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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 4DXU

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) **11/01/2006**

6. DATE OF SURVEY **09/15/2014** (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:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* 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):

17. SURVEYOR SIGNATURE — Date :
Gary Nederhoff, Unit Supervisor — 11/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 11/06/2014 (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
09/16/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245252

November 4, 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 programs.

Effective September 15, 2014 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

November 4, 2014

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

RE: Project Number S5252024

Dear Ms. Halvorson:

On August 12, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 31, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), On September 15, 2014, 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 July 31, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 15, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 31, 2014, effective September 15, 2014 and therefore remedies outlined in our letter to you dated August 12, 2014, will not be imposed.

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.

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 eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245252	A. Building B. Wing	9/15/2014

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 **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **09/15/2014**	ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **09/15/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/15/2014**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **09/15/2014**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **09/15/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/15/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/15/2014**	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	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GA/mm	11/04/2014	10160	09/15/2014
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
7/31/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4DXU

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Facility ID: 00448

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(L3) **THIEF RIVER CARE CENTER**
(L4) **2001 EASTWOOD DRIVE**
(L5) **THIEF RIVER 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 **07/31/2014** (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) :

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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):

17. SURVEYOR SIGNATURE Date :
Theresa Gullingsrud, HFE NEII 08/22/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 09/15/2014 (L20)

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

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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
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 12, 2014

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

RE: Project Number S5252024

Dear Ms. Halvorson:

On July 31, 2014, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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:

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

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

Remedies - 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

<u>Informal Dispute Resolution</u> - 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:

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 September 9, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 October 31, 2014 (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 January 31, 2015 (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 an ePoC 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
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

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 _____	07/31/2014

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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		9/15/14

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

Electronically Signed | 08/21/2014

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 _____	07/31/2014

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 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop care plan interventions for target behaviors for 1 of 5 residents (R69) reviewed for unnecessary medications. Findings include: R69's physician's orders dated 7/14/14, indicated R69 was started on Seroquel (an antipsychotic medication) 12.5 mg at 2:00 p.m. daily for unspecified dementia on 6/7/14. R69's psychiatrist's progress note dated 6/10/14, indicated R69 had a history of Parkinson's disease and dementia. R69s current care plan dated 7/18 /14, did not address the use of Seroquel or any behavioral symptoms which the Seroquel was being used for. During interview on 7/31/14, at 8:44 a.m. the director of nursing (DON) stated R69 was started on Seroquel 6/7/14, related to hallucinations and believing he was seeing his dead wife. The DON stated R69's behaviors related to the use of the antipsychotic medication should be addressed on the residents care plan but was not.	F 279	For resident R69 Care Plan was updated on 8-5-14 to include Hallucination and Agitation. Was seen by house Psychiatrist on 8-1-14, for a medication review and follow-up. During this visit it was determined to discontinue his Seroquel and to start Trazodone tid for his agitation and hallucination. The Trazodone has been effective for managing his hallucination and behaviors will continue with Trazodone. All residents with behaviors will be identified and have a behavior care plan entered into the new computer system identifying the target behaviors, goals, and interventions. These care plans will be printed out and placed in a three ring binder. This binder will be placed at the nurse□s station for all staff to have access to as not all intervention will fit on the NAR assignment sheets. All staff has been educated on the location of the binder on 8-21-14. We will be meeting with our new Pharmacist on a monthly basis to review a class of psychotropic medications e.g. antipsychotics, antianxiety, antidepressant, and hypnotics. During this meeting we will discuss each resident taking those medications and ensure they have the appropriate diagnosis and care plan in the computer as well as see if they are appropriate for a medication reduction. DON or RN nurse manager	

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 _____	07/31/2014

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F 279	Continued From page 2	F 279	will review the 24 hour report daily. If there is a new onset or a change in behavior they will be discussed the following day in stand-up to determine if a change in the care plan needs to occur or an assessment of the resident needs to happen to determine the cause of the behavior. The DON or designee will audit a minimum of seven records of resident□s having behaviors weekly x4 weeks, then monthly thereafter to ensure residents with behaviors are addressed in the care plan. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. Audit results will be brought forward to the QAPI committee for further recommendations.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop an admission (initial) care plan to include a turning and repositioning schedule to minimize the worsening of a pressure ulcer for 1 of 2 residents (R112) reviewed with pressure ulcers. R112's Face Sheet dated 7/31/14, indicated R112 was admitted to the facility on 7/22/14 with	F 281	For resident R112 Resident is now care planned to be cued/assisted with turning and repositioning q 2 hours from left to right. Resident was also educated on limiting time spent on back. Resident was provided with a body pillow to assist with comfort while lying on side and to help remind him that he needs to lie on his side.	9/15/14

