Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

March 19, 2025

Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

RE: I47Y13

Dear Administrator:

On March 18, 2025, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of $300.00 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violations had been corrected. A reinspection was held on March 17, 2025 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $300.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling $40.60, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Minnesota Department of Health in the amount of $340.60 within 15 days of the receipt of this notice.

Please send a copy of this letter and the check to:

Department of Health
Health Regulation Division,
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

cc: Shellae Dietrich, Program Assurance Superviosr
Kami Fiske-Downing, Licensing and Certification Program
HRD Deposit Team

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 19, 2025

Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

RE: CCN: 245252
Cycle Start Date: January 16, 2025

Dear Administrator:

On February 4, 2025, we notified you a remedy was imposed. On March 17, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 14, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 19, 2025 be discontinued as of March 14, 2025. (42 CFR 488.417 (b))

In our letter of February 4, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 19, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 7, 2025

Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

RE: CCN: 245252
Cycle Start Date: January 16, 2025

Dear Administrator:

On February 4, 2025, we informed you of imposed enforcement remedies.

On February 27, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found 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 attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

F657 -- S/S: D -- 483.21(b)(2)(i)-(iii) -- Care Plan Timing And Revision
F880 -- S/S: F -- 483.80(a)(1)(2)(4)(e)(f) -- Infection Prevention & Control

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), was effective February 19, 2025.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 19, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 19, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your

obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of February 4, 2025, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 19, 2025.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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).

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 16, 2025 (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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolutioN

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 4, 2025

Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

RE: CCN: 245252
Cycle Start Date: January 16, 2025

Dear Administrator:

On January 16, 2025, a 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 constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedies listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 19, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 19, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 19, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of

payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 19, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Thief River Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 19, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.

- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

A Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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 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.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 16, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	C 01/16/2025

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
E 000	Initial Comments On 1/13/25 through 1/16/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/13/25 through 1/16/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H52524561C (MN00109675) with a deficiency issued at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	F 558		2/19/25

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

Electronically Signed | 02/11/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 01/16/2025

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 558	Continued From page 1 §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an assessment was completed for an electric scooter to increase mobility for 1 of 1 residents (R57) reviewed for accomadation of needs. Findings include: R57's significant change Minimum Data Set (MDS) dated 12/30/24, identified R57 was cognitively intact, was independent with bed mobility, no functional limitation in range of motion of upper or lower extremities, and used a walker and wheelchair for mobility. R57 participated in physical and occupational therapy during the assessment period. R57's care plan revised on 11/14/24, identified R57 was independent with bed mobility, required assistance of one staff and gait belt to transfer between surfaces, and required stand-by assistance while walking with a walker. The plan failed to identify use of an electric scooter. On 1/13/25 at 6:20 p.m., R57 stated she had an electric scooter at home and talked to staff about it. R57's son brought the scooter to the facility; however, R57 stated she had not received any follow-up from staff. R57 stated she received therapy every day and had not had any	F 558	The resident has the right to reside and receive services in the facility. Residents at TRCC have the right for reasonable accommodation of needs and preferences. Therapy did an electric scooter evaluation on R57 so that she could start utilizing her electric scooter. This could happen to any residents that require assistance with mobility. The DON or designee will review all residents' mobility, have therapy screen residents with changes to ensure that they are receiving the type of accommodation they need for mobility. Staff will communicate and follow through with residents' requests and mobility needs changes. DON or designee will review/revise electric wheelchair policy, Accommodation of Needs policy, and Care Conference Process policy. DON or Designee will educate all staff on accommodation of needs and all policies/procedures. The DON or designee will complete audits	

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 _____	C 01/16/2025

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 558	Continued From page 2 discussion or assessments related to use of the scooter. R57's care conference notes from 11/27/24 were reviewed; however, the notes did not identify any discussion regarding the electric scooter use. R57's medical record lacked any assessment or referral for the use of the electric scooter. On 1/16/25 at 9:13 a.m., social services (SS)-A stated R57's electric scooter was in the building by the front entrance and was under the impression R57 was assessed by occupational therapy but was not strong enough to drive the scooter independently. SS-A stated she was uncertain what R57 had been told regarding using the scooter. On 1/16/25 at 12:13 p.m., physical therapy assistant (PTA)-A stated therapy had not received a referral to assess R57 for use of the electric scooter. On 1/16/25 at 12:13 p.m., SS-A provided an undated and untitled document with R57's name and written notes that identified "scooter eval. - key in top drawer." SS-A stated the document was notes she made to herself, although she failed to pass the information onto nursing staff. A policy regarding following up on resident's requests was requested but not provided.	F 558	to ensure that residents' needs/preferences for mobility are being met. This will happen 3x/wk. for 4 wks., 2x/wk. for 3 wks., 1x/wk. x 3wks, and then monthly thereafter. Results will be taken to quarterly QAPI meetings for recommendations and further monitoring.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		2/19/25

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F 657	Continued From page 3 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to update the care plan with a new transfer status for 1 of 2 residents (R32) reviewed for falls; and the facility failed to update the care plan with a new turning and repositioning schedule for 1 of 2 residents (R8) reviewed for pressure ulcers. Findings include: R32's significant change Minimum Data Set (MDS) dated 11/25/24, identified R32 had severe	F 657	Comprehensive care plans. TRCC failed to update the care plan with a new transfer status. TRCC also failed to update the care plan with a new turning and repositioning schedule. R32's care plan was not accurate and did not match transfer status. Care plan updated to current transfer status. R8's care plan was not updated with new turning and repositioning schedule. The	

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F 657	Continued From page 4 cognitive impairment. R32 was dependent on staff for toileting transfer. R32's History and Physical dated 1/7/25, identified R32 was seen for a left intertrochanteric hip fracture following a fall in the nursing home. R32 was to be admitted to the hospital for orthopedic surgery. R32's care plan dated 1/14/25, identified R32 required assistance with activities of daily living (ADLs) and was weight bearing as tolerated. Staff were to assist R32 with assist of one and gait belt to transfer. R32 had a recent left hip fracture related to a fall with surgical intervention. Staff were directed to anticipate and meet needs, make sure call light was with in reach and to respond promptly to all requests for assistance. R32 was able to be weight bear as tolerated with physical and occupational therapy evaluations ordered. During observation on 1/14/25, at 5:34 p.m. R32 was lying in bed with bed low to the floor and head of the bed elevated to sitting position. Nursing assistant (NA)-B sat at R32's bedside and stated they did not get R32 up to the toilet or commode or in her wheel chair because the Hoyer lift (full lift) transfers were to painful for R32. A joint interview was conducted with registered nurse consultant (RN)-I and director of nursing (DON) on 1/15/25, at 1:37 p.m. The DON stated after R32 fell on 11/10/24, she was non weight bearing and needed a Hoyer lift to transfer, as the family opted not to have surgical repair to R32's right hip. RN-I stated when a resident returned from the hospital, licensed staff	F 657	care plan was updated to the current repositioning schedule. This could happen to any resident that requires assistance with transferring and turning/repositioning. The DON or designee will review all residents that are dependent on turning, repositioning and transferring. Care plans will be reviewed and updated if changes are needed. Staff will be updated on any changes. The DON or Designee will review and revise if needed the tissue tolerance policy, repositioning policy, and Person-Centered Care Planning. The DON or designee will educate all nursing staff on the policies and any changes made. The DON or designee will complete audits on care planning timing and revision 3x/wk. for 4wks, then 2x/wk. for 3 weeks, weekly for 3 weeks, then monthly and PRN. Results will be taken to quarterly QAPI meetings for further recommendations and monitoring.	

