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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 60FN

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: **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 **09/14/2017** (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

X 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: **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 :
Carlene Lange, HFE-NE II 10/24/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 11/13/2017 (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
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 28, 2017

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

RE: Project Number S5252027

Dear Ms. Halvorson:

On September 14, 2017, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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**

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:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

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 24, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 24, 2017 the following remedy will be imposed:

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

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.

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 December 14, 2017 (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 14, 2018 (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
Health Regulation Division
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 electronic 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

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 _____	09/14/2017

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 On September 14, 2017, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's electronic Plan of Correction (ePoC) 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.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 157		10/24/17

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

Electronically Signed | 10/06/2017

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 157	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the physician of a significant deterioration in health for 1 of 1 (R106) residents reviewed for change of condition. Findings include: R106's Face Sheet identified diagnoses which included, weakness and unspecified heart failure.	F 157	Thief River care Center will notify the attending physician when there is a significant change in a resident□s status. R106 was a closed record. The facility□s □Notification of Change□ policy was reviewed and revised to include updates from the new regulation.	

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F 157	Continued From page 2 R106's admission Minimum Data Set (MDS) dated 6/8/17, indicated R106 had no cognitive impairment, required set up and supervision for eating, and extensive assistance for transfers, dressing, and personal hygiene. R106's Meals & Weight form, dated 6/1/17 indicated R106 weighed 135 pounds. A progress note, dated 6/1/17, indicated R106 was in the dining room for supper, did not want to eat any food, and drank liquids only. A progress note, dated 6/2/17, indicated R106 told staff she was very tired, that R106 was receiving therapy with hopes to increase her strength and move to senior living and was eating meals in the dining room. A progress note, dated 6/3/17, indicated R106 required assistance of 2 staff for both transfers and toilet use. R106 was up for both meals and ate well and rested in bed most of the shift. A progress note, dated 6/4/17, indicated R106 ate in her room for supper and ate about 95% of the meal. A Meal and Weight form dated 6/4/17, identified R106 weighed 131.4 pounds. (a loss of 3.6 pounds in 3 days.) A Meals &Weights form, dated 6/5/17, indicated R106 weighed 129.6 pounds. (a loss of 5.4 pounds in 4 days.) A progress note, dated 6/6/17, indicated R106 enjoyed visiting with residents and staff. R106	F 157	All nursing staff were re-educated on 10/12 on the □Notification of Change□ policy and the importance of updating the physician when there is a significant change in a resident□s status. Current residents who have sustained a deterioration in health will have their EMR audited to ensure the resident□s physician was informed of the change in status. After review of current charts, random audits will be conducted for documentation of notification of physician regarding a change in status, by the DON/designee 2x week x 4, weekly x4 and monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations.	

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F 157	Continued From page 3	F 157		

goes to the dining room for meals. R106 participates in therapy and is motivated for recovery.

A progress note, dated 6/7/17, indicated R106's receives a regular diet. Current weight 125 pounds. (a loss of 10 pounds in 6 days.) R106 has no problems with chewing at this time. Has no food dislikes. Likes mashed potatoes, gravy, and bread.

A progress note, dated 6/8/17, indicated a Patient Health Questionnaire (PHQ-9) assessment (depression assessment tool) score of 0/27, with no treatment needed at this time. R106 denied depression. Mood is stable. Cooperative and pleasant.

A progress note, dated 6/12/17, indicated R106 reported an emesis after breakfast, but has felt better since that time.

A progress note, dated 6/13/17, at 3:34 a.m. indicated R106 had no appetite and refused supper. "Appears depressed and talking about how old she is and ready to die." Drinking fluids, no solid intake on evening shift.

A progress note, dated 6/13/17, at 6:55 p.m. indicated R106 refused medication. No intake for supper. R106 asked if daughter was coming "...I won't be here much longer." Staff notified R106's daughter that R106 appeared depressed and R106 wished to see daughter. R106 offered and refused food and fluids.

A progress note, dated 6/14/17, indicated R106 has been refusing to go to the dining room for meals. "Has had little intake of food and liquid."

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F 157	Continued From page 4	F 157		

A progress note, dated 6/15/17, indicated "Daughter here visiting today and commented to staff that she feels that her mother is giving up. Refused to go to urgent care at this time. Appetite continues to be poor."

A progress note, dated 6/16/17, indicated "Resident stayed in bed most of the shift. Resident had a poor appeteite (sic) and just had no real energy of any kind to do anything. Resident did not have any pain complaints but did not appear to feel well."

