DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 0CRO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00448

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245252**
2.STATE VENDOR OR MEDICAID NO.
(L2) **591605000**

3. NAME AND ADDRESS OF FACILITY
(L3) **THIEF RIVER CARE CENTER**
(L4) **2001 EASTWOOD DRIVE**
(L5) **THIEF RIVER FALLS, MN** (L6) **56701**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/22/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
04/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **70** (L18)

13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 12/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 02/06/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
__X__ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
07/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/02/2013
(L33)

DETERMINATION APPROVAL

CCN 24-5252

On September 12, 2013, an OTC survey was completed at this facility. The most serious deficiency was at a S/S level of E.

Lack of verification of substantial compliance by the 70th day, we notified the facility that we recommended the following remedy to the CMS RO for imposition and CMS RO concurred:

Mandatory DOPNA, effective December 12, 2013.

If DOPNA goes into effect the facility would be subject to a loss of NATCEP for two years beginning December 12, 2013.

On November 22, 2013, a PCR was completed by review of the POC and corrected the deficiencies, effective November 12, 2013.

As a result, we recommended CMS RO rescind the following remedy:

Mandatory DOPNA, effective December 12, 2013, be rescinded.

Since DOPNA did not go into effect, the facility would not be subject to a two year loss of NATCEP.

See attached CMS-2567B from the November 22, 2013 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN 24-5252 February 6, 2014

Ms. Michele Halvorson, Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, Minnesota 56701

Dear Ms. Halvorson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 12, 2013 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5212

November 21, 2013

Ms. Michele Halvorson, Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, Minnesota 56701

RE: Project Number S5252023

Dear Ms. Halvorson:

On October 29, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 12, 2013 . This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 12, 2013. Based on our visit, we have determined that your facility has not achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on September 12, 2013.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 12, 2013. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective December 12, 2013. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 12, 2013. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Thief River Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 12, 2013. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

A copy of the Post Certification Revisit Form (CMS-2567B) from the September 12, 2013 revisit is enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 12, 2014 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

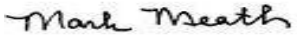
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5252r1_70dayNotice.rtf

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245252	A. Building B. Wing	11/22/2013

Name of Facility	Street Address, City, State, Zip Code
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **11/12/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **11/12/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **11/12/2013**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **11/12/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **11/12/2013**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **11/12/2013**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **11/12/2013**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **11/12/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/LB	12/20/2013	28035	11/22/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/12/2013			

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 20, 2013

Ms. Michele Halvorson, Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, Minnesota 56701

RE: Project Number S5252023

Dear Ms. Halvorson:

On November 21, 2013, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 12, 2013. (42 CFR 488.417 (b))

Also, we notified you in our letter of November 21, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 12, 2013.

This was based on the deficiencies cited by this Department for a standard survey completed on September 12, 2013, and lack of verification of substantial compliance with the health deficiencies at the time of our November 13, 2013 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On November 22, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 12, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 12, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 12, 2013, as of November 12, 2013.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of November 13, 2013. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 12, 2013, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective December 12, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective December 12, 2013, is to be rescinded.

In our letter of November 13, 2013, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 12, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 12, 2013, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5252r2_14_70dayAllcorr.rtf

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 0CRO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00448

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245252**
2.STATE VENDOR OR MEDICAID NO.
(L2) **591605000**

3. NAME AND ADDRESS OF FACILITY
(L3) **THIEF RIVER CARE CENTER 2001**
(L4) **EASTWOOD DRIVE THIEF RIVER**
(L5) **FALLS, MN** (L6) **56701**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2006**

6. DATE OF SURVEY **09/12/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
04/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **70** (L18)

13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Yvonne Switajewski, HFE NE II — 11/14/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 12/02/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/02/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

At the time of the standard survey completed September 12, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 1830 0003 8091 4462

October 29, 2013

Ms. Michele Halvorson, Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, Minnesota 56701

RE: Project Number S5252023

Dear Ms. Halvorson:

On September 12, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933

Telephone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 22, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 12, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 12, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal

regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
.