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F 281	Continued From page 3 diagnoses that included pressure ulcer, hemorrhage of rectum and anus, and colon cancer. The Braden Scale for Predicting Pressure Sore Risk dated 7/29/14 identified R112 with low risk. The Skin Condition/Wound Progression note dated 7/22/14 indicated R112 was admitted to the facility with a sacral and coccyx ulcer that had a wound vac (a dressing that delivered negative pressure or vacuum at the wound site to help draw the wound edges together, removed infectious materials and actively promoted granulation) in place. The note further identified a pressure reducing or relieving device was in place to the bed and chair surfaces and a turning and repositioning program was being implemented. The Skin Condition/Wound Progression note dated 7/25/12 indicated R112 was admitted from home with a mixed ulcer to his sacrum and rectum. The note also stated R112 had rectal surgery in 2004 that never healed and since that time, R112 had struggled with weakness, was not able to offload properly, and subsequently developed a pressure ulcer to his sacrum that tunneled and joined the rectal ulcer. The note further identified the sacral ulcer to measure 2.4 x 3.4 x 0.4 centimeters (cm) with undermining (a wider area of wounding that lies beneath the wound opening) and tunneling from 9-4 o'clock location and the rectal ulcer to measure 6.2 x 1.2 x 2.8 cm. The General Nurse's Observation note dated 7/29/14 indicated R112 required extensive assist of one staff for dressing, locomotion on and off	F 281	All charts for resident being admitted into the facility with a pressure ulcer will be reviewed for proper offloading schedules. All staff have been educated that a resident being admitted with a pressure ulcer must be assisted or cued for repositioning to ensure offloading occurs. A tissue tolerance will be complete per policy to determine the length of time the resident is able to stay on the non-effected surface. Audit results will be brought forward to the QAPI committee for further recommendations.	

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F 281	Continued From page 4	F 281		

unit and transfers, and limited assist of one staff for toileting and bed mobility. The note also indicated tissue tolerance showed R112 may lie in same position for 1 hour and then needed to be repositioned due to wound on coccyx.

The undated Thief River Care Center Interim Plan of Care identified R112 required assist of one with bed mobility and required an air mattress to his bed. However, the care plan lacked direction regarding turning or repositioning schedule for R112.

On 7/30/14, at 7:07 a.m. R112 was observed to be awake, resting supine in bed. The head of R112's bed was observed to be elevated 45 degrees. R112 was continuously observed in this position until 7:29 a.m.

At 7:29 a.m. licensed practical nurse (LPN)-A was observed to enter the room and bring R112 a urinal and exit the room. The resident remained supine in bed and was continuously observed until 9:09 a.m.

At 9:09 a.m. nursing assistant (NA)-C was observed to enter the room briefly, and exit. The resident remained supine in bed and was continuously observed until 9:47 a.m.

At 9:47 a.m. LPN-A entered the room and assisted R112 to pick out his clothing. R112 stated he wanted to get dressed to attend therapy.

On 7/30/14, at 12:37 p.m. R112 was observed dressed and lying supine in bed. The head and foot of the bed were observed to be slightly elevated.

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F 281	Continued From page 5	F 281		

On 7/30/14, at 12:40 p.m. occupational therapist (OT) stated she had been working with R112 on positioning, nutrition, and pressure relieving to help with healing. OT stated R112 was in agreement but she was not sure how good R112's follow through would be. OT further indicated she would be communicating with nursing staff the importance of positioning and giving verbal cues to R112 to reinforce positioning off of his back.

On 7/30/14, at 1:07 p.m. director of nursing (DON), LPN-A, and LPN- entered the room to change R112's pressure ulcer dressing. R112 was lying supine in his bed and turned himself onto his right side with minimal assistance after verbal prompting.

On 7/30/14 at 2:26 p.m. NA-B stated R112 needed encouragement and setup with cueing for hygiene. NA-B stated R112 positioned himself. She further stated R112 would lie on his left side facing the window at times, but preferred his back.

On 7/30/14, at 2:38 p.m. NA-A stated she had not worked with R112 much, as he was new, but stated she did know he preferred to lie on his back. NA-A also stated therapy had just relayed to her that day to encourage R112 to lie on his sides and to also lay clothes out for him so that he could dress himself.

On 7/31/14, at 9:15 a.m. DON stated R112 was assessed on his tissue tolerance to be independent with positioning. However, DON confirmed the resident was admitted with a stage

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F 281	Continued From page 6 3 ulcer with a wound that had been draining since 2004, and R112 had been noncompliant with positioning at home. DON confirmed the care plan did not address turning and repositioning and stated she would have expected it to be addressed on the interim care plan. The undated Tissue Tolerance - Positioning Observation Policy and Procedure indicated after the positioning observation was completed, the Tissue Tolerance/Repositioning observations should have been reviewed and an overall individualized repositioning schedule should have been determined for both the lying and sitting positions. The policy also indicated if a resident had a current pressure ulcer, the test should not proceed while sitting or lying on the ulcer and the resident should be encouraged to not be up on the ulcer longer than 1 hour. The policy further indicated the Nurse Assistant To Do Lists and the Care Plan should have been updated with the lying and sitting intervals and communicated to the nursing staff. The Care Planning policy dated 10/07; indicated residents would have an individualized, comprehensive interdisciplinary care plan which directed care based on resident's needs. It further indicated a temporary care plan would be in place within 24 hours of admission.	F 281		
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.	F 282		9/15/14