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F 657	Continued From page 5 completed a skilled progress note daily, bowel and bladder, fall, skin, and pain assessments were completed. Changes were then made to the resident's care plan and changes would go directly to the resident's Kardex where the aides could see what care needs and changes the resident had. Therapy was also seeing R32 and went by their recommendations as well for care plan items. When interviewed on 1/16/25, at 10:52 a.m. the DON stated therapy was seeing R32 since her hospital return and R32 was to be a Hoyer lift transfer. The DON had questioned several nursing assistants and they reported they were using a Hoyer lift when transferring R32; however, R32's care plan was not accurate and did not match her transfer status to reflect her needs. Updating the plan of care to accurately reflect what residents needed was an issue the DON had been aware of and was working on. R8's significant change MDS dated 10/21/24, identified severe cognitive impairment. R8 required substantial/maximal assistance with turning and repositioning and toileting. R8 was at risk for pressure ulcers, currently did not have any skin issues. Diagnoses included Alzheimer's disease and non-Alzheimer's dementia. R8's care plan dated 11/12/24, identified R8 should be repositioned every three hours as R8 had a potential for skin impairment.	F 657		

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F 657	Continued From page 6 R8's progress note dated 1/6/25 identified a new skin issue located on the inside of R8's right buttock. The area was 1.5 centimeters (cm) x 1.5 cm with 100% granulation tissue (a new, pink or red, moist tissue that forms at the site of a wound as it heals.). Primary care provider notified. Tissue tolerance identified to turn every 2 hours. During an interview on 1/15/25 at 11:06 a.m. NA-G stated they were assigned to care for R8 today. NA-G stated R8's care plan was recently updated and R8 was supposed to be repositioned every two hours, because R8 had a new area of impaired skin integrity on the identified R8's buttocks. NA-G was not sure when the last time R8 was repositioned. During an interview on 1/15/25 at 3:00 p.m., RN-C stated R8 had developed a new area on her inner right buttocks and were doing dressing changes every three days and as needed. R8 was also to be repositioned every two hours to keep pressure off the wound. The updates with repositioning R8 had been communicated with nursing staff and the nursing assistants, but not updated on the care plan. The facility policy Person Centered Care Planning revised 4/20/23, identified the resident's baseline care plan would be developed based on admission orders, information available from the transferring provider and discussion with the resident and resident representative. Information would be included necessary to properly care for the resident, including immediate health and safety concerns to prevent decline or injury and activities of daily living (ADL)s.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents	F 677		2/19/25

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F 677	Continued From page 7 CFR(s): 483.24(a)(2) §483.24(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 timely assistance with toileting/incontinence care for 1 of 3 residents (R8) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. Findings include: R8's significant change Minimum Data Set (MDS) dated 10/21/24, identified R8 had severe cognitive impairment and was dependent on staff for her ADLs. R8 was incontinent of bowel and bladder. The MDS included diagnoses of Alzheimer's disease, and non-Alzheimer's dementia. R8's Bowel and Bladder Risk Assessment dated 10/21/24, identified R8 was incontinent of bowel and bladder. R8's care plan dated 11/12/24, identified R8 required extensive assist of one for toileting and incontinence care every three hours and as needed. Continuous observations were completed on 1/15/25 at 7:18 a.m. through 11:13 a.m. and identfied the following: - At 7:18 a.m. R8 was seated in her wheelchair and wheeling herself down the hall heading to the	F 677	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. R8's tasks were updated for NAR charting to complete toileting. Toileting sheets are provided to document real time toileting. This could happen to all residents that are dependent on staff for their toileting needs. The nurse managers will review the care plans and NAR tasks to make sure that they are correct, current and being followed/charted on. Staff will be updated on any changes that are made. The DON or designee reviewed the Toileting residents policy. Nursing staff will be educated on this policy. The DON or designee will do toileting audits 3x/wks. for 4 wks., 2x/wk. for 3 wks., 1x/wk. for 3 wks., then monthly and PRN thereafter. Results will be taken to QAPI for further recommendations and monitoring.	

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F 677	Continued From page 8 common area. - At 8:08 a.m. R8 was in dining room for breakfast. She was seated in her wheel chair and had not been toileted or offered toileting. - At 9:24 a.m. R8 was taken by an unidentified activity staff to an activity in the common area of the nursing home. R8 had not been toileted or offered toileting. - At 9:40 a.m. R8 was brought to the common area when activity was completed and was watching TV. R8 remained in common area seated in the wheelchair and had not been toileted or offered toileting. - At 10:40 a.m. R8 remained in the common area and participated in a bible study that finished at 10:50 a.m. - At 11:00 a.m. R8 continued in her wheelchair and had not been toileted or offered toileting. During an interview on 1/15/25 at 11:06 a.m. nursing assistant (NA)-G stated they were assigned to care for R8 today. NA-G was not sure when the last time R8 was toileted. NA-G then went to bring R8 to the bathroom. During observation on 1/15/25 at 11:13 a.m., nursing assistant (NA)-G assisted R8 to the bathroom. When R8's incontinent brief was removed there was a small amount of feces in the brief and smeared on her buttocks and the brief had a small amount of urine. There was a scabbed area on R8's inner right buttocks that looked one cm in size, the skin around the area was intact. During an interview on 1/15/25 at 11:04 a.m., NA-F stated staff reviewed the communication board or it would be passed on in report when a resident was to be assisted with toileting and/or	F 677		

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F 677	Continued From page 9 have their brief checked. The facility recently updated their electronic charting system and staff could also see the care planned interventions in the Kardex . NA-F stated she had not worked with R8 and did not know when she needed to be checked. During an interview on 1/15/2 at 11:07 a.m., NA-G stated they were assigned care of R8. R8's care plan was recently updated and was supposed to be offered toileting and check and change every 2 hours because an area of impaired skin integrity was identified on her buttocks. NA-G was not sure of when the last time R8 was checked or offered toileting assistance. NA-G stated they usually checked her right after breakfast, but did not do it today and was unsure if it was done. The last time NA-G knew R8 was checked was when she got up this morning and NA-G brought R8 to the bathroom. During an interview on 1/15/25 at 3:00 p.m., registered nurse (RN)-C stated R8 was to be checked and changed every 2 hours, which was changed from check and change every 3 hours due to a new area of impaired skin integrity. Residents who sat in soiled incontinent briefs had an increased chance of skin breakdown and should be checked and changed frequently. During an interview on 1/16/25 at 9:55 a.m., the director of nursing (DON) stated it was the expectation staff would have followed resident care plan related to check and change of incontinent briefs to ensure R8's care was done. The facility's Urinary Incontinence Program policy dated 4/6/15, identified each resident will receive the appropriate care and services to prevent	F 677		

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F 677	Continued From page 10 incontinence related complications to the extent possible.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify a significant increase in weight with dependent edema in the lower extremeties and conducted a comprehensive assessment and implement interventions for 1 of 1 residents (R55) reviewed for edema. Findings include: R55's admission Minimal Data Set (MDS) dated 11/4/24, identified R55 had intact cognition and required moderate to maximal assist with activities of daily living (ADLs). R55's admission weight was recorded as 203 pounds (lbs). Diagnoses included acute embolism and thrombosis of deep veins of superior vena cava, kidney failure, hypertension and pulmonary hypertension. R55's undated care plan identified R55 required assistance with ADL's and staff were directed to	F 684	The residents have the right to have assessments when their condition changes and have needs addressed and provided. Residents are to be given appropriate treatment and services in accordance with professional standards of practice and person-centered care. R55 had a long-term care evaluation assessment done along with getting wraps ordered for his legs. Nurses are documenting daily on edema; nursing staff are encouraging him to elevate his lower extremities and to document refusals. The nurse manager addressed his weight gain with the primary physician and will continue to monitor his weight and update the physician if there is increased weight gain. Resident's care plan was updated with new interventions for edema. This could happen to any resident that	2/19/25

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F 684	Continued From page 11 assist R55 with dressing, grooming, toileting, bed mobility and transfers. The plan of care failed to identify issues with intact skin, weight or edema. R55's medical record identified the following weights: - 10/30/24, R55 weighted 203 lbs. - 11/26/24, R55 weighted 219 lbs. - 12/03/24, R55 weighted 231 lbs. (28 lb weight gain from admission, 13.79% gain) - 12/10/24, R55 weighted 229 lbs. - 12/17/24, R55 weighted 232 lbs. - 12/24/24, R55 weighted 231 lbs. - 1/14/25, R55 weighted 225 lbs(22 lb weight gain from admission, 10.84% gain) R55's medical record lacked evidence the significant weight gains were assessed and interventions implemented. R55's progress note dated 12/23/24, identified family member (FM)-A requested a nurse to look at R55's left foot. FM-A requested the facility obtain an order for ace wrap to R55's left leg. A fax was sent to R55's primary provider to update on R55's skin and request ACE wrap for R55's left leg. On 1/13/25, at 5:53 p.m. R55 was observed seated in a wheelchair in his room. R55's legs were in a dependent position and feet were placed on the wheelchair foot rests. There was significant swelling in both of R55's lower extremities from his knees to his toes with greater swelling noted on his left leg. On 1/14/25, at 3:22 p.m. R55 was observed seated in wheelchair in his room watching television. R55 was observed with his legs in a	F 684	has potential for increased weight or edema. Nurse managers will look over documentation, interventions for residents that are on a diuretic, or could have the potential for increased weight or edema to see that interventions are in place or do interventions need to be implemented, assessment completed and if the physician needs to be updated or was updated. The DON or designee will review the edema policy, and significant weight gain policy. Nursing staff will be educated on the policies and on elevating lower extremities, document refusals, and daily edema monitoring. The DON or designee will do audits on weight gain, edema, physician notification and assessments, 3x/wk. for 4 wks., 2x/wk. for 3 wks., 1x/wk. for 3 wks., and then monthly and PRN thereafter. Results will be brought to QAPI for further recommendation and monitoring.	