A progress note, dated 6/17/17, indicated "Resident stayed in bed all shift and refused all her medications and did not eat her meals. Resident is noted to either be depressed or not feeling well but she is unclear as to which one it is. Resident stated she did not want to go to the doctor."

A progress note, dated 6/18/17, indicated R106 "...is noted to seem overall depressed." "Resident refused to eat and take medications." "Resident is noted to be very down in the dumps and has made statements like 'I'm not going to be here much longer,"

A progress note, dated 6/19/17, indicated R106 "...stayed in her room in bed this shift. She did not eat any supper and needs to have extensive assist and prompting to drink anything." Drank sips of water. No appetite.

A Meal & Weight form identified R106's weighed 119.8 pounds on 6/19/17. (a significant loss of 15.2 pounds/ or 11.26% in 18 days.)

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F 157	Continued From page 5	F 157		

A progress note, dated 6/27/17, at 3:49 p.m., indicated an initial care conference was held on 6/20/17. R106 willing to try ensure twice a day due to not much appetite and loss of weight.

A progress note, dated 6/20/17, indicated R106 stayed in bed for the entire morning shift. Did have some fluid intake of Ensure (nutritional supplement.)

A progress note, dated 6/21/17, indicated R106 "...has now refused to work with therapy and is remaining in bed." R106 states she is "...too tired to get up."

A progress note, dated 6/23/17, indicated R106 has again chosen to stay in bed today. Continued to drink some fluids, eating very little. Sleeping a lot. Continue to observe and try to increase food and fluid intake.

A progress note, dated 6/26/17, at 3:26 a.m., indicated R106 was weepy, requested her daughter. Staff called R106's daughter per R106's request. Daughter unable to come until the morning. R106 stated "That's ok." R106 was thirsty and took a few sips of water.

A progress note, dated 6/27/17, at 3:29 a.m., indicated R106 rated pain 5 out of 10 (1 least and 10 worst.) R106 stated "I just don't feel well." when asked about location of pain.

A progress note, dated 6/27/17, at 9:31 a.m. indicated R106 "has had increased loose stools with red blood observed. Daughter was informed and requested to have ambulance called to have her brought in. Ambulance called."

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F 157	Continued From page 6	F 157		

A progress note, dated 6/27/17, at 5:17 p.m. indicated R106 was returning from the hospital. R106 was "...actively dying and there was nothing else they could do for her for treatment so she was coming (sic) home to pass away in comfort with her family at bedside."

A progress note, dated 6/27/17, at 10:13 p.m. indicated R106 passed away at 6:40 p.m.

Despite R106's decreased intake with significant weight loss and changes in mood, R106's record lacked documentation the physician was notified of these changes.

During an interview with registered nurse (RN)-A, registered nurse (RN)-B and the director of nursing (DON) on 9/14/17, at 8:58 a.m. RN-A stated when R106 first came, she was attending therapy and was going to the dining room for meals. R106 started to refuse to go out for meals and started to make statements she was giving up. Complained of feeling tired. R106's intake started to decline and R106 lost weight. The nursing assistants offered R106 food and fluids several times a day. Nutritional supplements were tried. Initially R106 would drink the supplement, then started to refuse. Staff contacted R106's daughter frequently. DON stated staff asked R106 on a few occasions if she wanted to go to the clinic to see a physician and R106 refused. Family aware of refusals. The DON stated the policy is to contact the physician via phone or fax when a resident shows a decline. The DON stated the clinic was notified of abnormal INR's (blood test used to identify clotting time of blood,) but had no tangible evidence to show physician (B) was notified of the resident's decline.

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 _____	09/14/2017

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 157	Continued From page 7 During an interview on 9/14/17, at 10:59 a.m., physician-B stated he could not remember staff notifying him of R106's poor intake, weight loss, or mood changes. Physician-B stated if R106 was refusing treatments and refusing to see a physician, he would have honored those wishes. Physician-B went on to say it probably would not have changed anything, but he would have expected to be notified of R106's decline. The facility policy MD, Family and/or Responsible Party Notification, dated "7-2014" directed the physician to be notified when there is: "A significant change in the resident's physical, mental, or psychosocial status i.e. a deterioration in health, mental, or psychosocial status..."	F 157		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 assistance with shaving as directed per the care plan for 1 of 3 residents (R27) reviewed for activities of daily living (ADLs). Findings include: R27's quarterly Minimum Data Set (MDS), dated	F 282	R27 Care Plan has been updated that he occasionally refuses assistance with shaving but will be re-approached if refusal occurs. Nurse Aide Care Plan forms have had formatting changes to ensure that the Nurse Aides know what is expected. Information regarding updated caregiver	10/24/17