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (612) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with the resident's written plan of care (POC) for 1 of 1 resident (R79) in the sample who required assistance with oral hygiene, 1 of 1 resident (R48) who required assistance with incontinence care and positioning and 1 of 1 resident (R38) who required readily accessible emergency supplies related to dialysis access, and fluid restriction. Findings include: Oral hygiene:	F 282	F 282 R 79 Was assessed for the time preferred for oral cares 9-12-13. Resident stated that he likes to brush his teeth after meals as this is what he did at home. His care plan was update on 9-12-13 to indicate am brushing can be completed after breakfast. R 48 Skin check was completed after being informed of the delay in repositioning. Skin check revealed that her skin was clean, dry, and intact without any sign of breakdown. Her toileting schedule and tissue tolerance were reviewed and determined to remain appropriate. Therefore, we will continue with toileting and repositioning q three hours. Approved 11/14/13 SB - c Addendum	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Hallin — TITLE: Administrator — (X6) DATE: 10/29/2013

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 R79 did not receive oral hygiene on the morning of 9/11/13, as directed by the POC. R79's POC current as of 9/11/13, indicated R79 required assistance of one staff to perform oral cares twice a day. However, on the morning of 9/11/13, at 8:35 a.m. nursing assistant (NA)-A was observed to complete personal cares for R79, but was not observed to provide oral cares. On 9/11/13, at 11:00 a.m. NA-A stated she did not complete oral hygiene on R79 because his daughter came in every afternoon and completed the oral hygiene. On 9/11/13, at 11:30 a.m. registered nurse (RN)-A verified the POC was correct and stated staff should have provided oral hygiene. On 9/11/13, at 1:05 p.m. the director of nursing (DON) stated R79 should have received oral cares as directed by his POC. Review of the facility's undated policy entitled, Oral Hygiene, revised 7/13, directed staff to provide oral cares at least two times a day for residents, and more frequently as determined by assessments or request. Incontinence cares and repositioning: R48 did not receive timely assistance with incontinence cares and repositioning on the morning of 9/11/13, as directed by the plan of care. R48's POC dated 7/17/13, directed staff to assist with incontinence cares every 2-3 hours and repositioning every three hours.	F 282	R38 – New clamp provided and labeled "do not remove from room" on 9-11-13. Clamp is located in top drawer of night stand. A weekly check for clamp added to LPN to do list. Resident has an intake flow sheet which is kept on a clip board in his room. He will inform staff when they enter his room what he has consumed. Nursing staff are reviewing the communication book when the resident returns from dialysis M-W-F to determine if any follow-up is needed. It is Thief River Care Center's practice to follow toileting and repositioning schedules, as well as offering and encouraging oral cares with am and hs cares. The staff failing to complete those tasks were provided with written education for not following care plan interventions. All staff have been educated on following care plan interventions on 9-19-13 and 10-3-13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2 On 9/11/13, at 7:30 a.m. NA-A and licensed practical nurse (LPN)-A were observed to transfer R48 out of bed and into her wheelchair. At 11:15 a.m. NA-A was asked by surveyor what R48's repositioning schedule was, NA-A stated R48 would be assisted with repositioning and incontinent cares before lunch at approximately 12:00 p.m. After review of R48's POC with the surveyor, NA-A assisted R48 to her room. NA-A was observed to assist R48 with repositioning. R48 was observed to be incontinent of urine and her coccyx and groin area was observed to have deep, red creases. R48 was not repositioned or provided incontinent cares for 3 hours and 45 minutes. At 11:30 a.m. RN-A verified R48's POC was not followed as written. At 1:05 p.m. the DON confirmed R48's POC and verified staff had not followed it as directed and should have. Dialysis R38 did not receive dialysis access site monitoring and did not have specified emergency safety equipment readily accessible at the bedside as directed by the POC. R38's diagnoses included diabetes and kidney disease. R38 required kidney dialysis treatments three times per week, outside the facility. Kidney dialysis treatments were provided to R38 using a vascular access, a sterile catheter tube inserted	F 282	A turning and repositioning worksheet was created for the staff to complete. The on-coming shift will now know when the resident was last repositioned. Staff informed that they need to track on their assignment sheet when they turn their resident or indicate those times on the repositioning flow sheet which is kept at the nurses' station. All residents that are not independent with repositioning are indicated on turning and repositioning worksheet. All nursing staff educated 9-19-13 of the importance of the clamp being left in room for res # 38, and educated to never remove the clamp from his room. All staff instructed to review the intake sheet when they enter his room to provide medications to assist with adding new items to that sheet as well as ensure he does not exceed his fluid restriction. Nurses educated on 9-19-13 to review his communication book when he returns from dialysis on M-W-F to determine if any follow-up is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 3 into a main blood vessel in the right side of the upper chest with two flexible tubes extending outside the body at the level of the collarbone, to allow attachment to the dialysis machine tubes. R38's POC