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F 684	Continued From page 12 dependent position with feet resting on wheelchair footrests. R55 had significant swelling in both feet and lower legs bilaterally. On 1/15/25, at 9:30 a.m. registered nurse (RN)-B entered R55's room to check R55's feet. RN-B removed R55's socks, both lower extremities had significant swelling from knees to toes. RN-B wrapped R55's left lower leg and foot with ace wrap after covering both legs with a soft sleeve. On 1/15/25, at 9:45 a.m. FM-A stated the facility staff never made attempts to have R55 lie down in bed or elevate his legs. If FM-A chased down the staff and begged them, they would come in and assist him to lie down. R55 needed to lie down to help with the swelling in his legs. When R55 was at home for three weeks in October, he did not have any swelling in his legs at all, because he had remained in bed a majority of the time. On 1/15/25, at 9:47 a.m., RN-B stated the facility had notified the provider about R55's edema, but they never get any response. Staff try to ask R55 to lie down or sit in recliner but he frequently refuses. The facility did not schedule for R55 to elevate his feet or document when he refused their attempts. RN-B stated the facility was not monitoring R55's weights or edema on R55's treatment record. There was no one tasked to assess edema or look at resident weights. Further, if a large weight gain was noted from week to week, the facility should print off the weights and see if the provider wanted to address them. RN-B would check with the charge nurse to see if anyone had addressed R55's weight gain. During interview on 1/15/25, at 10:46 a.m. RN-B	F 684		

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F 684	Continued From page 13 stated the facility had been requesting compression wraps for R55's left leg and his provider was faxed with that request on 12/23/24, however, the facility had never received a response back from R55's provider. During interview on 1/15/25, at 10: 26 a.m. RN-A stated the facility conducted weekly weight meetings which they discussed resident weight gain or losses and reviewed everything with dietary. RN-A did not document any notes related to the meetings, but they discussed resident weights, reviewed if they were felt to be accurate, if supplements were needed and such. RN-A knew R55's provider had been notified of his edema but the provider had not gotten back to them. No new interventions had been attempted to try to reduce R55's edema and RN-A had not reviewed R55's diet or spoken to him about the need to lie down or elevate his feet in the afternoons. During interview on 1/16/25, at 9:47 a.m. the director of nursing (DON) stated facility staff should be reviewing resident's weights when they documented them in the resident's medical record. R55 should have had orders for ACE wraps or compression hose. Residents with weight gain should be evaluated and staff should be assessing residents weights regularly. The facility policy Weight Monitoring Program dated 1/18/21, identified a medically significant weight gain was a weight gain of five or more pounds in one week which could indicate a change in health status. Weight data would be assessed, tracked, and entered into the residents medical record weekly. The attending practitioner would be contacted for any resident with a	F 684		

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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) COMPLETION DATE
F 684	Continued From page 14 medically significant weight gain of five pounds or more.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 2 residents (R8) reviewed for pressure ulcers. Findings include: R8's significant change Minimum Data Set (MDS) dated 10/21/24, identified severe cognitive impairment. R8 required substantial/maximal assistance with turning and repositioning and toileting. R8 was at risk for pressure ulcers, currently did not have any skin issues. Diagnoses included Alzheimer's disease and non-Alzheimer's dementia. R8's Braden Risk Assessment (a tool used to	F 686	The residents have the right to receive the necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing. R8's care plan and repositioning schedule was reviewed. The POC tasks for nursing assistants were updated with the reposition schedule and a repositioning sheet with the repositioning schedule was made available for the nursing staff. Staff were updated on her repositioning schedule. This could happen to all dependent residents and to residents with skin issues. The nurse managers will review	2/19/25

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F 686	Continued From page 15 assess a patient's risk of developing pressure ulcers) dated 11/1/24, identified R8 was at moderate risk of developing a pressure ulcer. R8's care plan dated 11/12/24, identified R8 should be repositioned every three hours as R8 had a potential for skin impairment. R8's Tissue Tolerance-Repositioning Observation dated 1/6/25, identified after R8 was in sitting or lying in same position after two hours redness was observed in areas of pressure. It identified R8 was to be repositioned every two hours. R8's progress note dated 1/6/25 identified a new skin issue located on the inside of R8's right buttock. The area was 1.5 centimeters (cm) x 1.5 cm with 100% granulation tissue (a new, pink or red, moist tissue that forms at the site of a wound as it heals.). Primary care provider notified. Tissue tolerance identified to turn every 2 hours. Continuous observations were completed on 1/15/25 at 7:18 a.m. through 11:13 a.m. and identfied the following - At 7:18 a.m. R8 was seated in her wheelchair and wheeling herself down the hall heading to the common area - At 8:08 a.m. R8 was in dining room for breakfast. She was seated in her wheel chair and had not been repositioned or offered respositioning. - At 9:24 a.m. R8 was taken by unidentified activity staff to an activity in the common area of the nursing home. R8 remained seated in her wheelchair and had not been repositioned or offered respositioning. - At 9:40 a.m. R8 was brought to the common area when activity was completed and was	F 686	the care plans of all residents that are dependent on staff for turning, repositioning and those that have pressure ulcers or at risk for pressure ulcers. The care plans and tasks will be updated if needed. The nursing staff will be updated on any changes to repositioning schedules. The DON or designee reviewed the repositioning policy, tissue tolerance repositioning policy, and skin integrity policy. Education will be done for all nursing staff. The DON or designee will do repositioning audits 3x/wk., for 4 wks., 2x/wk. for 3 wks., 1x/wk. for 3 wks., then monthly and PRN thereafter. Results will be brought to QAPI meetings for recommendations and further monitoring.	

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F 686	Continued From page 16 watching TV. R8 remained in common area seated in the wheelchair and had not been repositioned or offered repositioning. - At 10:40 a.m. R8 remained in the common area and participated a bible study that finished at 10:50 a.m. . R8 had not been repositioned or offered to be repositioned. - At 11:00 a.m. R8 remained in her wheelchair seated in the same position. R8 had not been repositioned or offered to be repositioned. During an interview on 1/15/25 at 11:06 a.m. nursing assistant (NA)-G stated they were assigned to care for R8 today. NA-G stated R8's care plan was recently updated and R8 was supposed to be repositioned every two hours, because R8 had a new area of impaired skin integrity on the identified R8's buttocks. NA-G was not sure when the last time R8 was repositioned. The aids usually repositioned R8 right after breakfast, but NA-G did not do it today and was unsure if it was done. The last time NA-G knew R8 was repositioned was when she got R8 up this morning. NA-G then went to bring R8 to the bathroom and reposition her. During observation on 1/15/25 at 11:13 a.m., nursing assistant (NA)-G assisted R8 to the bathroom. When R8's incontinent brief was removed there was a small amount of feces in the brief and smeared on her buttocks and the brief had a small amount of urine. There was a scabbed area on R8's inner right buttocks that looked one cm in size, the skin around the area was intact. During an interview on 1/15/25 at 3:00 p.m., registered nurse (RN)-C stated R8 had developed a new area on her inner right buttocks and were	F 686		

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F 686	Continued From page 17 doing dressing changes every three days and as needed. R8 was also to be repositioned every two hours to keep pressure off the wound. The updates with repositioning R8 had been communicated with nursing staff and the nursing assistants. R8 should not have gone more than two hours without repositioning as her ulcer could worsen. During an interview on 1/16/25 at 9:55 a.m., the director of nursing (DON) stated it is the expectation staff followed the care plan related to resident with impaired skin integrity and/or pressure sores. Which included timely repositioning of R8. A policy for pressure ulcers was request, but not received. The facility's Tissue Tolerance Repositioning Observation policy dated 11/26/24, identified it was to establish and adjust individualized repositioning schedules based on skin assessments. To provide guidelines to staff on the ability of the resident's skin and its supporting structures to endure the effects of pressure without adverse effects.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		2/19/25