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F 282	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a pressure reducing cushion in the wheelchair for 1 of 3 residents (R39) reviewed for repositioning. In addition, the facility failed to follow the care plan for 1 of 2 residents (R54) for heel positioning to minimize the worsening of a pressure ulcer. Findings include: R39's care plan dated 6/19/14, indicated R39 required a pressure reducing cushion in the wheelchair. On 7/29/14, at 9:05 a.m. R39 was observed up in her wheelchair without a cushion. On 7/30/14, at 7:51 a.m. R39 was observed up in her wheelchair. Nursing assistant (NA)-B brought R39 in to the bathroom. There was no cushion in the wheelchair. R39 was continuously observed until 9:15 a.m. At 9:15 a.m. NA-B brought R39 to the toilet. There was still no cushion in the wheelchair. At 9:23 a.m. NA-B brought R39 to the activity room. At 9:43 a.m. R39 was asleep in her wheelchair in the activity room. At 11:40 a.m. R39 was up in her wheelchair in the dining room with no cushion in the wheelchair At 12:10 p.m. R39 remained up in her wheelchair in the dining room without a wheelchair cushion. On 7/30/14, at 12:13 p.m. registered nurse (RN)-C stated the care plan directed staff to have	F 282	For resident F39 a new cushion was placed in her w/c on 7-30-14. For resident R54 a heel manager was provided to the resident on 7-30-14. To be used at all times while in bed and maybe used if comfortable for the resident while she is sitting in her recliner. Staff has reported that she is not kicking the heel manager out from under her feet and that it is working properly. All staff was educated on 8-7-14 and 8-21-14 to ensure all residents have a cushion in their w/c as this is our standard of practice. They should report to the RN manager if they notice that a cushion is missing by the use of the stop and watch forms. Staff was also educated on following the care plan, explained that if a resident is not complaint with the interventions that are put in place that it needs to be reported to the nurse and RN manager. When the manger is aware a new intervention can be tried until the appropriate intervention is found. DON or designee will audit the charts of seven residents to ensure all care planned interventions are being followed and the presents of a cushion in the w/c 4x weekly. Audits results will be brought forward to the QAPI committee for further recommendations.	

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F 282	Continued From page 8	F 282		

a pressure reducing cushion in the wheelchair. The director of nursing DON verified the care plan was not followed.
R54's Care Plan dated 6/19/14 directed staff to float R54's heels at all times while in bed and a pillow or blanket was to be used to keep R54's ankle off of the bed.

On 7/30/12, at 7:05 a.m. R54 was observed resting in bed with the room lights off. R54 was positioned on her right side with a pillow located behind her lower legs. R54's high-low bed was observed to be in the lowest position. R54 was continuously observed in this position until 8:09 a.m.

At 8:09 a.m. nursing assistant (NA)-C knocked and entered R54's room. When R54's bed covers were removed, she was observed lying on her right side with ankles crossed and her right ankle resting on the surface of the mattress. R54 was turned on her back by NA-C and NA-B and her right ankle was observed to have a brown scab (a hard coating on the skin formed during the wound healing) approximately 1 cm (centimeter) in diameter to the right lateral ankle.

On 7/30/14, at 12:35 p.m. R54 was observed resting in bed, lying on her right side, with a pillow located behind her lower legs and her right ankle resting on the surface of the mattress.

At 2:22 p.m. R54 was again observed resting in bed, lying on her right side, with a pillow located behind her lower legs and her right ankle resting on the surface of the mattress.

On 7/30/14, at 2:25 p.m. NA-B stated R54 required extensive assistance for all activities of

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F 282	Continued From page 9 daily living (ADLs) and needed assistance to turn in bed as she didn't turn herself. NA-B stated the NAs were directed to place a pillow under R54's ankles and between her knees when in bed. NA-B also stated R54 would kick the pillows out so they needed to be repositioned most of the time with each turn. On 7/30/14, at 2:54 p.m. NA-A stated R54 was turned every two hours while in bed. NA-A also stated R54 was not to wear shoes due to issues with her feet and toes. NA-A further stated R54 was to have a pillow under her feet but that she could, and did, kick it out from under her feet. On 7/31/14, at 8:52 a.m. registered nurse (RN)-A confirmed the care plan directed staff to keep R54's ankle off the bed with the use of a pillow to float R54's heels at all times when in bed. RN-A stated that should have been done or R54 should have been reassessed if unable to do so. On 7/31/14, at 9:23 a.m. director of nursing (DON) stated she would have expected R54's ankle to be kept off of the bed at all times as directed by the care plan. The Care Planning policy dated 10/07 indicated all staff who directly cared for each particular resident shall be knowledgeable of care plan content including problems, goals, and interventions and shall follow care plan as written.	F 282		
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	F 314		9/15/14

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F 314	Continued From page 10 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 provide a pressure reducing wheelchair cushion to minimize the development of pressure ulcers for 1 of 3 residents (R39) identified at risk for pressure ulcer development. In addition, the facility failed to provide heel positioning to minimize the worsening of a pressure ulcer for 1 of 2 residents (R54) reviewed with pressure ulcers. Findings include: R39's annual Minimum Data Set (MDS) dated 10/4/13 indicated R39 had severe cognitive impairment. The Pressure Ulcer (PU) Care Area Assessment (CAA) dated 10/16/13 indicated R39 required the extensive assistance of one staff for transfers, activities of daily living (ADLS), bed mobility and toileting. The PU CAA indicated a Tissue Tolerance (a tool to determine repositioning needs) completed indicated R39 would frequently reposition and offload (shift weight to reduce pressure in areas prone to skin breakdown) and would be cued by the staff every 3 hours. In addition, the PU CAA indicated R39 had a pressure reducing cushion in her wheelchair and a mattress on her bed. The Braden Scale for Predicting Pressure Sore	F 314	For resident F39 a new cushion was placed in her w/c on 7-30-14. For resident R54 a heel manager was provided to the resident on 7-30-14. To be used at all time while in bed and maybe used if comfortable for the resident while she is sitting in her recliner. Staff has reported that she is not kicking the heel manager out from under her feet and that it is working properly. All staff was educated on 8-7-14 and 8-21-14 to ensure all resident have a cushion in their w/c as this is our standard of practice. They should report to the RN manager if they notice that a cushion is missing by the use of the stop and watch forms. Staff was also educated on following the care plan. Explained that if a resident is not complaint with the intervention that are put in place that it needs to be reported to the nurse and RN manager. When the manger is aware a new intervention can be tried until the appropriate intervention is found. DON or designee will audit the charts of seven residents to ensure all care	