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 282	Continued From page 8 8/16/17, identified R27 exhibited cognitive deficit and was identified as needing total assistance with personal grooming. R27's care plan, printed 9/13/17, identified R27 was "Dependent on staff to provide all grooming/hygiene tasks with AO1 [Assist of one]" and directed staff to shave resident's face. A nursing assistant (NA) assignment listing, dated 9/13/17, identified R27 was to receive AO1 with grooming, but did not provide additional instruction regarding shaving. During observation on 9/11/17, at 4:51 p.m. R27 was noted to be asleep in bed and was unshaven in appearance, with whiskers measuring 1/8th inch over cheeks, upper lip, and chin. During follow up interview on 9/11/17, at 7:48 p.m. family member (F)-A was present and stated "He's [R27] got a couple of days growth right now. They do skip that quite often." F-A stated a new razor had recently been purchased, and was noted to be sitting on the window sill, ready for use. M-A asked R27 if he would rather be shaven than have a beard; resident responded "Yeah". On 9/12/17, at 9:00 a.m. R27 was observed to be in lying in bed unshaved. On 9/12/17, at 10:54 a.m. R27 was observed seated in his wheelchair and remained unshaved. Later, at 4:25 p.m. resident was noted to be up in his w/c and remained unshaven. On 9/13/17, at 11:23: a.m. R27 was observed up and dressed in w/c and was noted to have his cheeks and chin shaven, however facial hair remained on his upper lip in a mustache like appearance. During interview on 9/13/17, at 11:40 a.m. NA-A stated the night staff had performed morning cares for R27. NA-A stated R27 had been difficult	F 282	sheets will be communicated via shift reports, communication books, and meeting held on 10/12. After review of current charts, random audits will be conducted to ensure completion of ADL assistance as instructed by updated Care Plan Guides by the the DON/designee 2x week x 4, weekly x4 and monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations.	

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F 282	Continued From page 9	F 282		

to shave as he turned his head from side to side, as he "did not like to be shaved." NA-A stated when R27 was shaved, the staff shaved first with the electric razor, followed by a disposable razor. NA-A stated residents are shaved whenever facial hair is noted, however, if it was noted R27 had not been shaved when staff went to take him to lunch it probably would not be done as "Then we would get behind at dinner."

During interview on 09/13/17, at 3:17 p.m. NA-B stated she had assisted with morning cares for R27 and total assistance was provided with personal grooming. NA-B stated staff "Try, but he doesn't like it. We usually shave him on bath days" and his bath day was Sunday. NA-B stated she had attempted to shave him this morning, and had shaved his cheeks but had not attempted to shave the upper lip. NA-B did stated when unable to shave residents, she alerted oncoming staff, adding registered nurse (RN)-B was able to shave R27 "really good" .

During interview with RN's A and B on 9/13/17, at 3:23 p.m. RN-B stated he had shaved R27 on multiple occasions and staff would advise him if assistance was needed. RN-B stated he had not been requested to assist R27, although he identified R27 did need a shave. RN-A noted R27 had his cheeks shaven, however his upper lip had not been shaved. R27 nodded his head up and down when asked if he wished to be shaved, and shook his head back and forth when asked if he wished to have a mustache.

An undated facility policy titled, Resident Cares identified personal cares are provided for each resident to promote cleanliness and comfort. The policy identified under procedure, number five:

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F 282	Continued From page 10 Resident shaved per the plan of care.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) 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 document review, the facility failed to provide grooming care for 1 of 3 residents (R27) reviewed for activities of daily living (ADL's) and who was dependent of staff for care. Findings include: R27's quarterly Minimum Data Set (MDS), dated 8/16/17, identified R27 exhibited cognitive deficit, however, staff were unable to assess related to R27's inability to respond. R27 was identified as exhibiting total dependence with personal grooming. A review of behavior notes did not identify rejection of cares. R27's medical diagnoses included a neurological disease. R27's care plan, printed 9/13/17, identified R27 was "Dependent on staff to provide all grooming/hygiene tasks with AO1 [assist of one]" and directed staff to shave resident's face. During observation on 9/11/17, at 4:51 p.m., R27 was noted to be asleep in bed. R27 was unshaven, with whiskers measuring approximately 1/8 inches in length over cheeks, chin and upper lip. On 9/11/17, at 7:48 p.m. family member (F)-A was present with R27 and stated	F 312	R27 Care Plan has been updated that he occasionally refuses assistance with shaving but will be re-approached if refusal occurs. Nurse Aide Care Plan forms have had formatting changes to ensure that the Nurse Aides know what is expected. Information regarding updated caregiver sheets will be communicated via shift reports, communication books, and meetings held on 10/12. All Care Plans for residents have been updated with format changes to Nurse Aide Care Plan guides to allow easier recognition of what ADL's need assistance. After review of current charts, random audits will be conducted. Audits will be completed by the DON/designee 2x week x 4, weekly x4 and monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations.	10/24/17