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F 689	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a dependent resident was toileted per request for 1 of 2 residents (R32) reviewed for accidents. This resulted in actual harm for R32 who fell when self transferring to the toilet and fractured their hip. Findings include: R32's significant change Minimum Data Set (MDS) dated 11/25/24, identified R32 had severe cognitive impairment. R32 was dependent on staff for toileting transfer and required maximal assistance with toileting hygiene. R32 had no falls prior to admission, however had two or more falls, without injury, since admission. Diagnoses included dementia, kidney failure, diabetes and history of urinary tract infections (UTI). R32's History and Physical dated 1/7/25, identified R32 was being seen for a left intertrochanteric hip fracture following a fall in the nursing home. R32 was forgetful and tried to go to the bathroom on her own which caused her to fall. R32 was to be admitted to the hospital for orthopedic surgery. A Nursing Home Incident Report-Investigative Summary dated 1/10/25, identified activities aide (AA)-C observed R32 wheeling out of the facility dining room and asked R32 where she was going. R32 stated she needed to use the bathroom. AA-C reported to nursing assistant (NA)-AA and NA-BB who stated R32 had been toileted thirty minutes prior to going to the dining room and was reminded that she had just gone to the bathroom. AA-C asked R32 if she had just	F 689	The facility must ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents R32 was not assisted to bathroom resulting in a self-transfer and fractured hip. R32's care plan was updated to include a toileting plan, and staff were educated on the plan. Toileting sheets were implemented to have her toileting plan on it along with staff documentation on when she was toileted. This could happen to all dependent residents that need assistance with toileting. Nurse managers will look over their care plans to ensure that the toileting plan for dependent residents is correct/current. The nurse managers will educate staff on any changes made and also put their toileting plans on toileting sheets for staff to document toileting times. DON or designee will do a staff meeting and training for all nursing staff on the Dementia Care, Urinary Incontinence Program and residents' rights. Resident care audit and Toilet audits will be completed by DON or designee. This will be done 3x/wk for 4wks, then 2x/wk for 3 weeks, weekly for 3 weeks, and then	

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F 689	Continued From page 19 been to the bathroom and R32 shrugged and stated she was full up. AA-C told R32 to stay in the dining room and wait for someone to assist her to the bathroom. AA-C notified NA-AA and NA-BB, R32 was adamant she needed to use the bathroom and was trying to leave the dining room. Neither NA-AA or NA-BB knew when R32 had left the dining room as they continued to pass trays in the dining room. R32 was found on the floor, in the public bathroom at 5:20 p.m., complained of severe pain to her left hip and transferred to the emergency room at 5:30 p.m. R32's care plan dated 12/4/24, identified a risk for falls and injury related to cognitive deficit with a goal to be free from falls and injury. Interventions included call don't fall sign in room, call light in reach and encourage to call for assistance, appropriate footwear, bed in low position with fall mats and non skid strips next to bed. R32 required assistance with activities of daily living (ADLs) and was dependent on staff to transfer. Staff were directed to anticipate and meet needs, ensure call light was within reach and to respond promptly to all requests for assistance. Staff were directed to provide extensive assist of one to two for toileting. R32 was frequently incontinent of bladder and occasionally of bowel and staff were directed to assist with toileting on awakening, before and after all meals and every two hours. During telephone interview on 1/13/25, at 6:11 p.m. family member (FM)-A stated R32 did not have the patience to wait to go to the bathroom. When she had to go to the bathroom, she would not wait for staff to help her. R32 had already fallen in November trying to go to the bathroom herself. R32 could not remember to use the call light.	F 689	monthly and PRN thereafter. Results will be taken to quarterly QAPI meetings for review for any recommendations and further monitoring.	

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F 689	Continued From page 20 On 1/14/25, at 9:00 a.m. R32 was observed lying in bed with head of the bed elevated. The bed was in lowest position to the floor and a bedside mat was on the floor beside the bed. R32 was drowsy and difficult to arouse. Registered nurse (RN)-B entered room to administer medications. RN-B stated R32 had fallen in the public bathroom in the main entry area, had broken her hip and just returned from the hospital. The facility had put Velcro stop signs on the public bathroom doorways to prevent confused residents from entering the bathrooms to prevent future falls. R32's progress notes identified the following: - 12/4/24, When staff went to offer toileting, R32 was found in the bathroom transferring herself off of the toilet. - 12/16/24, R32 was found on floor in bathroom, after having toileted herself. R32 was to be care planned to toilet before and after meals and as needed. - 12/29/24, Staff noted resident room door was shut. On entering room, R32 was found to have self transferred to the toilet. - 1/6/25, R32 was found in public bathroom in common entry area. R32 had been trying to use the bathroom, urine was on the floor and R32's pants and brief were down. R32 was admitted to the hospital with left hip fracture. R32's current Urinary Continence Task flow sheet 1/11/25 to 1/15/25, identified the following: - 1/11/25, R32 was incontinent of urine at 1:30 a.m., 5:30 a.m., and 7:58 p.m. and did not void when toileted at 10:37 a.m. - 1/12/25, R32 was incontinent of urine at 3:10 a.m., 10:20 a.m. and 9:44 p.m.	F 689		

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F 689	Continued From page 21 -1/13/25, R32 was incontinent of urine at 2:38 a.m., 6:30 a.m., 2:30 p.m., 4:30 p.m., 6:15 p.m., and 8:15 p.m. -1/14/25, R32 was incontinent of urine at 3:26 a.m., 10:33 a.m. 3:49 p.m., 5:30 p.m., 7:15 p.m., 8:45 p.m. -1/15/25, R32 was incontinent of urine at 5:59 a.m., 1:59 p.m. and 4:11 p.m., 6:09 p.m., and 9:09 p.m. The flow sheet lacked documentation that R32 had been checked and/or changed every 2 hours and before and after meals as directed on R32's care plan. The Urinary Continence Task Flow sheet for the day of the fall was requested and not received. During interview on 1/14/25, at 2:44 p.m. NA-A stated he thought R32 felt the need to urinate frequently was related to her up and down blood sugars. Staff toileted R32 every two hours. R32 was hoyer lift transfer and could not bear weight, but would still try to get up on her own and toilet herself as R32 had no patience. NA-A was not working when R32 had fractured her hip, but he could see R32 getting up and to toilet herself as R32 had been so confused. When interviewed on 1/15/24, at 7:50 a.m. NA-CC stated she would toilet R32 before and after meals and every two hours but R32 was one that would ask to go to the bathroom ten minutes after just being taken. R32 was continent of bladder prior to her fall with fracture and may have been nervous about having accidents. R32 was very anxious and when R32 felt the urge to go she would have to go right then and nothing would stop her. R32 liked to be in her room and if tried to have her out by the nurses station, she	F 689		

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F 689	Continued From page 22 would just wheel away. When interviewed on 1/15/25, at 8:09 a.m. NA-C stated R32 was a handful. NA-C would leave R32's room door open, and continuously walk around the wing to keep an eye on her. If NA-C noticed R32 was getting slightly restless, she would immediately take her to the bathroom. R32 was continent prior to her fall and could have been nervous of having an accident in her pants. NA-C just checked on R32 all the time and took her to the bathroom. During joint interview with nurse consultant registered nurse (RN)-I and the director of nursing (DON) on 1/15/25, at 1:37 p.m. The DON stated she was present when R32 had her last fall and so had questioned all the staff involved immediately following the incident. NA-AA and NA-BB had been busy passing plates and getting supper going when R32 requested to go to the bathroom. The aides told R32 she had just been on the toilet and could hold on a little bit. AA-A notified the both NA-AA and NA-BB R32 needed to use the bathroom. The DON stated staff should have assisted R32 to the bathroom when she asked for help. The DON immediately educated the aides regarding providing assistance to residents and following resident's care plan. When interviewed on 1/16/25, at 9:37 a.m. the DON stated flow sheets for R32's turn and repositioning and toileting did not indicate R32 was checked or changed every two hours. Urinary Continence Task flow sheet was requested prior to her hospital return on 1/10/25, however, no flow sheets were available prior to her hospital return on 1/10/25, as the facility had	F 689		

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F 689	Continued From page 23 started tracking when she returned from the hospital. The DON stated there had been no audits or documentation to ensure staff were following R32's care planned interventions, specifically toileting every two hours, and R32 had been falling regarding toileting. The facility Fall Prevention and Management dated 6/5/23, identified a fall analysis would be completed if a resident had two or more falls to review fall trends, identify individual and systemic causes of falls, evaluate current interventions for effectiveness and if needed to determine additional interventions. If identified as a high fall risk, a comprehensive assessment would be completed. The assessment would identify resident's history of falls, activity level, visual impairment, balance and gait, elimination status and diagnoses and medications, and other contributing factors related to fall. Assessment data would be analyzed with a summary completed identifying interventions to mitigate the resident's fall risk. All interventions identified through the assessment/review process would be documented in the resident's care plan using person centered language.	F 689		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.	F 804		2/19/25