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F 314	Continued From page 11 Risk dated 6/26/14, indicated R39 was at low risk. The quarterly MDS dated 6/27/14, indicated R39 was diagnosed with dementia and Parkinson's Disease. The MDS also indicated R39 had moderate cognitive impairment, and required extensive assistance with transfers, bed mobility, ambulation in her room, and locomotion. The care plan dated 6/19/14 indicated R39 required a pressure reducing cushion in the wheelchair. On 7/29/14, at 9:05 a.m. R39 was observed up in her wheelchair without a cushion. When R39 was asked if her bottom got sore from being seated in the wheelchair without a cushion she stated yes. On 7/30/14, at 7:51 a.m. R39 was observed up in her wheelchair. Nursing assistant (NA)-B brought R39 in to the bathroom. There was no cushion in the wheelchair. R39 was continuously observed until 9:15 a.m. At 9:15 a.m. NA-B brought R39 to the toilet. There was still no cushion in the wheelchair. At 9:23 a.m. NA-B brought R39 to the activity room. At 9:43 a.m. R39 was asleep in her wheelchair in the activity room. At 11:40 a.m. R39 was up in her wheelchair in the dining room with no cushion in the wheelchair At 12:10 p.m. R39 remained up in her wheelchair in the dining room without a wheelchair cushion. On 7/30/14, at 11:37 a.m. NA-B stated she did not know how long it had been since she had seen a pressure reducing cushion in the wheelchair.	F 314	planned interventions are being followed and the presents of a cushion in the w/c 4x weekly. Audits results will be brought forward to the QAPI committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 12	F 314		

At 11:47 a.m. NA-A stated she had worked at the facility for 2 months and had never seen R39 using a cushion in the wheelchair.
At this time NA-C stated she had worked at the facility for the last 2 years, and had never seen a pressure reducing cushion in the wheelchair.

At 12:13 p.m. registered nurse (RN)-C stated the care plan directed staff to have a pressure reducing cushion in the wheelchair. The director of nursing (DON) stated all residents would have a cushion in their wheelchair. The DON stated she was not aware R39 did not have a cushion in the wheelchair. In addition, the DON stated, "I tell the staff all the time" if you would see a resident without a cushion in the wheelchair to let someone know. "
RN-C stated R39 had been identified at low risk for the development of skin breakdown. The DON verified the care plan was not followed.

At 12:50 p.m. R39 was asked if she felt more comfortable when seated on the cushion in her wheelchair and she nodded her head yes.

At 12:55 p.m. NA-B stated she went to the therapy department and placed a cushion under R39 at approximately 12:30 p.m. NA-B stated she did not want R39 to wait any longer for the cushion when she was supposed to have it. In addition, NA-B stated her assignment sheet did not address the use of a pressure reducing cushion in the wheelchair.
R54's Face Sheet dated 7/31/14 indicated R54 had diagnoses that included peripheral vascular disease, foot ulcer, and cellulitis & abscess of leg.

R54's quarterly Minimum Data Set (MDS) dated 4/18/14, indicated R54 had severe cognitive

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	245252	A. BUILDING _____ B. WING _____	07/31/2014

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

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F 314	Continued From page 13	F 314		

impairment and required extensive assist of 2+ persons for bed mobility, transfer, and toilet use. The MDS also indicated R54 was at risk for developing pressure ulcers and required a pressure reducing device in chair and bed.

The Skin Condition/Wound Progression note dated 6/27/14 indicated R54 had an unstageable pressure ulcer to her right ankle. The note described the ulcer as a brown scab (a hard coating on the skin formed during the wound healing) to the lateral malleolus of the right ankle that measured 0.9 x 0.9 centimeters (cm). The note further stated staff reported R54 preferred to lie on her right side while in bed and would have staff place a pillow under her foot or R54 would be encouraged to lie on her back or left side until the pressure ulcer healed. Additional Skin Condition/Wound Progression notes dated 7/2/14, 7/9/14, 7/17/4, and 7/24/14 identified no change in the size or appearance of the right lateral ankle pressure ulcer.

The Braden Scale for Predicting Pressure Sore Risk dated 7/17/14, indicated R54 was at low risk.

The Care Plan dated 6/19/14 directed staff to float R54's heels at all times while in bed and a pillow or blanket was to be used to keep R54's ankle off of the bed.

On 7/30/12, at 7:05 a.m. R54 was observed resting in bed with the room lights off. R54 was positioned on her right side with a pillow located behind her lower legs. R54's high-low bed was observed to be in the lowest position. R54 was continuously observed in this position until 8:09 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 14	F 314		

At 8:09 a.m. nursing assistant (NA)-C knocked and entered R54's room. When R54's bed covers were removed, she was observed lying on her right side with ankles crossed and her right ankle resting on the surface of the mattress. R54 was turned on her back by NA-C and NA-B and her right ankle was observed to have a brown scab approximately 1 cm in diameter to the right lateral ankle.

On 7/30/14, at 12:35 p.m. R54 was observed resting in bed, lying on her right side, with a pillow located behind her lower legs and her right ankle resting on the surface of the mattress.

At 2:22 p.m. R54 was again observed resting in bed, lying on her right side, with a pillow located behind her lower legs and her right ankle resting on the surface of the mattress.