dated 3/30/13, directed staff to assess R38's dialysis access site for bleeding and to have a clamp at the bedside in case of uncontrollable bleeding from the vascular access tubing. On 9/10/13, at 3:10 p.m. no clamp was observed at R38's bedside. On 9/12/13, at 8:10 a.m. no clamp was observed at R38's bedside. On 9/12/13, at 8:03 a.m. R38 allowed the surveyor to observe the dialysis external access site. The site was observed in the upper right chest area near the collarbone. Two flexible tubes were observed to extend from the access site and were covered with a clear dressing. On 9/12/13, at 8:21 a.m. R38 stated he was unaware of any emergency supply or clamp at the bedside. On 9/12/13, at 8:42 a.m. NA-A stated she was not aware of any particular things to watch for regarding R38's vascular access site other than making sure the site was covered during bathing. On 9/12/13, at 11:12 a.m. RN-A stated she was not aware of any specific emergency supplies needed related to R38's dialysis. RN-A stated she did not think a clamp was necessary for R38. Upon review of R38's POC, RN-A confirmed the direction for staff to have a clamp available at	F 282	All dialysis residents reviewed to ensure proper documentation for fluid restriction was completed and communication book was reviewed. DON or RN will complete random audits twice a week for two weeks, weekly for four weeks and monthly thereafter. All audits will be brought to QA Committee for review and further recommendation. Completion date: 11-12-13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 4 R38's bedside in case of bleeding from R38's vascular access site. The surveyor accompanied RN-A to R38's room and RN-A verified there was not an emergency clamp for R38's vascular access site in the room. On 9/12/13, at 11:51 a.m. the DON stated she had labeled a clamp to have at R38's bedside and was unaware the clamp was not present in the room. The DON confirmed that it would be expected that the emergency supplies for R38's vascular access site would be present at the bedside as indicated in R38's POC. Review of facility policy titled, End-Stage Renal Disease (ESRD), Care of a Resident with, dated 10/10, directed the resident's comprehensive care plan would reflect the resident's needs related to ESRD/dialysis care. Fluid Restriction R38's physician ordered fluid restriction was not being monitored per the POC. R38's diagnoses included diabetes and renal (kidney) failure and required dialysis treatments (artificial cleansing of the blood using an external mechanical device), three times per week, outside the facility. R38's admission Minimum Data Set (MDS) dated 4/5/13, indicated R38 had intact cognition and received dialysis treatments. R38's plan of care (POC) 3/30/13, indicated a 1500 milliliter (ml) daily fluid restriction in which R38 would record the amount consumed per day. The communication between the dialysis unit and facility regarding R38's condition was	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 5 documented in a white three ring binder with template pages which included spaces for R38's vital signs (blood pressure, temperature and heart rate), any nursing comments and concerns, and R38's weight before and after the dialysis treatment. The weight loss after the dialysis treatment would reflect the fluid removed from R38's body during the treatment. Review of R38's dialysis communication book revealed on 6/28/13, a note from the dialysis unit to the facility to, "please limit fluids per renal diet." On 9/9/13, the notes revealed another request to, "please encourage to limit fluids, [R38] gained 6.8 kilograms (14.9 pounds) over the weekend." On 9/9/13, during the supper meal, R38 was observed lying in bed eating a meal that consisted of a half of a hamburger, green salad and eight ounces of apple juice. No materials for R38 to record fluid intake were present in the room. On 9/9/13, during the supper meal in his room, R38 stated he was aware of a fluid restriction but not aware of the restricted amount. R38 also stated he did not record his fluid intake and also frequently obtained and drank oral fluids when out of the facility. On 9/10/13, at 9:59 a.m. there was a sheet of paper on R38's bedside table with columns for documentation of the amount of oral fluid intake. On 9/12/13, at 8:21 a.m. R38 stated the dialysis unit had sent a paper this week for him to fill out to keep track of oral fluid intake daily. R38 also stated the daily fluid restriction was 1500 ml's. (approximately 1 and 1/2 quarts) per day.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 6 On 9/12/13, at 8:43 am. nursing assistant (NA)-A stated she was unaware of any special issues to monitor regarding R38's dialysis care. Review of R38's NA care sheet lacked any direction to staff related to fluid restriction for the resident. On 9/12/13, at 10:12 a.m. registered nurse (RN) -A verified R38's 1500 ml/day fluid restriction should have been monitored as identified in the POC. RN-A stated staff had not documented any monitoring of R38's fluid restriction because he was independent and had been doing well on his own, however, confirmed there was no documentation of R38's recording of fluid intake and the POC did not direct staff to monitor. On 9/12/13, at 11:51 a.m. the director of nurses (DON) stated staff were expected to and should have monitored R38's fluid intake / restriction. A three-ring binder identified as the facility policy titled Dialysis Services, copyright Meritcare 2009, directed toward dialysis patient education was provided. The policy directed the patient should be able to state what role fluid balance played in the treatment plan. The policy further explained details of reasons fluids would be limited for dialysis patients. The policy revealed a 200 pound person should gain no more than 8.8 pounds between dialysis treatments.	