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F 804	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served at warm, palatable temperatures for 5 of 5 residents (R30, R4, R32, R11,R18) who received meal trays out of temperature range. Findings include: R30's significant change MDS dated 11/18/24, identified R30 had intact cognition and was independent with eating. On 1/14/25, at 2:00 p.m. R30 stated he ate his meals in his room and the meal trays served were almost always cold. R30 stated this occurred with all the meals served in his room and it did not matter if was breakfast, lunch or supper. On 1/14/25, at 4:56 p.m. the supper meal services were observed on the "Blueberry" unit where several residents were seated in the dining area waiting for the supper meal. Residents were served a meal of hot dogs and tater tots in the dining room. The supper trays were on an open metal cart with three shelves. Each tray was covered with a dish cover over the plate of food. At 5:18 p.m. nursing assistant (NA)-O began delivering supper trays to the residents in their rooms. At 5:19 p.m. NA-O delivered a supper tray to R30's room. At 5:20 p.m. NA-O delivered a supper tray to R4's room. At 5:20 p.m. NA-O delivered a supper tray to R32's room. At 5:21 p.m. NA-O delivered a supper tray to R11's room. At 5:23 p.m. NA-O delivered a supper tray to R18's room. At 5:25 p.m. a test tray was removed from the resident cart and cook (CK)-A tested the hotdog and tater tots for temperature.	F 804	1. The Dietary Manager created a New Policy for Dietary Aides &/or for those serving food from the Blueberry and Evergreen kitchenettes. Each Dietary Aide will read and sign. 2. New procedure will be implemented: The staff will temp the food at the point of service to ensure that the food is at a palatable temp. The steam tables will be refilled to ½ full, by the dietary aides, after the breakfast and Lunch meals and will be left on in the medium heat position and 1 hour before serving the lunch and dinner meals the steam tables will be turned on high after checking the water level. If water level has dropped down to less than ½ full hot water will be added to the hot water wells. 3. Audits to ensure that the water wells are properly heated will be conducted. Please see attachment A for the schedule. 4. Since the dietary department already uses a plate warmer, the Dietary Manager has contacted maintenance to have a repair person come and check the heat producing plate warmer units to make sure that they are working correctly. 5. Currently dietary aides only have the hot plates in the warmer, so we are implementing that the hot plates and dinner plates be stacked the plate warmer together. 6. Trays for Room Trays will be delivered in an insulated heat holding container. 7. The Dietary Manager or the cook on shift will perform audits of the food temperatures on test plates and if the food	

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F 804	Continued From page 25 The hot dog measured 99.5 degrees, and the tater tots measured 94 degrees. CK-A stated the food was cold and should temp around 145 degrees. On 1/14/25, at 5:40 p.m. CK-A stated the food had been hot when leaving the kitchen area and he thought the problem with the food cooling off so quickly was the dietary aide had not allowed the steam table to warm up adequately prior to meal service. The dietary aide had also not been trained on using the plate warmer function of the steamer table and that may have contributed to the cold food as well. When interviewed on 1/15/25, at 1:28 p.m. the director of nursing (DON) stated the food temperatures at supper service was not acceptable and should have been warmer. The cold food did not taste very palatable and was unappetizing. During interview on 1/15/25, at 2:16 p.m. the director of dietary services (DODS) stated she observed food service at the facility in the past and could recall the facility used an open tray cart, which could contribute to the food cooling off quickly. Food was not safe if the temperature was dropped below 135 degrees and cold food was just not palatable. The facility policy General Food Preparation and Handling dated 10/23, identified all meats were to be heated to a safe minimum internal temperature. Staff were to refer to the charts Minimum Cooking Food Temperatures and Holding Times and Suggested Food Cooking Temperatures and Holding Times, which identified hot holding temperature of 135 degrees.	F 804	is not at the temperature of 135 it will immediately be brought back to the kitchen for a proper reheat.	

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the final rinse on the dishwasher reached 180 degrees Fahrenheit (F) to sanitize dishes. This had the potential to affect 61 of 62 residents who consumed food from the main production kitchen. Findings include: On 1/13/25, at 11:58 a.m., an initial kitchen tour was completed with dietary aide (DA)-A. A single commercial dishwasher was observed along the wall with several hard plastic racks on the conveyor belt in front of machine. DA-A loaded several plate covers onto a hard plastic rack and placed them into the dishwasher. Two gauges	F 812	1. Dietary Manager created “Why & How to use Guide” for training all dietary staff on how to use the high temperature dishwasher. 2. Dietary Manager created an employee quiz for the “Why & How use Guide” This quiz was given after the employees read through the guide and dietary manager had answered all their questions. 3. The Dietary Manager will meet with all employees that did not score 100% on the quiz and will reinstruct them and conduct a new quiz until it is passed at 100%. 4. New procedures will be implemented: Before washing any dishes, an empty dish tray will be ran through the dishwasher	2/19/25

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F 812	Continued From page 27 were located on the top front of the dishwasher. One gauge was labeled wash and on the gauge next to the 150 F degrees there was black marker identifying the temperature. A second gauge was labeled rinse, and the black marker was marked at 180 F next to the gauge. DA-A identified the temperatures were the minimum required for the dishwasher to reach when monitoring the temperatures. DA-A ran the rack with plate covers through the dishwasher machine three times. On the first run, the rinse temperature registered 160 F., on the second run the rinse temperature registered 172 F, and on the third run, the rinse temperature registered 180 F just after the dish tray exited the dishwasher and the cycle was completed. DA-A stated the third tray had not reached the rinse temperature of 180 when in the dishwasher. The Dishwashing Machine Temp Sheet for the month of January 2025, identified from January 25 through January 29, 2025, the dishwasher rinse temperature was recorded between 150 degrees and 160 degrees for the am shift/meal. The Dishwashing Machine Temp Sheet for the month of December 2024, identified 12 of 49 recorded dishwasher rinse temperatures were recorded below 180 degrees when monitored for the three meals. During interview on 1/13/25, at 12:00 p.m. cook (CK)-B stated the dishwasher repair person had told dietary staff to shut off and drain the washer every shift to help it to reach adequate temperatures and she was not sure that was being done. The dishes would not be rinsed properly if the rinse temperature did not reach the required 180 degrees. When it was identified the	F 812	until the wash temperatures are 150 and the rinse cycle reaches 180. 5. If staff are unable to obtain the correct temperatures a temperature test strip will be sent through the dishwasher. A plate thermometer is on order and after receiving the plate that will be used also. 6. If the temperature test strip fails Employees are instructed to switch to the 3-compartment sink set up for washing, rinsing and sanitizing. Instructions on how to properly use the 3-compartment sink are listed on the wall by the sinks. 7. The employee must alert the Dietary Manager, EVS or the person in charge at the time. 8. Temperatures of the dishwasher must be recorded 3x/day. To ensure this is being completed by the employees the Dietary Manager or the person in charge will audit the logs 3xday.	

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F 812	Continued From page 28	F 812		

dishwasher was not reaching adequate temperatures, staff were to call the dishwasher repair person. Staff were to keep running the dishes through the dishwasher until it reached the adequate rinsing temperature to ensure the dishes were sanitized and she would let maintenance know they were having problems with the dishwasher.

During interview on 1/13/25, at 12:32 p.m. maintenance (MAINT)-A observed the dishwasher cycle with rinse temperature at 160 degrees. MAINT-A stated he had never been notified the dishwasher was not working properly. He did not work on the dishwasher but would call the repair person to come.

A joint interview was completed with DA-A and CK-B on 1/13/25, at 12:40 p.m. CK-B stated they never manually sanitized dishes in the sink. CK-B could only remember hand washing dishes one time when the dishwasher was being replaced. CK-B stated currently the dishwasher was not working properly if the rinse did not reach 180 degrees. DA-A stated maybe they should be hand washing the dishes to sanitize them.

During a second tour of the kitchen on 1/13/25, at 1:05 p.m. DA-A was observed hand washing cooking equipment, pots and utensils in a sink with soapy water. DA-A put the hand washed equipment into a hard plastic rack and ran three racks of hand washed pots, equipment and utensils through the dishwasher. The dishwasher rinse gauge registered 175 degrees. DA-A stated she ran the dishes through the dishwasher after hand washing them in order to sanitize the dishes. DA-A stated the dishes were not getting properly sanitized since the rinse temperature did

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F 812	Continued From page 29 not reach 180 degrees, but she did not know what else she could do. At 1:24 p.m. DA-A completed washing all the lunch dishes through the dishwasher and the rinse temperature reached 180 degrees and greater. DA-A stated it was just the first few trays that were run through that the rinse was below 180 degrees. DA-A was watching all the trays going through now to make sure the rinse reached 180 degrees or more. During interview on 1/14/25, at 10:30 a.m. MAINT-A stated the dishwasher repair person checked the dishwasher, and it was working properly. The repair person indicated the surface temperature needed to be 160 degrees and was reaching 168 degrees. The staff needed to run a holding thermometer or test strip or plate through the machine to get the most accurate readings. During observation of dishwasher on 1/14/25, at 4:29 p.m. DA-B ran a rack of plastic glasses through the dishwasher. The rinse temperature registered 160 degrees. DA-B stated she always ran resident glasses through two times. DA-B ran the glasses through the dishwasher a second time. The rinse temperature registered 178 degrees. DA-B stated she did not know where to locate or how to run a thermometer or temperature plate through the dishwasher, as she had never been taught. DA-B stated she only looked at the front gauges to record the dishwasher temperatures and had never been told or taught to do it any other way. During interview on 1/14/25, at 5:35 p.m. MAINT-A stated the dishwasher took a while to heat up to the 180 degree rinse. MAINT-A was not aware the dietary staff were not trained on how to check dishwasher temperatures other	F 812		