On 7/30/14, at 2:25 p.m. NA-B stated R54 required extensive assistance for all activities of daily living (ADLs) and needed assistance to turn in bed as she didn't turn herself. NA-B stated the NAs were directed to place a pillow under R54's ankles and between her knees when in bed. NA-B also stated R54 would kick the pillows out so they needed to be repositioned most of the time with each turn.

On 7/30/14, at 2:54 p.m. NA-A stated R54 was turned every two hours while in bed. NA-A also stated R54 was not to wear shoes due to issues with her feet and toes. NA-A further stated R54 was to have a pillow under her feet but that she could, and did, kick it out from under her feet.

On 7/31/14, at 8:52 a.m. registered nurse (RN)-A confirmed the care plan directed staff to keep

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 _____	07/31/2014

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F 314	Continued From page 15 R54's ankle off the bed with the use of a pillow to float R54's heels at all times when in bed. RN-A stated that should have been done or R54 should have been reassessed if unable to do so. On 7/31/14, at 9:23 a.m. director of nursing (DON) stated she would have expected R54's ankle to be kept off of the bed at all times as directed by the care plan. The facility Skin Ulcer Protocol dated 6/4/14 directed staff to review all current interventions to ensure they remained appropriate including pressure relieving/reducing devices.	F 314		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess weight loss and implement nutritional interventions to minimize further weight loss for 1 of 4 residents (R98) who lost twenty two pounds in two months.	F 325	For resident R98, this resident has been discharged to home. For R98 she was reviewed as a closed recorded. Not able to make correction to closed charts.	9/15/14

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F 325	Continued From page 16 Findings include: R98's the admission face sheet identified the resident as having diagnoses which included: chronic kidney disease, diverticulosis of colon, open fracture of intertroch femur, and edema. R98 was admitted on 4/28/14 and discharged to home on 6/28/14. The admission Minimum Data Set (MDS) dated 5/4/14, identified R98 as being independent with eating, having no problems with swallowing and included a weight of 145 pounds. Review of the MDS dated 5/5/14, identified R98 as having a weight of 126 pounds. The 5 day MDS dated 6/17/14 identified R98 as having a weight of 119 pounds, with no identified weight loss or gain and remained independent with eating. The care area assessment (CAA) dated 5/9/14, indicated that based on indicators and analysis of findings of nutritional status, care area triggered, will be care planned for R98. The CAA triggered as R98 is on a no added salt diet with diagnosis of atrial fibrillation. Currently has a pacemaker with a steady rhythm. No oral pain or difficulty eating noted. Appetite fair. Will include diet in plan of care. Weight currently 145. The current care plan in R98's clinical record did not include any dietary problems, goals or approaches. Review of the weight record for R98 revealed on 4/25/14 was 145 pounds, On 4/30/14, was 132 pounds, on 5/7/14, was 126 pounds, On 5/21/15, was 121 pounds, on 6/4/14, was 118 pounds, on 6/25/14, was 122 pounds. The record indicated R98 had lost 22 pounds from 4/25/14 to 6/28/14.	F 325	All new admissions will be weighed on day of admission and 2 days later. Updated and revised the Nutritional Policy. Policy was reviewed with IDT team on 8-21-14 Dietary manager will complete dietary risk assessment, Nutritional risk assessment, and dietary assessment for all admission by day 8 of admission. A summary of the assessment will be completed in the dietary progress note. Dietician will email dietary manager and Director of Nursing with recommendations from his visit. Dietary manager will review all resident for a wt. loss of 3#, 5% loss in 30 days, and 10% in 180 days. The list of residents identified will be brought to the weekly weight loss committee meeting, where the team will discuss the resident□s current status and identify causes for the wt. loss. Based on identified area an intervention will be implemented during the meeting. All residents brought to the weight loss committee will be reviewed weekly until they have maintained their weight for 4 weeks. The list of resident followed by the weight loss committee will be discussed in the quarterly QI meeting.	

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F 325	Continued From page 17	F 325		

Review of the dietary risk assessment dated 5/23/14, indicated dietary risk score of 3 indicating moderate risk.

Review of the dietary manager (DM) progress note dated 5/23/14, indicated signs and symptoms with potential to cause nutritional alterations: intake and elimination issues: lack of appetite, nausea, weight loss. Resident is on a no added salt diet, she said she hasn't had much of an appetite but it is getting better. She has had some nausea. We will continue to monitor weight.

Review of the dieticians progress note dated 6/2/14; indicated resident has lost 6 pounds which is 5% of her body weight in less than 30 days. It is recommended for her to get a nutritional supplement 120 ml twice daily to help stop weight loss and stabilize her nutritional status.

Review of the DM progress note dated 6/17/14; indicated Resident has lost a significant amount of weight over the last 30 days, 5.54%. Need to start a supplement.

During an interview with registered nurse (RN)-B on 7/31/14, at 8:48 a.m. RN-B stated, "I don't believe the admission weight is correct I am not sure where that number came from, I question the changes in R98's weight." RN-B verified the changes in R98's weights and the recommendations for a supplement should have been addressed but were not.