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F 312	Continued From page 11	F 312		

"He's got a couple of days growth right now. They do skip that quite often.". F-A stated a new razor had been recently been purchased, and was noted to be sitting on the window sill, ready for use. F-A stated R27 liked to be shaved. F-A asked R27 if he would rather be shaven than have a beard; resident responded "Yeah". On 9/12/17, at 9:00 a.m. R27 was observed to be in bed, unshaved in appearance. On 9/12/17, at 10:54 R27 was noted to seated in his wheelchair (w/c) and remained unshaved. On 9/12/17, at 4:25 p.m. R27 was seated in his w/c and was unshaved. On 9/13/17, at 11:23: a.m. R27 was observed up and dressed and seated in the w/c. At this time, R27 was noted to have facial hair remaining on his upper lip, which appeared as a mustache, however his cheeks and chin appeared clean-shaven.

During interview on 9/13/17, at 11:40 a.m. nursing assistant (NA)-A stated the night staff had performed morning cares for R27. NA-A stated R27 had been difficult to shave as he turned his head from side to side, as he "did not like to be shaved.". NA-A stated when R27 was shaved, the staff shaved first with the electric razor, followed by a disposable razor. NA-A stated residents are shaved whenever facial hair is noted, however, if it was noted that R27 had not been shaved when staff went to take him to lunch it probably would not get done as "Then we would get behind at dinner."

During interview on 09/13/17, at 3:17 p.m. NA-B stated she had assisted with morning cares for R27 and stated R27 received total assistance with personal grooming. NA-B stated staff "Try, but he doesn't like it. We usually shave him on bath days" and his bath day was Sunday. NA-B

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F 312	Continued From page 12	F 312		

stated she had attempted to shave him this morning, and had shaved his cheeks but had not attempted to shave the upper lip. NA-B did state when unable to shave, she alerted oncoming staff, adding registered nurse (RN)-B was able to shave R27 "really good" .

During interview with RN's A and B on 9/13/17, at 3:23 p.m. RN-B stated he had shaved R27 on multiple occasions and staff would advise him if assistance was needed. RN-B identified R27 did need a shave. RN-A noted R27 had his cheeks shaven, however his upper lip had not been shave. R27 nodded his head up and down when asked if he wished to be shaved, and shook his head back and forth when asked if he wished to have a mustache.

An undated facility policy titled Resident Cares identified personal cares are provided for each resident to promote cleanliness and comfort. The policy identified under procedure, number five: Resident shaved per the plan of care.

Electronically delivered
September 28, 2017

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

Re: State Nursing Home Licensing Orders - Project Number S5495027

Dear Ms. Halvorson:

The above facility was surveyed on September 11, 2017 through September 14, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Kathy Lucas at (320) 223-7343 or email: kathy.lucas@state.mn.us**.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

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
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

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
	00448	A. BUILDING: _____ B. WING _____	09/14/2017

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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

Electronically Signed | 10/06/17

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 9/11, 9/12, 9/13, and 9/14/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		10/24/17

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2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to notify the physician of a significant deterioration in health for 1 of 1 (R106) residents reviewed for change of condition. Findings include: R106's Face Sheet identified diagnoses which included, weakness and unspecified heart failure. R106's admission Minimum Data Set (MDS) dated 6/8/17, indicated R106 had no cognitive impairment, required set up and supervision for eating, and extensive assistance for transfers, dressing, and personal hygiene. R106's Meals & Weight form, dated 6/1/17 indicated R106 weighed 135 pounds. A progress note, dated 6/1/17, indicated R106 was in the dining room for supper, did not want to eat any food, and drank liquids only. A progress note, dated 6/2/17, indicated R106 told staff she was very tired, that R106 was receiving therapy with hopes to increase her strength and move to senior living and was eating meals in the dining room. A progress note, dated 6/3/17, indicated R106 required assistance of 2 staff for both transfers and toilet use. R106 was up for both meals and ate well and rested in bed most of the shift. A progress note, dated 6/4/17, indicated R106 ate	2 265	Corrected	