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F 812	Continued From page 30 than to read the front gauges. The dishwasher repair technician who checked the machine earlier that day had not trained the dietary staff on alternative methods to check dishwasher temperatures. During interview on 1/15/25, at 1:11 p.m. CK-A stated he thought he had figured out the problem with the facility's dishwasher. The dishwasher took a while to heat up to the required 180-degree rinse temperature. CK-A instructed all the dietary staff to run a tray through the dishwasher several times until the rinse temperature reached 180 degrees before washing any dishes with the dishwasher. Staff had not been getting the dishwasher up to the required temperature before washing dishes. The staff would just run the dishes through right away in order to get done for the day quickly. The staff have been instructed now to get the dishwasher up to required temperature prior to starting to wash any dishes. When interviewed on 1/15/25, at 1:28 p.m. the director of nursing (DON) stated if dietary staff were not running dishes through a properly working dishwasher, they ran the risk of the dishes not being sanitized properly. The DON would expect the dietary staff to try to problem solve and find out the reason the dishwasher was not reaching the required temperature and to reach to the dietary manager or maintence when equipment was not working properly. During telephone interview on 1/15/25, at 2:16 p.m. the director of dietary services (DODS) stated running dishes through the dishwasher at low rinse temperatures meant the dishes were not being sanitized, which was not appropriate.	F 812		

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F 812	Continued From page 31 DODS stated it was an area staff would need training on. The facility policy Cleaning Dishes/Dish Machine dated 4/20/22, identified the facility used a high temperature dishwasher which used heat for sanitization. Minimum wash temperatures were 150 degrees and minimum rinse temperature was 180 degrees. If minimum temperatures were not obtained, staff were to utilize sanitation process and indicate on the temperature log the corrective action used to ensure dishes were sanitized.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880		2/19/25

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F 880	Continued From page 32 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 33 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to expand COVID-19 testing/ and or contact tracing of staff and residents on other units after residents tested positive for COVID19 per Centers for Disease Control (CDC) guidelines. In addition, the facility failed to implement enhanced barrier precautions (EBP) for 1 of 3 residents (R53) reviewed for activities of daily living (ADLs). This had the potential to affect all 60 residents residing in the facility. Findings include: COVID-19 Testing: The current CDC guidance on COVID-19 in the Nursing Home dated June 2024 included : "Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated. Empiric use of Transmission-Based Precautions for residents and work restriction for HCP who met criteria can be discontinued as described in Section 2 and the Interim Guidance for Managing Healthcare	F 880	Enhanced Barrier Precautions R53 has a foley catheter and a feeding tube and enhanced barrier precautions (EBP) were not used. Personal protective equipment (PPE) was available and an EBP sign was up. Staff training was performed on when they needed to use EBP when entering R53□s room. This could happen to all residents who require staff to use EBP. The DON and IPCO nurse ensured that PPE was available, and signs were up outside the residents□ rooms. Staff were trained on who they need to use EBP for and when they need to use EBP. The DON or designee reviewed the Enhanced Barrier Precautions policy along with the CDC guidelines. Education was provided for all staff. The DON or designee will complete audits on EBP use 3x/wk. for 4 wks., 2x/wk. for 3 wks., 1x/wk. for 3 wks., and them monthly and PRN thereafter. Results will be taken to quarterly QAPI meetings for recommendations and further review. COVID Testing	

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F 880	Continued From page 34 Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, respectively. If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days), should be considered." On 1/13/25 at 1:25 p.m., R10 stated she was waiting for her shower because the NA that was supposed to help her was pulled to the other unit (Evergreen) to work. On 1/15/25 at 2:37 p.m., maintenance worker-A stated there was a potential that housekeeping staff would be pulled to work from one unit to the other during the same shift. Review of the facility covid outbreak document dated 1/7/25, identified the following: - NA-E worked the night shift (10:00 p.m. - 6:30 a.m.) on 1/6/25 and evening shift on 1/7/25 on Evergreen unit. Throughout the evening on 1/7/25, NA-E developed symptoms (not listed) and at 9:00 p.m. tested positive for COVID-19. NA-E immediately left the facility. The morning of 1/8/25, infection surveillance and tracking was initiated. The document identified NA-E had high risk contact with all 29 residents on Evergreen Unit and 16 staff (RN-C, RN-G, RN-H, LPN-C, TMA-A, NA-R, NA-S, NA-T, NA-U, NA-V, NA-W, NA-X, NA-Y, NA-Z, Hsk-C, Scheduler) that worked in the facility.	F 880	COVID testing was done on all staff and residents that live on Blueberry on 1/15/25. Then they were tested again on day 3 and day 5 to get caught up with the staff and residents on Evergreen that were already being tested. All were tested until no positives for 14 days. DON, IPCO nurse or designee will follow the current CDC guidance on testing. They will also perform contact tracing to see who requires to be tested or if broad-based testing needs to be done when a staff member, resident or visitor was COVID positive or exposed to a COVID positive person. The DON or designee reviewed the COVID testing policy along with CDC guidelines. The DON or designee will educate all staff on COVID testing and steps to determine on how you test. The DON or designee will do audits on COVID testing when there is a positive COVID staff, resident, volunteer or visitor. Findings will be brought to QAPI for recommendations and further monitoring.	

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F 880	Continued From page 35 - On 1/8/25, 4 residents (R3, R17, R36 and R43) tested positive for COVID-19 and were immediately placed on droplet precautions and were quarantined to their rooms. R3's symptoms included cough, congestion and sore throat. R17's symptoms included cough and congestion. R36 and R43 were asymptomatic. - On 1/10/25, all residents on Evergreen unit were tested for day 3 outbreak testing. One additional resident, R46, tested positive for COVID-19. R46 had symptoms including cough and runny nose and was immediately placed on droplet precautions and quarantined to the room. The previously identified high risk staff all tested negative for COVID-19. - On 1/12/25, all residents on Evergreen unit and previously identified high risk staff were tested and were negative for COVID-19. The facility staff schedules identified 19 staff, including 11 nursing staff (RN-B, RN-E, RN-F, LPN-A, LPN-B, NA-B, NA-H, NA-I, NA-J, NA-K, NA-L, NA-M, NA-O, NA-P, NA-Q), 5 dietary aides (DA-A, DA-B, DA-C, DA-D), 2 activity aides (AA-A, AA-B) and 1 housekeeping staff (HSK-A), worked on 1/8/25, and were not tested for COVID-19. The schedules did not identify if staff were pulled to the other unit during their shift. During joint interview on 1/15/25 at 1:02 p.m., registered nurse (RN)-C and RN-D identified the on 1/7/25, nursing assistant (NA)-E was working the evening shift (2:00 p.m.-10:30 p.m.). Throughout the shift NA-E developed body aches and congestion. At 9:00 p.m., NA-E tested positive for COVID-19 and was immediately sent	F 880		

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F 880	Continued From page 36 home by the nurse. The morning of 1/8/25, RN-C and RN-D were notified of NA-E's positive COVID-19 result and started employee contact tracing. All high risk staff identified through, contact tracing, and all residents on Evergreen unit were tested for COVID-19. Of those tested, zero staff tested positive; however, four residents tested positive. The positive residents were immediately placed in droplet precautions and a mass text was sent to inform all other employees of the positive cases. - The facility continued to test the originally identified high risk staff and all residents on Evergreen unit on day 3 (1/10/25), day 5 (1/12/25), day 7 (1/14/25) and planned to test on 1/17/25. The facility failed to expand the contact tracing, to include staff/residents exposed to the positive residents; or complete broad-based testing of all staff and residents after continued positive cases of COVID-19 were identified. Staff continued to worked in close proximity with residents and other staff from both units throughout their workday. The facility tried to keep staff, (including nursing, dietary, and housekeeping staff) on one unit or the other during their shift, although there was a potential for staff to be pulled from one unit to the other during, as well as residents from either unit to co-mingle during times including meals and activities. The facility failed to complete additional employee contact tracing and failed to consider broad-based testing for all staff and residents even after the facility continued to have positive COVID-19 test results. On 1/16/25 at 10:33 a.m., RN-C stated she was monitoring the residents on Blueberry unit for symptoms of COVID-19 by reviewing their	F 880		

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	245252	A. BUILDING _____ B. WING _____	C 01/16/2025

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 880	Continued From page 37	F 880		

progress notes and receiving verbal report from nursing staff. She had not tested the residents on Blueberry because she thought symptom monitoring was sufficient. Additional staff were not tested because staff were monitoring their own symptoms. In addition, RN-C stated there was a potential for staff, including nursing, housekeeping, activities and dietary staff, to work on both units during the same shift, as well as residents from either unit to come into contact with each other during facility activities.