The director of nursing (DON) was interviewed on 7/31/14, at 11:40 a.m. the DON stated; since we have started with our new electronic program it

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F 325	Continued From page 18 has been hard to track resident ' s weights and admission information. We have a problem with our weight monitoring. We are working on implementing a program to evaluate and monitor weight loss better. The DON confirmed that R98's weight loss had not been compressively assessed to accurately identify weight loss or weight discrepancies, and interventions to prevent further weight loss had not been implemented or addressed and should have been.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		9/15/14

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F 329	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to adequately monitor behaviors of hallucinating for 2 of 3 residents (R69, R46). In addition, the facility failed to properly document the diagnosis in the clinical record that warranted the use of the antipsychotic medication for 1 of 3 residents (R69) who received an antipsychotic medication. Findings include: R69's significant change Minimum Data Set (MDS) dated 4/21/14 indicated R69 had moderate cognitive impairment. The Psychotropic Drug Use Care Area Assessment (CAA) was not addressed at this time as R69 had not received an antipsychotic medication. R69s MDS further indicated he had experienced depressive symptoms, and had no behavioral symptoms including hallucinations or delusions. The physician's orders dated 7/14/14, indicated R69 was started on Seroquel (an antipsychotic medication) 12.5 mg at 2:00 p.m. daily for unspecified dementia on 6/7/14. The Seroquel was ordered by the psychiatrist. The psychiatrist's progress note dated 6/10/14, indicated R69 had a history of Parkinson's Disease and dementia. R69 was seen at the facility due to complaints of recurrent agitation, verbal and physical aggression. Symptoms seemed to start later in the afternoon and would worsen in the evenings. There was no evidence of hallucinations/delusions.	F 329	For resident R69 Care Plan was updated on 8-5-14 to include Hallucination and Agitation. Resident was seen by house Psychiatrist on 8-1-14, for a medication review and follow-up visit. During this visit it was determined to discontinue his Seroquel and to start Trazodone tid for his agitation and hallucination. Trazodone has been effective for managing his hallucinations and behaviors. Resident will continue with Trazodone. For resident R46 She was seen by Dr. K on 8-1-14. It was determined to discontinue her Risperdal. Documentation was put in place to have her behaviors documented for 3 days after the medication was discontinued. Also educated the staff on why she is yelling out. Educated that she yells out when she is lonely and wants company, she needs to get into bed or her w/c or she needs a snack. Informed staff if they try all these interventions and she continues to yell out may need to try the prn Ativan. Care plan was updated to include above listed information. DON spoke with Dr. K on 8-1-14 to ensure she understood the regulation of use of antipsychotic with elderly residents with dementia. She stated she understood the regulation. She stated she would like to see all residents newly placed on antipsychotic every 2 months or sooner if	

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F 329	Continued From page 20 On 6/18/14, the consulting pharmacist recommended a diagnosis be given for the Seroquel 12.5 milligrams (mg) daily. The primary physician documented a diagnosis of agitation with delusions. On 6/22/14, the primary physician documented a progress note which indicated mild dementia, cognitive impairment and no hallucinations. The current care plan reviewed 7/18 /14, did not address any behavioral symptoms including hallucinations or delusions. In addition, the care plan did not address the use of Seroquel. The nursing progress notes were as follows: -5/8/14, R69 was extremely confused, attempted eloping. -5/30/14, R69 noted to be confused most of the shift. Was packing and moving belongings around in the room, adamant that he was going home. R69 was redirected and was unsuccessful on multiple occasions. -6/6/14, the psychiatrist visited and new orders were received. -6/29/14, R69 was receiving cares and resisted and picked up his cane. R69 shook his cane and attempted to hit staff with it. R69 attempted to grab and pull at the nurse. The nursing assistant (NA) was able to calm the resident. -7/11/14, R69 was found standing in his room with the brown facility chair upside down. R69 resisted going back in the wheelchair, and was hitting and kicking at the NA. Was having paranoid thoughts, and thought staff were trying to cause him harm. -7/15/14, R69 was wandering into other resident's	F 329	no improvement to ensure they remain appropriate for the medication. NAR will be educated on behavior documentation on 8-21-14. They will be able to chart behaviors seen on the computer system. The DON or designee will audit a minimum of seven records of resident□s having behaviors weekly x4 weeks, then monthly thereafter to ensure residents with behaviors are addressed in the care plan. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. Audit results will be brought forward to the QAPI committee for further recommendations.	

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 _____	07/31/2014

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F 329	Continued From page 21	F 329		

rooms, when being redirected became agitated and grabbed the NAs arm and would not let go. Proceeded to shoot people with his finger gun, screamed at everyone to leave the building, and pinned the other nurse against the wall. R69 was hallucinating about horses and kicking at visitors. Many different staff tried to redirect R69. The primary physician order Ativan (an antianxiety medication) 1 mg every 4 hours as needed. The medication greatly improved resident's behaviors and staff were able to put R69 to bed with no aggressiveness.
-7/16/14, R69 repeatedly attempted to reach down to the floor and pick up an object that was not there. R69 stated he wanted to go home right now, and do you see the towel right there?
-7/18/14, R69 has had a long standing history of hallucinations with episodes of confusion.
-7/23/14, at the care conference, R69s family requested an increase in Seroquel from the psychiatrist due to increased behaviors.

On 7/30/14, at 6:50 a.m. R69 was up in the wheelchair right outside the dining room.
At 8:05 a.m. R69 finished eating his breakfast and was drinking coffee.
At 8:43 a.m. R69 was watching TV in his room.

On 7/30/14, at 12:40 p.m. the director of nursing (DON) stated R69 would go by her office and stated he saw a fire and told her she needed to get out as it was on fire. The DON stated R69 was less distraught now since he had started the Seroquel.

