering Covid-19 isolation rooms, but stopped three to four weeks ago. During observation on [DATE], at 3:43 p.m. unidentified NA entered R370's room with face shield, mask, and gloves on. The NA did not apply an isolation gown. Upon entering the room, the NA applied a blood pressure cuff to R370's arm, obtained R370's temperature and oxygen level. Throughout the observation, the NA's uniform was noted to come into contact with the side rail as she leaned over R370. On [DATE], at 3:45 observed RN-C wearing face shield, mask and gloves during direct patient wound care for R370. RN-C's clothing came in direct contact with R370's bed. RN-C was within six feet of R370 for approximately one hour during wound care. On [DATE], at 2:03 p.m. a laminated sign was noted on R370's room door. The sign identified R370 was on precautions from [DATE] - [DATE], and included pictures of gloves, mask, faceshield and gowns; however, the picture of the gowns was crossed off indicating not needed. A cart was positioned outside of R370's door which contained gloves and hand sanitizer. The cart did not contain any isolation gowns. During interview on [DATE] 2:31 p.m. NA-E stated she cleaned resident rooms with disinfectant Sani wipes and also used bleach wipes for deep cleaning along with glass cleaner. NA-E stated they performed a deep clean once a week on the resident's bath day and surface cleaning on a daily basis or as needed. NA-E also stated weekly cleaning of the the room consisted of sweeping, mopping, cleaning the bathroom and dusting the rooms as well. NA-E stated they do not document their daily cleaning. NA-E stated in between the weekly cleaning, if she noted a room needed to be cleaned or items picked up or if a resident asked her to clean their room, she would do so. R420's admission MDS dated [DATE], identified R420 had [DIAGNOSES REDACTED]. The MDS identified R420 had moderate cognitive impairment and required physical assistance with his ADL's. R420's care plan dated [DATE], identified R420 required COVID-19 isolation precautions until [DATE]. R420's care plan interventions included: anyone entering room must don surgical mask, eye goggles or face shield and gloves. On [DATE], at 2:08 p.m. a droplet precaution sign was observed on R420's door which included instructions to apply gloves, a mask and face shield upon entry to the room. The picture identifying gown use was crossed off indicating not needed. A three tiered cart was positioned outside of R420's room which contained gloves, visitor log, wipes and hand sanitizer. The cart was not stocked with isolation gowns. During an observation on [DATE], at 3:16 p.m. NA-F entered R420's room without a gown on, however NA-F was wearing mask, face shield and gloves. Shortly there-after, NA-F exited with gloves, mask and a face shield on. When interviewed on [DATE], at 3:23 p.m. NA-F stated the picture on the door indicated R420 was on droplet precautions and directed staff to wear gloves, mask and face shields. NA-F verified the directive to wear an isolation gown was crossed off which indicated they were not needed. NA-F stated it had been about a month since gowns were last required to be worn when in a resident room with droplet precautions related to COVID-19 isolation precautions. When interviewed on [DATE], 9:34 a.m. occupational therapist (OT)-B was observed wearing gloves, mask and face shield during an occupational therapy session in R420's room. OT-B stated she had not been wearing an isolation gown when inside R420's room providing occupational therapy which included transfer exercises requiring direct contact with R420. OT-B stated it had been weeks since gowns were required to be worn in a resident's rooms who was on droplet precautions for isolation related to COVID-19. Policy titled Emerging Threats-Acute Respiratory Syndromes Coronavirus (COVID)-Enterprise, dated [DATE] indicates that healthcare workers, when in close contact or providing cumulative care for 15 minutes or more, will wear eye protection unless the resident is wearing a surgical or cloth mask. Gowns to be worn if the resident is COVID positive or has an additional infection such as [MEDICAL CONDITION].