F 282	F309 Resident 38 – On 9-10-13 resident started an intake flow sheet which is kept on a clip board in his room. He will inform staff when they enter his room what he has consumed. Nursing staff are reviewing the communication book when the resident returns from dialysis M-W-F to determine if any follow-up is needed. All staff instructed on 9-19-13 and 10-3-13 to review the intake flow sheet when they enter his room to provide medications to assist in adding consumed items to the sheet as well as ensuring he does not exceed the fluid restriction. Also educated staff to review his communication book when he returns from dialysis to determine if any follow-up is needed. All current dialysis residents will be reviewed to ensure proper documentation for fluid restriction was completed and communication book was reviewed upon return from dialysis.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 7 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement care planning interventions related to the coordinated care for 1 of 1 resident (R38) receiving dialysis services and required the monitoring of fluid intake. Findings include: R38 diagnoses included diabetes and renal (kidney) failure which required dialysis treatments. R38's admission Minimum Data Set (MDS) dated 4/5/13, indicated R38 had intact cognition and received dialysis treatments. R38's plan of care (POC) dated 3/30/13, revealed directions for a fluid restriction of 1500 milliliters (ml) of fluid per day which R38 would record. The POC further directed staff to contact the physician if R38 had severe shortness of breath due to fluid overload and to maintain the communication book between the dialysis unit and the facility. The communication between the dialysis unit and the facility regarding R38's condition was documented in a white three ring binder with template pages which included spaces for R38's vital signs (blood pressure, temperature and heart rate), any nursing comments and concerns, and R38's weight before and after the dialysis treatment. The weight loss after the dialysis treatment would reflect the fluid removed from	F 309	DON or RN will complete fluid intake and communication book audits twice a week for two weeks, weekly for four weeks and monthly thereafter. All audits will be brought to QA Committee for review and further recommendation. Completion date: 11-12-13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8 R38's body during the treatment. Review of R38's dialysis communication book revealed on 6/28/13, a note from the dialysis unit to the facility to, "please limit fluids per renal diet". On 9/9/13 the notes revealed another request to, "please encourage to limit fluids, [R38] gained 6.8 kilograms (14.9 pounds) over the weekend." On 9/9/13, during the supper meal, R38 was observed lying in bed eating a meal that consisted of half of a hamburger, green salad and 8 ounces of apple juice. No materials for R38 to record fluid intake were present in the room. On 9/9/13, during the supper meal in his room, R38 stated he was aware of a fluid restriction but not aware of the restricted amount, did not record his fluid intake and that he frequently consumed oral fluids when out of the facility. On 9/10/13, at 9:59 a.m. there was a sheet of paper on R38's bedside table with columns for documentation of amount of oral fluid intake. On 9/12/13, at 8:21 a.m. R38 stated the dialysis unit had sent a paper this week for him to fill out in order to keep track of his oral fluid intake daily. R38 stated the daily fluid restriction was 1500 ml's. (approximately 1 and 1/2 quarts) per day. On 9/12/13, at 8:43 am. nursing assistant (NA)-A stated she was unaware of any special issues to monitor regarding R38's dialysis care. Review of R38's NA care sheet lacked any direction to staff related to R38's fluid restriction. On 9/12/13, at 10:12 a.m. registered nurse (RN) -A confirmed R38's POC dated 3/30/13. RN-A verified the fluid restriction of 1500 ml/day and	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 9 stated R38's fluid intake should have been monitored as identified in the POC. RN-A stated staff had not documented any monitoring of the fluid restriction for R38 because he was independent and had been doing well on his own, however, RN-A verified there was no documentation or evidence of R38's recording of fluid intake. On 9/12/13, at 11:51 a.m., the director of nurses (DON) stated staff were expected to monitor R38's fluid restriction and should have. A three-ring binder identified as the facility policy titled Dialysis Services, copyright Meritcare 2009, directed toward dialysis patient education was provided. The policy directed the patient should be able to state what role fluid balance played in the treatment plan. The policy further explained details of reasons fluids would be limited for dialysis patients. The policy revealed a 200 pound person should gain no more than 8.8 pounds between dialysis treatments.	F 309	F312 R79 was reassessed for time preferred for oral cares. Resident stated that he likes to brush his teeth after meals as this is what he did at home. His care plan was update on 9-12-13 to indicate am brushing can be completed after breakfast. All staff education completed on 9-19-13 and 10-3-13 on offering and encouraging all residents to have oral cares provided with AM and HS cares. If a resident refuses oral care NAR will report to LPN or nurse manger on the resident refusals.