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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) COMPLETE DATE
2 265	Continued From page 4 in her room for supper and ate about 95% of the meal. A Meal and Weight form dated 6/4/17, identified R106 weighed 131.4 pounds. (a loss of 3.6 pounds in 3 days.) A Meals &Weights form, dated 6/5/17, indicated R106 weighed 129.6 pounds. (a loss of 5.4 pounds in 4 days.) A progress note, dated 6/6/17, indicated R106 enjoyed visiting with residents and staff. R106 goes to the dining room for meals. R106 participates in therapy and is motivated for recovery. A progress note, dated 6/7/17, indicated R106's receives a regular diet. Current weight 125 pounds. (a loss of 10 pounds in 6 days.) R106 has no problems with chewing at this time. Has no food dislikes. Likes mashed potatoes, gravy, and bread. A progress note, dated 6/8/17, indicated a Patient Health Questionnaire (PHQ-9) assessment (depression assessment tool) score of 0/27, with no treatment needed at this time. R106 denied depression. Mood is stable. Cooperative and pleasant. A progress note, dated 6/12/17, indicated R106 reported an emesis after breakfast, but has felt better since that time. A progress note, dated 6/13/17, at 3:34 a.m. indicated R106 had no appetite and refused supper. "Appears depressed and talking about how old she is and ready to die." Drinking fluids, no solid intake on evening shift.	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	09/14/2017

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) COMPLETE DATE
2 265	Continued From page 5 A progress note, dated 6/13/17, at 6:55 p.m. indicated R106 refused medication. No intake for supper. R106 asked if daughter was coming "...I won't be here much longer." Staff notified R106's daughter that R106 appeared depressed and R106 wished to see daughter. R106 offered and refused food and fluids. A progress note, dated 6/14/17, indicated R106 has been refusing to go to the dining room for meals. "Has had little intake of food and liquid." A progress note, dated 6/15/17, indicated "Daughter here visiting today and commented to staff that she feels that her mother is giving up. Refused to go to urgent care at this time. Appetite continues to be poor." A progress note, dated 6/16/17, indicated "Resident stayed in bed most of the shift. Resident had a poor appeteite (sic) and just had no real energy of any kind to do anything. Resident did not have any pain complaints but did not appear to feel well." A progress note, dated 6/17/17, indicated "Resident stayed in bed all shift and refused all her medications and did not eat her meals. Resident is noted to either be depressed or not feeling well but she is unclear as to which one it is. Resident stated she did not want to go to the doctor." A progress note, dated 6/18/17, indicated R106 "...is noted to seem overall depressed." "Resident refused to eat and take medications." "Resident is noted to be very down in the dumps and has made statements like 'I'm not going to be here much longer,"	2 265		

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	00448	A. BUILDING: _____ B. WING _____	09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 265	Continued From page 6 A progress note, dated 6/19/17, indicated R106 "...stayed in her room in bed this shift. She did not eat any supper and needs to have extensive assist and prompting to drink anything." Drank sips of water. No appetite. A Meal & Weight form identified R106's weighed 119.8 pounds on 6/19/17. (a significant loss of 15.2 pounds/ or 11.26% in 18 days.) A progress note, dated 6/27/17, at 3:49 p.m., indicated an initial care conference was held on 6/20/17. R106 willing to try ensure twice a day due to not much appetite and loss of weight. A progress note, dated 6/20/17, indicated R106 stayed in bed for the entire morning shift. Did have some fluid intake of Ensure (nutritional supplement.) A progress note, dated 6/21/17, indicated R106 "...has now refused to work with therapy and is remaining in bed." R106 states she is "...too tired to get up." A progress note, dated 6/23/17, indicated R106 has again chosen to stay in bed today. Continued to drink some fluids, eating very little. Sleeping a lot. Continue to observe and try to increase food and fluid intake. A progress note, dated 6/26/17, at 3:26 a.m., indicated R106 was weepy, requested her daughter. Staff called R106's daughter per R106's request. Daughter unable to come until the morning. R106 stated "That's ok." R106 was thirsty and took a few sips of water. A progress note, dated 6/27/17, at 3:29 a.m.,	2 265		

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2 265	Continued From page 7	2 265		

indicated R106 rated pain 5 out of 10 (1 least and 10 worst.) R106 stated "I just don't feel well." when asked about location of pain.