On 1/16/25 at 10:53 a.m., the director of nursing (DON) stated the facility dropped the ball on testing staff and residents for COVID-19. Once there were additional cases of COVID-19 they should have tested the entire facility because staff work back/forth on both units and there was a risk that the staff were exposed and worked with other residents and/or staff when they had not been tested. The DON stated the risk of not testing appropriately is the risk of spreading the illness to other residents, staff or visitors.

The facility Coronavirus Prevention, Screening, and Identification policy reviewed/revised 10//11/23, included the following: The facility will assess and identify the potential staff risk. Low risk includes when there is no direct exposure to a COVID-19 infected person. Contact risk is identified as close (within 6 feet for 15 minutes or more, or within same living space) contact of person(s) with COVID-19 within 48 hours. The facility will communicate the risk level and recommendations to staff. Care center wide testing includes: if the care center becomes aware of a COVID-19 positive case among staff who have worked within the past 2 days and/or residents, an assessment to determine exposure

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F 880	Continued From page 38 will begin immediately. Residents and staff with close contact with someone with COVID-19 will begin testing 24 hours after exposure. If unable to determine close exposure to the COVID-19 positive individual broad testing of all staff and residents (regardless of vaccination status) will occur. The facility Suspected (or Confirmed) Coronavirus (COVID-9) Outbreak policy reviewed/revised 7/25/23, identified the purpose was to provide guidance for care center staff on handling suspected or confirmed Cornona virus (COVID-19) disease. During an outbreak of COVID-19 disease the facility would begin testing all exposed staff and residents immediately day one, (two days after exposure) day three, and day five after exposure, and 5-7 days after testing until 14 days of no further positive results. Enhanced Barrier Precautions: R53's quarterly Minimum Data Set (MDS) dated 12/17/24, identified R53 had severely impaired cognition and was dependent on staff for all activities of daily living (ADLs). R53 was incontinent of bowel and had an indwelling catheter and a feeding tube. Diagnosis included spastic quadriplegic cerebral palsy. On 1/14/25, at 8:55 a.m. a personal protective equipment (PPE) cart was observed in the hall beside R53's room door. The PPE cart's drawers contained disposable hospital gowns, disposable gloves and masks. A sign was posted above the cart which identified enhanced barrier precautions were required when providing high contact care with resident residing in the room. The poster identified when and what staff were required to don prior to entering the room.	F 880		

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F 880	Continued From page 39 During observation on 1/14/25, at 9:02 a.m. nursing assistant (NA)-Q entered R53's room to assist her with her morning care. NA-Q was wearing a surgical mask and put on gloves. NA-Q removed R53's brief and washed up R53's peri area with disposable wipes. NA-Q turned R53 away and then rolled her back toward her, leaning over R53 to perform the peri care. NA-Q changed her gloves after performing incontinence care and rolled R53 from side to side to secure the clean brief. R53's body would lean against NA-Q uniform at times, when rolling R53 toward her. NA-B entered the room wearing a face mask, gloves and disposable gown. NA-B and NA-Q placed a Hoyer (full lift) lift sheet underneath R53's body, again rolling her from side to side and at times leaning into NA-Q's uniform. Both aides utilized the Hoyer lift to transfer R53 into her wheelchair and secured her catheter bag to the side of the wheelchair and adjusted R53's feeding tube lines to ensure placement was appropriate. When interviewed on 1/14/25, at 9:14 a.m. NA-Q stated she wore a disposable gown in the moring when she got R53 dressed. It was especially important to wear a gown and gloves when working with R53's indwelling catheter. NA-Q had not worn a gown when assisting with incontinent peri care, as she was just getting the resident up in her wheelchair and not emptying her catheter or anything like that. R53 had touched NA-Q's uniform when she was assisting her, and NA-Q had provided bowel incontinent peri care without a gown on. NA-Q should have worn a gown before assisting R53 with personal care. During interview on 1/14/25, at 9:18 a.m. NA-B	F 880		

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F 880	Continued From page 40 stated staff were suppose to a wear gown and gloves with any residents who had a catheter or open wounds. Staff were to wear the PPE whenever providing care to those type of residents; however, were not required to wear the PPE when just passing water or going in room to speak with them. During joint interview with infection preventionist registered nurse (RN)-C and RN-D on 1/16/25, at 10:15 a.m. RN-C stated R53 was on enhanced barrier precautions and staff should wear the appropriate PPE of gown, mask and gloves to perform peri care. Staff were educated on the use of PPE with enhanced barrier precautions (EBP) in April 2024, and were to wear PPE whenever providing care, transfers, or toileting. The resident's that required EBP had PPE carts outside of their room doors and EBP posters on their doors to direct staff. The facility policy Enhanced Barrier Precautions dated 8/20/24, identified EBP were to be used when providing high contact care to residents who were colonized or infected with a multi-drug-resistant organism. EBP would also be used for residents with chronic wounds and/or indwelling medical devices. EBP was to be employed when performing high contact resident care activities such as dressing, bathing, changing linen, transferring, hygiene care, toileting, peri care, emptying catheter bag, wound care, indwelling medical device care and therapy treatment. The CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multi-drug-resistant Organisms (MDROs) manual, dated 7/2022, identified MDRO	F 880		

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F 880	Continued From page 41 transmission within a nursing home was common and contributed to substantial resident morbidity and mortality. The feature outlined EBP were defined as, " ... expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing ... MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities ... residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs." The feature identified several examples of high-contact resident care activities including dressing, bathing, providing hygiene, transferring, changing linens or briefs, and wound care.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 4, 2025

Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

Re: State Nursing Home Licensing Orders
Event ID: I47Y11

Dear Administrator:

The above facility was surveyed on January 13, 2025 through January 16, 2025 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	C 01/16/2025

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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: On 1/13/25 through 1/16/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H52524561C (MN00109675) with a licensing order issued at MN Rule 4658.0520 Subp. 1 (0830). 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota 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.	2 000		

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2 000	Continued From page 2 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure a dependent resident was toileted per request for 1 of 2 residents (R32) reviewed for accidents. This resulted in actual harm for R32 who fell when self transferring to the toilet and fractured their hip. Findings include: R32's significant change Minimum Data Set	2 830	Corrected	2/19/25

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2 830	Continued From page 3 (MDS) dated 11/25/24, identified R32 had severe cognitive impairment. R32 was dependent on staff for toileting transfer and required maximal assistance with toileting hygiene. R32 had no falls prior to admission, however had two or more falls, without injury, since admission. Diagnoses included dementia, kidney failure, diabetes and history of urinary tract infections (UTI). R32's History and Physical dated 1/7/25, identified R32 was being seen for a left intertrochanteric hip fracture following a fall in the nursing home. R32 was forgetful and tried to go to the bathroom on her own which caused her to fall. R32 was to be admitted to the hospital for orthopedic surgery. A Nursing Home Incident Report-Investigative Summary dated 1/10/25, identified activities aide (AA)-C observed R32 wheeling out of the facility dining room and asked R32 where she was going. R32 stated she needed to use the bathroom. AA-C reported to nursing assistant (NA)-AA and NA-BB who stated R32 had been toileted thirty minutes prior to going to the dining room and was reminded that she had just gone to the bathroom. AA-C asked R32 if she had just been to the bathroom and R32 shrugged and stated she was full up. AA-C told R32 to stay in the dining room and wait for someone to assist her to the bathroom. AA-C notified NA-AA and NA-BB, R32 was adamant she needed to use the bathroom and was trying to leave the dining room. Neither NA-AA or NA-BB knew when R32 had left the dining room as they continued to pass trays in the dining room. R32 was found on the floor, in the public bathroom at 5:20 p.m., complained of severe pain to her left hip and transferred to the emergency room at 5:30 p.m.	2 830		

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2 830	Continued From page 4 R32's care plan dated 12/4/24, identified a risk for falls and injury related to cognitive deficit with a goal to be free from falls and injury. Interventions included call don't fall sign in room, call light in reach and encourage to call for assistance, appropriate footwear, bed in low position with fall mats and non skid strips next to bed. R32 required assistance with activities of daily living (ADLs) and was dependent on staff to transfer. Staff were directed to anticipate and meet needs, ensure call light was within reach and to respond promptly to all requests for assistance. Staff were directed to provide extensive assist of one to two for toileting. R32 was frequently incontinent of bladder and occasionally of bowel and staff were directed to assist with toileting on awakening, before and after all meals and every two hours. During telephone interview on 1/13/25, at 6:11 p.m. family member (FM)-A stated R32 did not have the patience to wait to go to the bathroom. When she had to go to the bathroom, she would not wait for staff to help her. R32 had already fallen in November trying to go to the bathroom herself. R32 could not remember to use the call light. On 1/14/25, at 9:00 a.m. R32 was observed lying in bed with head of the bed elevated. The bed was in lowest position to the floor and a bedside mat was on the floor beside the bed. R32 was drowsy and difficult to arouse. Registered nurse (RN)-B entered room to administer medications. RN-B stated R32 had fallen in the public bathroom in the main entry area, had broken her hip and just returned from the hospital. The facility had put Velcro stop signs on the public bathroom doorways to prevent confused residents from entering the bathrooms to prevent future falls.	2 830		