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure oral cares had	F 312	DON or nurse manager will complete oral care audits twice a week for two weeks, weekly for four weeks and monthly thereafter. All audits will be brought to QA Committee for review and further recommendation. Completion date: 11-12-13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 10 been provided for 1 of 1 resident (R79) in the sample reviewed for assistance with activities of daily living (ADL). Findings include: R79's was diagnosed with a stroke. The admission Minimum Data Set (MDS) dated 6/24/13, indicated R79 had cognitive impairment and required extensive assistance with all ADLs. The ADL Care Area Assessment (CAA) dated 6/27/13, indicated R79 had functional impairment which limited ability to perform personal hygiene with a loss of voluntary arm movement, impaired hand dexterity and functional limitation in upper extremity range of motion. The CAA also indicated R79 had a full upper denture plate and his own natural teeth on the bottom which appeared to be in poor condition. The computerized plan of care (POC) printed on 9/11/13, identified R79 as requiring extensive assist of one staff to maintain oral hygiene. The POC directed staff to brush R79's upper denture plate, and to assist R79 with hand over hand directions, prepare the tooth brush for R79 to brush his own lower natural teeth. On 9/11/13, at 8:35 a.m. nursing assistant (NA)-A was observed to complete personal cares for R79, but was not observed to provide or offer oral cares. On 9/11/13, at 11:00 a.m. NA-A stated she did not complete oral hygiene for R79 because his daughter came in everyday in the afternoon and completed the oral hygiene then.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 11 On 9/11/13, at 11:30 a.m. registered nurse (RN)-A verified the POC was correct and staff should have provided oral hygiene. On 9/11/13, at 1:05 p.m. the director of nursing (DON) stated R79 should have received oral cares as directed by his POC. Review of the facility's undated policy entitled, Oral Hygiene, revised 7/13, directed staff to provide oral cares at least two times a day for residents, and more frequently as determined by assessments or request.	F 312	F314 R48 Skin check was completed after being informed of the delay in repositioning. Skin check revealed that her skin was clean, dry, and intact without any sign of breakdown. Her toileting schedule and tissue tolerance was reviewed and determined to remain appropriate. Therefore, we will continue with toileting and repositioning q three hours. All residents upon admission will have a tissue tolerance completed for all surfaces that they use. Tissue tolerances are reviewed quarterly and redone annually, sig changes, and new skin concerns. All staff educated on 9-19-13 and 10-3-13 on following turning and repositioning schedules and to report to LPNs or nurse managers if the resident is non-compliant with repositioning schedule.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident identified at risk for pressure ulcers received assistance with repositioning in order to prevent the development of pressure ulcers for 1 of 1 resident (R48) in the sample. Findings include:	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 12 R48's diagnoses included a stroke, muscle spasms, congestive heart failure (CHF) and diabetes. The annual Minimum Data Set (MDS) dated 7/18/13, indicated R48 had cognitive impairment and was totally dependent on staff for bed mobility and transfers. The MDS also indicated R48 was non ambulatory and at risk for pressure ulcers. The 4/18/13, Skin Condition Questionnaires indicated R48 was at risk for skin breakdown, was incontinent of bowel and bladder and received extensive to total assistance with mobility and ADL's. The Pressure Ulcer Care Area Assessment (CAA) also indicated R48 was unable to make her needs known and a "tissue tolerance" assessment indicated she could tolerate 3 hours in the chair, in one position R48's current plan of care (POC) reviewed on 7/24/13, indicated R48 was to be repositioned every three hours while in the chair. On 9/11/13, at 7:30 a.m. nursing assistant (NA)-A and licensed practical nurse (LPN)-A were observed to transfer R48 out of bed and into the wheelchair. At 11:15 a.m. NA-A stated R48 would be provided repositioning assistance before lunch which was at 12:00 p.m. NA-A was asked by surveyor what R48's POC indicated for repositioning needs. After discussion of R48's POC, NA-A wheeled R48 to her room. At this time NA-A and NA-B were observed to scoot R48 up	F 314	Staff were re-educated on the use of the stop and watch forms to communicate any changes between the NAR and the Nurse. DON or Nurse Manager will complete repositioning audits twice a week for two weeks, weekly for four weeks and monthly thereafter. All audits will be brought to QA Committee for review and further recommendation. Completion date: 11-12-13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 13 into her wheelchair. The surveyor asked if that was considered R48's repositioning and NA-A stated yes. The surveyor asked NA-A if R48 was going to be provided with incontinence care. NA-A and NA-B were observed to transfer R48 on to the bed. R48's incontinence brief was observed wet and R48's coccyx and groin area was observed to have deep, red creases. R48 was observed to remain in the wheelchair until 11:15 a.m. without repositioning for 3 hours and 45 minutes. At 11:30 a.m. RN-A verified R48 was at risk for pressure ulcers and should have been repositioned every 3 hours while in the wheelchair. At 1:05 p.m. the director of nursing (DON) verified the POC and stated the NAs should have followed the POC as directed. The facility policy Skin Care/Prevention of Skin Breakdown dated 9/09, indicated cares and services are provided to prevent, treat and monitor progress of all healing ulcer(s). The policy indicated the purpose of the policy was to prevent pressure ulcers and establish an assessment and monitoring process for skin ulcers.	