A progress note, dated 6/27/17, at 9:31 a.m. indicated R106 "has had increased loose stools with red blood observed. Daughter was informed and requested to have ambulance called to have her brought in. Ambulance called."

A progress note, dated 6/27/17, at 5:17 p.m. indicated R106 was returning from the hospital. R106 was "...actively dying and there was nothing else they could do for her for treatment so she was coming (sic) home to pass away in comfort with her family at bedside."

A progress note, dated 6/27/17, at 10:13 p.m. indicated R106 passed away at 6:40 p.m.

Despite R106's decreased intake with significant weight loss and changes in mood, R106's record lacked documentation the physician was notified of these changes.

During an interview with registered nurse (RN)-A, registered nurse (RN)-B and the director of nursing (DON) on 9/14/17, at 8:58 a.m. RN-A stated when R106 first came, she was attending therapy and was going to the dining room for meals. R106 started to refuse to go out for meals and started to make statements she was giving up. Complained of feeling tired. R106's intake started to decline and R106 lost weight. The nursing assistants offered R106 food and fluids several times a day. Nutritional supplements were tried. Initially R106 would drink the supplement, then started to refuse. Staff contacted R106's daughter frequently. DON stated staff asked R106 on a few occasions if she wanted to go to

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2 265	Continued From page 8 the clinic to see a physician and R106 refused. Family aware of refusals. The DON stated the policy is to contact the physician via phone or fax when a resident shows a decline. The DON stated the clinic was notified of abnormal INR's (blood test used to identify clotting time of blood,) but had no tangible evidence to show physician (B) was notified of the resident's decline. During an interview on 9/14/17, at 10:59 a.m., physician-B stated he could not remember staff notifying him of R106's poor intake, weight loss, or mood changes. Physician-B stated if R106 was refusing treatments and refusing to see a physician, he would have honored those wishes. Physician-B went on to say it probably would not have changed anything, but he would have expected to be notified of R106's decline. The facility policy MD, Family and/or Responsible Party Notification, dated "7-2014" directed the physician to be notified when there is: "A significant change in the resident's physical, mental, or psychosocial status i.e. a deterioration in health, mental, or psychosocial status..." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could update policies and procedures and then educate staff on examples on when the physician should be notified. The DON or designee could perform audits of medical records to determine if the physician had been notified appropriately. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 265		

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2 565	Continued From page 9	2 565		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with shaving as directed per the care plan for 1 of 3 residents (R27) reviewed for activities of daily living (ADLs). Findings include: R27's quarterly Minimum Data Set (MDS), dated 8/16/17, identified R27 exhibited cognitive deficit and was identified as needing total assistance with personal grooming. R27's care plan, printed 9/13/17, identified R27 was "Dependent on staff to provide all grooming/hygiene tasks with AO1 [Assist of one]" and directed staff to shave resident's face. A nursing assistant (NA) assignment listing, dated 9/13/17, identified R27 was to receive AO1 with grooming, but did not provide additional instruction regarding shaving. During observation on 9/11/17, at 4:51 p.m. R27 was noted to be asleep in bed and was unshaven in appearance, with whiskers measuring 1/8th inch over cheeks, upper lip, and chin. During follow up interview on 9/11/17, at 7:48 p.m. family member (F)-A was present and stated "He's	2 565	Corrected	10/24/17

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2 565	Continued From page 10	2 565		

[R27] got a couple of days growth right now. They do skip that quite often." F-A stated a new razor had recently been purchased, and was noted to be sitting on the window sill, ready for use. M-A asked R27 if he would rather be shaven than have a beard; resident responded "Yeah". On 9/12/17, at 9:00 a.m. R27 was observed to be in lying in bed unshaved. On 9/12/17, at 10:54 a.m. R27 was observed seated in his wheelchair and remained unshaved. Later, at 4:25 p.m. resident was noted to be up in his w/c and remained unshaven. On 9/13/17, at 11:23: a.m. R27 was observed up and dressed in w/c and was noted to have his cheeks and chin shaven, however facial hair remained on his upper lip in a mustache like appearance.