On 7/31/14, at 8:44 a.m. the DON stated the first time an antipsychotic medication was ordered for R69 was on 6/7/14. At 9:41 a.m. the DON stated R69 had hallucinations and would see his dead

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F 329	Continued From page 22 wife. The DON stated the staff needed to work on better documentation regarding the hallucinations. The DON' stated R69 would go to the other end of the building looking for his wife, and would be real agitated on re-direction. At 10:40 a.m. the DON stated the staff documented behaviors by exception, however; the hallucinations occurred on a daily basis, and the behaviors were not being documented daily. The DON stated giving the as needed Ativan was not really an option as by the time they would need to give it R69 was too upset to take a medication orally. The DON stated staff would document confusion for R69, and did not document the actual behavior that occurred. The DON stated the psychiatrist would be visiting R69 on 8/1/14, to review the medications. The DON stated the psychiatrist's progress note dated 6/10/14, did not arrive at the facility until 7/30/14, when requested by the surveyor. The DON stated she was not aware that both the psychiatrist and the primary physician had documented R69 was not having hallucinations. The DON stated the nurse should have reviewed the physician progress note prior to placing it in the chart. At 11:10 a.m. licensed practical nurse (LPN)-A stated towards the end of the day about 2:30 p.m. to 3:00 p.m. R69 would want to leave the facility looking for his wife. LPN-A stated at times R69 could be difficult to re-direct, and most of the behaviors occurred on the evening shift. At 11:18 a.m. the DON verified the behaviors and the use of the antipsychotic medication was not addressed on the care plan and should have been. The Unnecessary Drugs/Drug Regimen Review/Pharmacy Services policy revised 4/12, read residents who have not used antipsychotic drugs are not given these drugs unless	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 23	F 329		

antipsychotic drug therapy is necessary to treat a specific psychiatric condition as diagnosed and documented in the clinical record.
R46 did not have an adequate indication for use of antipsychotic medication.

The Face Sheet dated 7/31/14, indicated R46 had diagnoses that included, but were not limited to: dementia with behavioral disturbance, Anxiety, Alzheimer's disease, type II diabetes mellitus, and generalized pain. The cumulative diagnoses list on the face sheet had not identified R46 had a diagnosis that included psychotic features.

Review of the physician orders revealed R46 had started receiving the antipsychotic medication Risperdal 0.25 milligrams (mg) twice a day on 10/22/13.

The behavioral health psychiatrist progress notes dated 10/21/13, identified that R46 had progressing dementia and indicated "Concerns from the staff are auditory and visual hallucinations, behavioral problems with yelling and screaming." The psychiatrist prescribed the antipsychotic medication Risperdal 0.25 mg twice a day after explaining the purpose of the medication to the daughter of R46 and obtaining consent for the use of the medication.

The primary physician notes dated 1/9/14 identified that R46 had less outbursts since the addition of the Risperdal 2 months prior. The primary physician visit note dated 5/15/14, identified that R46 had been irritable the last 2 times he had seen her and the family of R46 wished for Risperdal to be cut back due to drowsiness. The Risperdal medication was decreased from 0.25 mg twice a day to one time

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F 329	Continued From page 24 a day. The medical record for R46 including the physician progress notes, licensed staff progress notes, behavior monitoring spreadsheets & summary's and physician orders were reviewed from 9/1/13-7/30/14, and there was no documentation which identified that R46 was having difficulty with visual or auditory hallucinations. Behavior monitoring for R46 indicated the resident had 52 behaviors from 5/17/14-7/27/14. It also identified that R46 was sad or tearful on more than 15 occasions. There is no behavior documented which identified that R46 had psychotic, delusional behavior, or hallucinations. The Mood and Behavior -Summary Based Report form 5/1/14-7/29/14, revealed the following: "[R46] will call out for family members who are not here, which can be overheard by other residents. Staff offer assistance and reassurance as needed, also redirects her as needed. Psychosis-none observed." The pharmacist monthly drug regimen review from 10/1/13-7/30/14, had not identified R46 lacked appropriate diagnosis for the use of antipsychotic medication and had not identified R46 lacked an appropriate indication for the use of antipsychotic medication. The behavior care plan for R46 with a start date of 6/19/14 identified the following problem: "Calling out/disruptive noises." The interventions were identified as the following: "Answer call light timely; ask resident is there anything they need/reason for calling out/disruptive noises.	F 329		

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 _____	07/31/2014

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(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 329	Continued From page 25	F 329		

Attempt to meet resident ' s needs when calling out/making disruptive noises. Monitor frequency of calling out/disruptive noises. Remove from situation should behavior be disruptive for others. Use distraction and or redirection; offer activity, food, or beverage. " The care plan does not identify psychotic behavior justifying the use of antipsychotic medications. The care plan does not identify to monitor for auditory or visual hallucinations.

R46 was observed on 7/30/14, from 11:30 a.m. to 1:16 p.m. and it was noted that R46 was pleasant and did not display any inappropriate behavior.

Licensed practical nurse (LPN)-B was interviewed on 7/30/14, at 12:05 p.m. and established that she had been employed by the facility for greater than 5 years. LPN-B stated that R46 had inappropriate behavior that included loudly calling out for her daughter and family members. LPN-B stated that R46 did not display any physical abuse to herself or others and the calling out behavior was easily redirected by offering toileting or assisting R46 into or out of bed. LPN-B stated R46 did not have auditory or visual hallucinations or delusions.