F 314	F315 R 48 Skin check was completed after being informed of the delay in repositioning. Skin check revealed that her skin was clean, dry, and intact without any sign of breakdown. Her toileting schedule and tissue tolerance was reviewed and determined to remain appropriate. Therefore, we will continue with toileting and repositioning q three hours. All resident are assessed on admission for bowel and bladder continence. This is reviewed and updated quarterly, annually, and with any significant change. All staff education was completed on 9-19-13 or 10-3-13 on following toileting programs. Staff were informed that if the current plan is not appropriate for the resident that they can complete a stop and watch form to inform nursing of a change in the resident status.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 14 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely incontinence care on 9/11/13, for 3 hours and 45 minutes for 1 of 1 (R48) resident who required every 2-3 hour assistance for incontinence needs. Findings include: R48's diagnoses included a stroke, congestive heart failure (CHF) and diabetes. The annual Minimum Data Set (MDS) dated 7/18/13, indicated R48 had cognitive impairment, was totally dependent on staff for bed mobility, transfers, personal hygiene and was non ambulatory. The MDS also indicated R48 was always incontinent of bowel and bladder. The 8/1/13, Urinary Incontinence Care Area Assessment (CAA) indicated R48 had restricted mobility, had urinary urgency and was completely dependent on staff for all toileting needs. The CAA also indicated R48 wore an incontinence brief and was always incontinent of bowel and bladder and was not aware of the urge to void or defecate. The July 16, 2013, bowel and bladder assessment indicated R48 was always incontinent of bowel and bladder, was completely dependent on staff to complete the toileting	F 315	Also informed them that if a resident is non-compliant with toileting that they need to let their nurse know so that can be addressed on the care plan. DON or Nurse Manager will complete toileting audits twice a week for two weeks, weekly for four weeks and monthly thereafter. All audits will be brought to QA Committee for review and further recommendation. Completion date: 11-12-13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 15 process and was dependent on two staff to check/change incontinent brief and provide peri-cares. The current plan of care (POC) reviewed on 7/24/13, indicated R48's incontinent brief was to be checked and changed every two- three hours. On 9/11/13, at 7:30 a.m. nursing assistant (NA)-A and licensed practical nurse (LPN)-A were observed to transfer R48 from bed and into the wheelchair. At 11:15 a.m. when asked by surveyor, NA-A stated R48 would be provided cares before lunch which was at 12:00 p.m. NA-A was asked by surveyor what R48's POC directed for incontinence cares. After review and discussion of R48's POC directives, NA-A wheeled R48 to her room. NA-A and NA-B were observed to scoot R48 up in her wheelchair. The surveyor then asked NA-A if R48 was going to be provided with incontinence care. NA-A and NA-B were then observed to transfer R48 on to the bed and changed R48's incontinence brief. R48's incontinence brief was observed to be wet and R48's coccyx and groin was observed to have deep, red creases. At 11:30 a.m. RN-A verified R48 was to be provided incontinence cares every 2- 3 hours as directed by the POC and should have been.	F 315	F332 R8 New order to cocktail medication obtained on 9-11-13 as this was a previous order that was not entered correctly in the computer initially. Pharmacy and MD contacted to change the Tylenol order. New order received to give Tylenol elixir 20ml via G-tube bid. All resident medications reviewed to determine if there were any other dosages that nurses were not able to measure properly. All RNs, LPNs, and TMAs educated on 9-19-13 to review medication and to clarify all orders for medications that have a dose that is not easily measured. If the nurse has a concern with a dose they need to clarify it with pharmacy or the nurse manager before administering.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that it was free of medication error rate of five percent or greater, during the medication passes observed, which revealed a medication error rate of 8%. This practice affected 1 of 5 residents (R8). Findings include: On 9/9/13, at 6:40 p.m. licensed practical nurse (LPN)-A was observed preparing R8's medications to be administered via a gastrostomy tube (GT). During preparation LPN-A was observed to mix all R8's liquid medications together in a drinking cup. The medications were Colace 15 milliliters (ml), Keppra 15 ml, and mapap (Tylenol) 19.5 ml. While dispensing the liquid mapap, LPN-A was not observed to measure the dosage, and just poured the medication into a 20 ml medication cup. After mixing the medications, LPN-A was observed to administer R8 120 mls of water via the GT with a syringe. Immediately following the water administration, LPN-A was observed to administer the combined medications in the same manner. LPN-A was observed to administer another 220 mls of water. After the medications and water administration, LPN-A started R8's Jevity GT feeding. On 9/9/13, at 7:28 p.m. R8's current Physicians Orders dated 9/6/13, were reviewed and lacked an order to cocktail (mix all medications together) the medications.	F 332	Nurse Manager will review all orders during monthly medication reconciliation and with new admissions. Any concerns noted at this time will be addressed with the MD upon identification. Completion date: 11-12-13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 17 On 9/11/13, at 3:37 p.m. LPN-A verified she used a plastic 20 ml medication cup to measure the prescribed 19.5 cc dosage of Tylenol. LPN-A also verified the 20 ml medication cup would not accurately measure the prescribed 19.5 ml of Tylenol. LPN-A stated she was just recently told to use a syringe in order to accurately measure the Tylenol. LPN-A also stated she had not been instructed to flush the GT between each medication. LPN-A added, she just followed the physician orders to flush with water prior to and after giving the medications. On 9/12/2013, at 10:36 a.m. registered nurse (RN)-B verified R8's current physician orders did not reflect an order to cocktail the GT medications. RN-B stated staff are expected to flush the GT with 30 ml's of water after the administration of each individual medication. RN-B also stated she was aware of the incorrect Tylenol dosage administration and stated the liquid medication should have been measured with a syringe. Policies were requested for medication administration and not provided.	