During interview on 9/13/17, at 11:40 a.m. NA-A stated the night staff had performed morning cares for R27. NA-A stated R27 had been difficult to shave as he turned his head from side to side, as he "did not like to be shaved." NA-A stated when R27 was shaved, the staff shaved first with the electric razor, followed by a disposable razor. NA-A stated residents are shaved whenever facial hair is noted, however, if it was noted R27 had not been shaved when staff went to take him to lunch it probably would not be done as "Then we would get behind at dinner."

During interview on 09/13/17, at 3:17 p.m. NA-B stated she had assisted with morning cares for R27 and total assistance was provided with personal grooming. NA-B stated staff "Try, but he doesn't like it. We usually shave him on bath days" and his bath day was Sunday. NA-B stated she had attempted to shave him this morning, and had shaved his cheeks but had not attempted to shave the upper lip. NA-B did stated when unable to shave residents, she alerted

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2 565	Continued From page 11 oncoming staff, adding registered nurse (RN)-B was able to shave R27 "really good" . During interview with RN's A and B on 9/13/17, at 3:23 p.m. RN-B stated he had shaved R27 on multiple occasions and staff would advise him if assistance was needed. RN-B stated he had not been requested to assist R27, although he identified R27 did need a shave. RN-A noted R27 had his cheeks shaven, however his upper lip had not been shaved. R27 nodded his head up and down when asked if he wished to be shaved, and shook his head back and forth when asked if he wished to have a mustache. An undated facility policy titled, Resident Cares identified personal cares are provided for each resident to promote cleanliness and comfort. The policy identified under procedure, number five: Resident shaved per the plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could update policies and procedures and then educate staff on examples on when the physician should be notified. The DON or designee could perform audits of medical records to determine if the physician had been notified appropriately. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 565		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:	2 850		10/24/17

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2 850	Continued From page 12 D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide grooming care for 1 of 3 residents (R27) reviewed for activities of daily living (ADL's) and who was dependent of staff for care. Findings include: R27's quarterly Minimum Data Set (MDS), dated 8/16/17, identified R27 exhibited cognitive deficit, however, staff were unable to assess related to R27's inability to respond. R27 was identified as exhibiting total dependence with personal grooming. A review of behavior notes did not identify rejection of cares. R27's medical diagnoses included a neurological disease. R27's care plan, printed 9/13/17, identified R27 was "Dependent on staff to provide all grooming/hygiene tasks with AO1 [assist of one]" and directed staff to shave resident's face. During observation on 9/11/17, at 4:51 p.m., R27 was noted to be asleep in bed. R27 was unshaven, with whiskers measuring approximately 1/8 inches in length over cheeks, chin and upper lip. On 9/11/17, at 7:48 p.m. family member (F)-A was present with R27 and stated "He's got a couple of days growth right now. They do skip that quite often.". F-A stated a new razor had been recently been purchased, and was noted to be sitting on the window sill, ready for use. F-A stated R27 liked to be shaved. F-A	2 850	Corrected	

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2 850	Continued From page 13 asked R27 if he would rather be shaven than have a beard; resident responded "Yeah". On 9/12/17, at 9:00 a.m. R27 was observed to be in bed, unshaved in appearance. On 9/12/17, at 10:54 R27 was noted to seated in his wheelchair (w/c) and remained unshaved. On 9/12/17, at 4:25 p.m. R27 was seated in his w/c and was unshaved. On 9/13/17, at 11:23: a.m. R27 was observed up and dressed and seated in the w/c. At this time, R27 was noted to have facial hair remaining on his upper lip, which appeared as a mustache, however his cheeks and chin appeared clean-shaven. During interview on 9/13/17, at 11:40 a.m. nursing assistant (NA)-A stated the night staff had performed morning cares for R27. NA-A stated R27 had been difficult to shave as he turned his head from side to side, as he "did not like to be shaved.". NA-A stated when R27 was shaved, the staff shaved first with the electric razor, followed by a disposable razor. NA-A stated residents are shaved whenever facial hair is noted, however, if it was noted that R27 had not been shaved when staff went to take him to lunch it probably would not get done as "Then we would get behind at dinner." During interview on 09/13/17, at 3:17 p.m. NA-B stated she had assisted with morning cares for R27 and stated R27 received total assistance with personal grooming. NA-B stated staff "Try, but he doesn't like it. We usually shave him on bath days" and his bath day was Sunday. NA-B stated she had attempted to shave him this morning, and had shaved his cheeks but had not attempted to shave the upper lip. NA-B did state when unable to shave, she alerted oncoming staff, adding registered nurse (RN)-B was able to shave R27 "really good" .	2 850		