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to maintain resident equipment in a clean and

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F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) sanitary manner for 1 of 1 resident (R56) whose wheelchair was soiled. In addition, the facility failed to maintain resident room cleanliness for 2 of 2 residents (R420, R220) who had debris scattered on their floors. Findings include: R56's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R56 had severe cognitive impairment and required extensive assistance of two staff with cares. The MDS identified R56 had [DIAGNOSES REDACTED]. The MDS indicated R56 used a wheelchair and required extensive assistance of one staff with locomotion on the unit. R56's current care plan revised 7/31/20, identified R56 required extensive assistance with activities of daily living (ADL's) and used a wheelchair for locomotion, required staff to propel to specific destinations. During observation on 8/17/20, at 3:28 p.m. R56 was seated in front of the television in the common area. R56's wheelchair had of dry crusted debris on the right side of the wheelchair cushion 3 inches in diameter, the frame and side of arm rest contained a one eight inch coating of brown and white substance identified by nursing assistant (NA)-B to be crumbs and dried food. On the left side of the wheelchair there was an approximately one inch white spot with a line of dried white substance down the side of the wheelchair to the bottom frame with white substance lines around the wheel spokes and onto the tire. The frame and spokes of wheel contained a layer of crusted white and brown substance. When interviewed on 8/19/20, at 10:06 a.m. NA-B stated resident wheelchairs were to be spot cleaned when staff observed food or liquid debris on them and the staff person that observed the debris was to spot clean it. NA-B further stated wheelchairs were washed in the wheelchair washer weekly, on bath day, by the evening or overnight staff and then were brought to the hallway outside of the resident's room to allow the wheelchair to dry. Wheelchair cushion covers were to be washed by hand then hung up to dry. During interview on 8/19/20, at 1:43 p.m. NA-C indicated resident wheelchairs were washed weekly on their bath day, but if there was a spill or crumbs on the wheelchair in between washing, it should be cleaned right away by the staff member that identified the wheelchair was dirty. NA-C stated the were to be kept clean for resident comfort and dignity as she would not want my family to sit in a dirty, crumby wheelchair. When interviewed on 8/20/20, at 8:58 a.m. registered nurse (RN)-A stated any staff member was able to spot check and clean a wheelchair, and verified the night shift performed thorough cleaning per the schedule. RN-A confirmed R56's wheelchair and cushion had a buildup of dried liquid and food crumbs and stated she would expect R56's wheelchair to have been kept clean. An undated facility policy titled, Wheelchair Washing, indicated afternoon and nights were responsible for washing all resident wheelchairs on the day they received their baths. The policy lacked direction for periodic cleaning of resident wheelchairs. R420's admission Minimum Data Set ((MDS) dated [DATE] identified R420 had moderate cognitive impairment and had [DIAGNOSES REDACTED]. The MDS identified R420 required physical assistance with ADL's. On 8/18/20, at 9:52 a.m. R420 stated food crumbs had been at the end of the bed for over a week. Food crumbs were observed at the end of his bed on the floor and a cloth arm protector was on the floor by nightstand. R420 stated no one had cleaned his room or picked up things from the floor since being admitted to facility over a week ago. R420 voiced his frustration with lack of cleaning from staff. R420 stated staff had not been in his room to clean for over a week. On 8/18/20, at 3:28 p.m. a facility housekeeper walked past R420's room, was not observed to enter or look into R420's room. On 8/19/20, at 7:21 a.m. the food crumbs on R420's floor remained at the end of R420's bed. R420 stated no one had been in his room to clean and stated he wanted his room to be cleaned. On 8/19/20, at 10:06 a.m. upon entry of R420 room, R420 was in recliner, sitting upright in seated position, awake and watching TV. It was observed several, less than a dozen, food crumbs on the floor by end of bed. R420 confirmed no one had been there to clean his/her room. R220's admission MDS dated [DATE], identified R220 had [DIAGNOSES REDACTED]. The MDS identified R220 required physical assistance with ADL's. On 8/19/20, at 8:54 a.m. R220 stated random staff would take her garbage out but no one had cleaned her room. R220 stated she had cleaned her floors by the recliner with her foot and a paper towel due to needing space cleaned and the staff had never offered to clean for her. At this time, 2 tissues were observed below the window and throughout the floor of her room. On 8/19/20, at 9:17 a.m. NA-G stated the NA's would deep clean resident rooms on their shower days and the housekeeping staff cleaned the building. NA-G stated the NA's were responsible for maintaining resident room cleanliness which deep cleaning such as changing linens, sweeping and mopping the floor, and wiping down the shower and toilet. NA-G stated she was not aware when R220's room was last cleaned. NA-G confirmed R220's floor had random trash below the window and throughout the floor of R220 room and stated the floor needed to be swept. NA-G stated if a room was in need of cleaning, it should be cleaned however, felt there was not enough nursing staff to provide resident cares and cleaning. When interviewed on 8/19/20, at 12:53 p.m. housekeeper (H)-B stated housekeeping was responsible for cleaning all the common areas of the facility which included all entrances and the elevators. H-B stated the elevators and entrances were cleaned three times a day, handrails were cleaned one to two times a day. H-B stated the aides were responsible to clean the residents' rooms unless housekeeping was specifically asked to clean a resident room. On 8/20/20, at 12:57 p.m. the facility administrator verified the nurses and NA's were responsible for cleaning residents' rooms and stated the facility was trying to get more housekeeping staff but had not been successful. The administrator stated the expectation of the nurses and aides was to clean residents' rooms daily, when it was needed, noticeable or requested by a resident. Cleaning policy was requested and not provided.