F 332	F334 R 18, 24, 48, and 70 had received the Flu vaccine but the person administering the vaccine did not sign that they gave the medication. New Influenza Vaccine process: Consent form will be sent to all family members along with the current years Influenza fact sheet. Upon receipt of the consent form, a label will be placed on the consent form indicating the Information of the flu vaccine, date, and signature of who gave the vaccine. After the vaccine is given the consent form will be placed in the resident's chart. DON, RN, or ward secretary will review the consent form prior to it being placed into the chart. Completion Date: 11-12-13	
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 334		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 18 immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 19 the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure influenza immunizations were administered during the 2012/2013, influenza season for 4 of 5 residents (R18, R24, R48, R70) reviewed. Findings include: R18, admitted 4/17/2007, with diagnosis of dementia. During review of R18's medical record, no documentation was found indicating the resident had received or had been offered the influenza immunization for 2012. R24, admitted 12/30/2008, with the diagnosis of dementia, hypertension (HTN), and neurogenic bladder. During review of R24's medical record, no documentation was found indicating the resident had received or had been offered the influenza immunization for 2012.	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 20 R48, admitted 11/10/2009, with diagnosis of Hypertension, and CVA. During review of R48's medical record, no documentation was found indicating the resident had received or had been offered the influenza immunization for 2012. R70, admitted 8/14/2012, with the diagnosis of HTN, anemia, and diabetes mellitus. During review of R70's medical record, no documentation was found indicating the resident had received or had been offered the influenza immunization for 2012. On 9/11/13, at 2:18 p.m. registered nurse (RN)-C, infection control nurse, stated she was unable to find any documentation in R18, R24, R48, clinical records or the residents medication administrations records that indicated the residents had received or been offered the influenza immunization. In addition, RN-C stated she was unable to find any documentation in R70's clinical record that indicated R70 had refused of the immunization. RN-C provided the facility's policy dated 11/07, titled, Influenza and Pneumococcal Disease Prevention which indicated, "The resident's medical record includes, but is not limited to: Documentation that the resident either received the influenza and/or pneumococcal immunization or did not due to medical contraindications or refusal." RN-C verified that influenza documentation for 2012, should have been in the residents chart and was not. RN-C verified the facility's influenza policy was not followed.	F 334	F356 The following modifications have been implemented – new daily nursing staffing information was posted as of 9/10/13. This has the breakdown of hours each shift and number of staff working each shift. All staff have been educated on the need to update the sheet when changes occur and the ward secretary is not in the building. Administrator/DON will do audits of posted nurse staffing. Audits will be completed daily X 1 wk, then 2Xwk X2, then weekly X4 to ensure modifications made are necessary and information is adequate. Audit results will be brought to the QA Committee for review and further recommendations. Completion date: 11-12-13	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 21 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post the actual hours worked for nursing staff directly responsible for resident care per shift. This had the potential to affect all 69 residents who resided in the facility.	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 22 Findings Include: On 9/9/2013, at 2:16 p.m. during the initial tour of the facility a Full Time Equivalents posting form was observed on a 8" X11" sheet of paper hanging on the wall in the lobby area of the facility. The posted nurse staffing information lacked the actual shift hours worked by licensed and unlicensed staff responsible for providing direct resident care. Review of the forms provided by the facility titled, Full Time Equivalents from 9/9/13, to 9/11/13, revealed the usual shifts licensed and unlicensed staff were scheduled to work but did not identify the actual shift hours worked. On 9/12/13, at 9:30 a.m. the director of nursing (DON) verified the Full time Equivalents posting information was incorrect with no actual shift hours worked by licensed or unlicensed staff that provided direct resident care identified. Review of the facility's, Posted Nurse Staffing policy effective 12/11, did not include listing the actual shift hours for each shift.	F 356	Addendum for F314. All other residents with current pressure ulcers were reviewed. Addendum for F315. All other residents with catheters were reviewed. Addendum for F332. Random observations audits will be performed while medication administration is occurring. Addendum for F334. A resident audit will be performed by the Director of Nursing on those residents that received an influenza vacation. Reviewed 11/14/13 Approved 11/14/13	