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2 850	Continued From page 14 During interview with RN's A and B on 9/13/17, at 3:23 p.m. RN-B stated he had shaved R27 on multiple occasions and staff would advise him if assistance was needed. RN-B identified R27 did need a shave. RN-A noted R27 had his cheeks shaven, however his upper lip had not been shave. R27 nodded his head up and down when asked if he wished to be shaved, and shook his head back and forth when asked if he wished to have a mustache. An undated facility policy titled Resident Cares identified personal cares are provided for each resident to promote cleanliness and comfort. The policy identified under procedure, number five: Resident shaved per the plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could update policies and procedures and then educate staff on examples on when the physician should be notified. The DON or designee could perform audits of medical records to determine if the physician had been notified appropriately. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 850		

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	245252	A. BUILDING **02 - THEIF RIVER CARE CENTER NEW BLDG** B. WING _____	**09/12/2017**

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

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K 000	INITIAL COMMENTS FIRE SAFETY 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 WILL BE USED AS VERIFICATION OF 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 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 not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/06/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	245252	A. BUILDING **02 - THEIF RIVER CARE CENTER NEW BLDG** B. WING _____	**09/12/2017**

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K 000	Continued From page 1	K 000		

By e-mail to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

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 two smoke barriers and two 2 hour fire barriers

The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems. 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" . All sleeping rooms have smoke detection with other hazardous areas have automatic fire detectors, that are on the fire alarm system. The fire alarm is monitored for automatic fire department notification.

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 _____	**09/12/2017**

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 2 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 NOT MET.	K 000		
K 341 SS=F	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install fire alarm controls in accordance with NFPA 101 Life Safety Code (2012) section 9.6.6. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect all of the 67 residents and an undetermined amount of staff and visitors. Findings include:	K 341	In order to comply with NFPA 101 Life safety code and NFPA 70 National electric code and NFPA 72 National fire alarm code, remote annunciator will be installed in a 24 hour monitored location. Staff will be educated on the operation and function of the remote annunciator. This will include initial instruction and during fire drills.	10/24/17

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K 341	Continued From page 3 At 11:30 am on 09/12/17 observations revealed there was no fire alarm remote annunciator in a 24 hour monitored location. This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services.	K 341	The Environmental Services director is responsible for the installation, testing and annual inspection of the fire alarm system. Information will be brought to the quarterly QAPI meetings.	
K 345 SS=F	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to verify the DACT signal as required by the Life Safety Code,(LSC) 2012 edition, section 9.6.1.3 and NFPA 72, The National Fire Alarm and Signaling Code, 2010 edition, table 14.3.1. This deficient condition could delay alarm notification to emergency personnel in case of a failure and affect all 67 residents and an undetermined amount of staff and visitors. Findings include: At 8:30 am on 09/12/17 record review revealed	K 345	In order to comply with NFPA 101 Fire Alarm System □ Testing and Maintenance the Annual Fire Alarm System was testing and inspected on September 15th, 2017. The Environmental Services Director and Administrator have added a reminder one month prior to the inspection and testing deadline to both physical and computer generated calendars. The Environmental Services Director is responsible for the scheduling of the	10/24/17

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	245252	A. BUILDING **02 - THEIF RIVER CARE CENTER NEW BLDG** B. WING _____	**09/12/2017**

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K 345	Continued From page 4 there was no documentation of the fire alarm system inspection in the last 12 months. This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services.	K 345	annual Fire Alarm System Testing and Maintenance. Information will be brought to the quarterly QAPI meetings.	
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one of two smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 33 of the 67 residents and an undetermined amount of staff and visitors. Findings include: At 11:00 am on 9/12/17 observations revealed unlisted fire stopping around a bar joist penetrating the smoke barrier in the Blueberry	K 372	In order to comply with NFPA 101 section 19.3.7.3.8.8.7.1 (1) the area noted in the Fire Marshal Inspection will be fire stopped using an approved foam sealant. The Environmental Services Director has toured the facility and found no other areas that are not properly fire stopped. The Environmental Services Director will monitor any future construction, renovation, or work by contractors that may cause penetrations in a fire or smoke wall and ensure they are properly fire	10/24/17

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K 372	Continued From page 5 wing. This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services	K 372	stopped. The Environmental Services Director is responsible for ensuring all penetrations in fire and smoke compartment walls are properly fire stopped. Information will be brought to the quarterly QAPI meetings.	