Nursing assistant (NA)-D was interviewed on 7/30/14, at 12:25 p.m. and established that she had known R46 since the day of admission to the facility. NA-D stated that R46 will loudly call out for her deceased husband and family members but it usually means that R46 needs something and it trying to summon help. NA-D stated that when R46 is loudly calling out for family members she is either needing to use the toilet or wanting to get up from bed or go back into bed. NA-D stated that she has not noticed R46 having any

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	245252	A. BUILDING _____ B. WING _____	07/31/2014

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THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

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F 329	Continued From page 26 hallucinations or delusions. During interview with the director of nursing (DON) on 7/31/14, at 9:54 a.m. she stated that the psychiatrist added this medication for R46's agitation and spells of yelling out and paranoia. The DON stated R46 did not have hallucinations or delusions; R46 did not have identified psychotic behavior, and was not a danger to herself or others.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the consultant pharmacist identified an adequate indication for use of antipsychotic medication for 1 of 3 residents (R46) reviewed for antipsychotic medications. R46 did not have an adequate indication for the ongoing use of antipsychotic medication. The Face Sheet dated 7/31/14, indicated R46 had diagnoses that included, but were not limited	F 428	For resident R46 She was seen by Dr. K on 8-1-14. It was determined to discontinue her Risperdal. Document was put in place to have her behaviors document for 3 days after the medication was discontinued. Also educated the staff on why she is yelling out. Educated that she yells out when she is lonely and want company, she needs to get into bed or her w/c or she needs a snack. Informed staff if they try all these interventions and she	9/15/14

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F 428	Continued From page 27 to: dementia with behavioral disturbance, Anxiety, Alzheimer's disease, type II diabetes mellitus, and generalized pain. The cumulative diagnoses list on the face sheet had not identified R46 had a diagnosis that included psychotic features. Review of the physician orders revealed R46 had started receiving the antipsychotic medication Risperdal 0.25 milligrams (mg) twice a day on 10/22/13. The behavioral health psychiatrist progress notes dated 10/21/13, identified that R46 had progressing dementia and indicated "Concerns from the staff are auditory and visual hallucinations, behavioral problems with yelling and screaming." The psychiatrist prescribed the antipsychotic medication Risperdal 0.25 mg twice a day after explaining the purpose of the medication to the daughter of R46 and obtaining consent for the use of the medication. The medical record for R46 including the physician progress notes, licensed staff progress notes, behavior monitoring spreadsheets & summary's and physician orders were reviewed from 9/1/13-7/30/14, and there was no documentation which identified that R46 was having difficulty with visual or auditory hallucinations. Behavior monitoring for R46 indicated the resident had 52 behaviors from 5/17/14-7/27/14. It also identified that R46 was sad or tearful on more than 15 occasions. There is no behavior documented which identified that R46 had psychotic, delusional behavior, or hallucinations. The Mood and Behavior -Summary Based	F 428	continues to yell out may need to try the prn Ativan. Care plan was updated to include above listed information. We have a new pharmacist that started 8-13-14. She will do her monthly review of each resident with a new computer based system. She will be able to print out reports at the end of her visit and review that report with the IDT team to ensure all psychotropic medications have appropriate diagnosis, target behaviors, and non-pharmacological intervention. Each month we will focus on one class of psychotropic meds. This way we are able to look in depth for each medication and resident. The DON or designee will audit a minimum of seven records of resident□s having behaviors weekly x4 weeks, then monthly thereafter to ensure residents with behaviors are addressed in the care plan. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. Audit results will be brought forward to the QAPI committee for further recommendations.	

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F 428	Continued From page 28	F 428		

Report form 5/1/14-7/29/14, revealed the following: "[R46] will call out for family members who are not here, which can be overheard by other residents. Staff offer assistance and reassurance as needed, also redirects her as needed. Psychosis-none observed."

The pharmacist monthly drug regimen review from 10/1/13-7/30/14, had not identified R46 lacked appropriate diagnosis for the use of antipsychotic medication and had not identified R46 lacked an appropriate indication for the use of antipsychotic medication.

Licensed practical nurse (LPN)-B was interviewed on 7/30/14, at 12:05 p.m. and established that she had been employed by the facility for greater than 5 years. LPN-B stated that R46 had inappropriate behavior that included loudly calling out for her daughter and family members. LPN-B stated that R46 did not display any physical abuse to herself or others and the calling out behavior was easily redirected by offering toileting or assisting R46 into or out of bed. LPN-B stated R46 did not have auditory or visual hallucinations or delusions.

Nursing assistant (NA)-D was interviewed on 7/30/14, at 12:25 p.m. and established that she had known R46 since the day of admission to the facility. NA-D stated that R46 will loudly call out for her deceased husband and family members but it usually means that R46 needs something and it trying to summon help. NA-D stated that when R46 is loudly calling out for family members she is either needing to use the toilet or wanting to get up from bed or go back into bed. NA-D stated that she has not noticed R46 having any hallucinations or delusions.

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F 428	Continued From page 29 During interview with the director of nursing (DON) on 7/31/14, at 9:54 a.m. she stated that the psychiatrist added this medication for R46's agitation and spells of yelling out and paranoia. The DON stated R46 did not have hallucinations or delusions; R46 did not have identified psychotic behavior, and was not a danger to herself or others. The facility consultant pharmacist was interviewed by telephone on 7/31/14, at 11:56 a.m. and confirmed that dementia with behavioral disturbance was not an adequate diagnosis to warrant the use of anti-psychotic medication. Additionally, the pharmacist stated that he did not have time to review each resident ' s record to ensure that the resident had appropriate behaviors or symptoms to warrant the use of a medication.	F 428		

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

F9252023

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	245252	A. BUILDING **02 - THEIF RIVER CARE CENTER NEW BLDG** B. WING _____	**07/30/2014**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Thief River Care Center 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 67 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	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.