S5252023
THIEF RIVER CARE CENTER

ASE-Q SURVEY – Supervisor Checklist

Scan This.
Date Certain 11/12 (CP 10/22 as stated in letter due to shut down)

1. **Review package in ACO and close**
   - **If complaint**, be sure to initial comments includes verbiage that a complaint investigation was conducted and whether substantiated or not.
   - Enter 027 time on timesheet for H# (project number)
2. **Exit survey in Paradise** Close in HCD
3. **Email MN Enforcement of survey completion – follow template for MN Enforcement**
4. **When the POC comes back from the facility:**
   - Ensure POC is date stamped when received
   - Verify provider signed and dated first page
   - If licensing orders were issued ensure the facility returned a signed copy of the orders by the time of the PCR
   - Verify each deficiency has a correction date 11/12
   - Verify completion date is same as date certain (as in the cover letter) or earlier
   - Date and initial the first page of the 2567 once approved
   - Complete a plan of correction letter (POCA) and send to the facility
   - Enter the date the package has been scanned in the Project Tracking screen under Sent to L&C in Paradise 10/22
   - Check Admin folder in QIS Pool to ensure 671/672 saved electronically
5. **If onsite PCR, ensure PCR package has a copy of the 2567 with the POC (including licensing orders, if applicable)**
6. **Administrative support staff will scan the following forms into the Admin folder into the QIS pool.**
   - MN 1513 – Ownership Information
   - Approved POC
   - First page of signed licensing orders
7. **For IJ or SQC, email to MN Enforcement once an acceptable POC is received. Program Assurance will send out the appropriate notices.**
   - N/A Send letter to the Board of Nursing Home Administrator
   - Send letter to the Board of Nursing, if directed by the APM
   - Include list of names/addresses of the physicians for any residents involved in the SQC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING **02 - THEIF RIVER CARE CENTER NEW BLDG** B. WING _____	**09/16/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	**2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 03006 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Thief River Care Center 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Thief River Care Center building was constructed in 2011 is 1-story, without a basement and was determined to be of a Type II (000) construction. The building is divided into three smoke zones by 90-minute fire barriers. The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems 1999 edition. The facility has a fire alarm system with automatic smoke detection in the all corridors and in all common use spaces in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have smoke detection with other hazardous areas have automatic fire detectors, that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm is monitored for automatic fire department notification. The facility has a capacity of 70 beds and had a census of 69 at the time of the survey. The facility was surveyed as a single building.	K 000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING **02 - THEIF RIVER CARE CENTER NEW BLDG** B. WING _____	**09/16/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	**2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		