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2 830	Continued From page 5 R32's progress notes identified the following: - 12/4/24, When staff went to offer toileting, R32 was found in the bathroom transferring herself off of the toilet. - 12/16/24, R32 was found on floor in bathroom, after having toileted herself. R32 was to be care planned to toilet before and after meals and as needed. - 12/29/24, Staff noted resident room door was shut. On entering room, R32 was found to have self transferred to the toilet. - 1/6/25, R32 was found in public bathroom in common entry area. R32 had been trying to use the bathroom, urine was on the floor and R32's pants and brief were down. R32 was admitted to the hospital with left hip fracture. R32's current Urinary Continence Task flow sheet 1/11/25 to 1/15/25, identified the following: - 1/11/25, R32 was incontinent of urine at 1:30 a.m., 5:30 a.m., and 7:58 p.m. and did not void when toileted at 10:37 a.m. - 1/12/25, R32 was incontinent of urine at 3:10 a.m., 10:20 a.m. and 9:44 p.m. -1/13/25, R32 was incontinent of urine at 2:38 a.m., 6:30 a.m., 2:30 p.m., 4:30 p.m., 6:15 p.m., and 8:15 p.m. -1/14/25, R32 was incontinent of urine at 3:26 a.m., 10:33 a.m. 3:49 p.m., 5:30 p.m., 7:15 p.m., 8:45 p.m. -1/15/25, R32 was incontinent of urine at 5:59 a.m., 1:59 p.m. and 4:11 p.m., 6:09 p.m., and 9:09 p.m. The flow sheet lacked documentation that R32 had been checked and/or changed every 2 hours and before and after meals as directed on R32's care plan. The Urinary Continence Task Flow sheet for the day of the fall was requested and	2 830		

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2 830	Continued From page 6 not received. During interview on 1/14/25, at 2:44 p.m. NA-A stated he thought R32 felt the need to urinate frequently was related to her up and down blood sugars. Staff toileted R32 every two hours. R32 was hoyer lift transfer and could not bear weight, but would still try to get up on her own and toilet herself as R32 had no patience. NA-A was not working when R32 had fractured her hip, but he could see R32 getting up and to toilet herself as R32 had been so confused. When interviewed on 1/15/24, at 7:50 a.m. NA-CC stated she would toilet R32 before and after meals and every two hours but R32 was one that would ask to go to the bathroom ten minutes after just being taken. R32 was continent of bladder prior to her fall with fracture and may have been nervous about having accidents. R32 was very anxious and when R32 felt the urge to go she would have to go right then and nothing would stop her. R32 liked to be in her room and if tried to have her out by the nurses station, she would just wheel away. When interviewed on 1/15/25, at 8:09 a.m. NA-C stated R32 was a handful. NA-C would leave R32's room door open, and continuously walk around the wing to keep an eye on her. If NA-C noticed R32 was getting slightly restless, she would immediately take her to the bathroom. R32 was continent prior to her fall and could have been nervous of having an accident in her pants. NA-C just checked on R32 all the time and took her to the bathroom. During joint interview with nurse consultant registered nurse (RN)-I and the director of nursing (DON) on 1/15/25, at 1:37 p.m. The DON	2 830		

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2 830	Continued From page 7 stated she was present when R32 had her last fall and so had questioned all the staff involved immediately following the incident. NA-AA and NA-BB had been busy passing plates and getting supper going when R32 requested to go to the bathroom. The aides told R32 she had just been on the toilet and could hold on a little bit. AA-A notified the both NA-AA and NA-BB R32 needed to use the bathroom. The DON stated staff should have assisted R32 to the bathroom when she asked for help. The DON immediately educated the aides regarding providing assistance to residents and following resident's care plan. When interviewed on 1/16/25, at 9:37 a.m. the DON stated flow sheets for R32's turn and repositioning and toileting did not indicate R32 was checked or changed every two hours. Urinary Continence Task flow sheet was requested prior to her hospital return on 1/10/25, however, no flow sheets were available prior to her hospital return on 1/10/25, as the facility had started tracking when she returned from the hospital. The DON stated there had been no audits or documentation to ensure staff were following R32's care planned interventions, specifically toileting every two hours, and R32 had been falling regarding toileting. The facility Fall Prevention and Management dated 6/5/23, identified a fall analysis would be completed if a resident had two or more falls to review fall trends, identify individual and systemic causes of falls, evaluate current interventions for effectiveness and if needed to determine additional interventions. If identified as a high fall risk, a comprehensive assessment would be completed. The assessment would identify resident's history of falls, activity level, visual	2 830		

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2 830	Continued From page 8 impairment, balance and gait, elimination status and diagnoses and medications, and other contributing factors related to fall. Assessment data would be analyzed with a summary completed identifying interventions to mitigate the resident's fall risk. All interventions identified through the assessment/review process would be documented in the resident's care plan using person centered language. SUGGESTED METHOD OF CORRECTION: The DON or designee could review/ and or revise policies and procedures related to requests for toileting and then re-educate all staff on the policies and procedures to ensure staff follow resident care plans and are able to locate interventions. The DON or designee could develop monitoring systems and audit to ensure ongoing compliance and bring the results to the quality assurance team. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least	2 840		2/19/25

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2 840	Continued From page 9 every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely assistance with toileting/incontinence care for 1 of 3 residents (R8) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care.	2 840	Corrected	

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2 840	Continued From page 10 Findings include: R8's significant change Minimum Data Set (MDS) dated 10/21/24, identified R8 had severe cognitive impairment and was dependent on staff for her ADLs. R8 was incontinent of bowel and bladder. The MDS included diagnoses of Alzheimer's disease, and non-Alzheimer's dementia. R8's Bowel and Bladder Risk Assessment dated 10/21/24, identified R8 was incontinent of bowel and bladder. R8's care plan dated 11/12/24, identified R8 required extensive assist of one for toileting and incontinence care every three hours and as needed. Continuous observations were completed on 1/15/25 at 7:18 a.m. through 11:13 a.m. and identfied the following: - At 7:18 a.m. R8 was seated in her wheelchair and wheeling herself down the hall heading to the common area. - At 8:08 a.m. R8 was in dining room for breakfast. She was seated in her wheel chair and had not been toileted or offered toileting. - At 9:24 a.m. R8 was taken by an unidentified activity staff to an activity in the common area of the nursing home. R8 had not been toileted or offered toileting. - At 9:40 a.m. R8 was brought to the common area when activity was completed and was watching TV. R8 remained in common area seated in the wheelchair and had not been toileted or offered toileting. - At 10:40 a.m. R8 remained in the common area and participated in a bible study that finished at	2 840		

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2 840	Continued From page 11 10:50 a.m. - At 11:00 a.m. R8 continued in her wheelchair and had not been toileted or offered toileting. During an interview on 1/15/25 at 11:06 a.m. nursing assistant (NA)-G stated they were assigned to care for R8 today. NA-G was not sure when the last time R8 was toileted. NA-G then went to bring R8 to the bathroom. During observation on 1/15/25 at 11:13 a.m., nursing assistant (NA)-G assisted R8 to the bathroom. When R8's incontinent brief was removed there was a small amount of feces in the brief and smeared on her buttocks and the brief had a small amount of urine. There was a scabbed area on R8's inner right buttocks that looked one cm in size, the skin around the area was intact. During an interview on 1/15/25 at 11:04 a.m., NA-F stated staff reviewed the communication board or it would be passed on in report when a resident was to be assisted with toileting and/or have their brief checked. The facility recently updated their electronic charting system and staff could also see the care planned interventions in the Kardex . NA-F stated she had not worked with R8 and did not know when she needed to be checked. During an interview on 1/15/2 at 11:07 a.m., NA-G stated they were assigned care of R8. R8's care plan was recently updated and was supposed to be offered toileting and check and change every 2 hours because an area of impaired skin integrity was identified on her buttocks. NA-G was not sure of when the last time R8 was checked or offered toileting assistance. NA-G stated they usually checked her right after breakfast, but did	2 840		

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2 840	Continued From page 12 not do it today and was unsure if it was done. The last time NA-G knew R8 was checked was when she got up this morning and NA-G brought R8 to the bathroom. During an interview on 1/15/25 at 3:00 p.m., registered nurse (RN)-C stated R8 was to be checked and changed every 2 hours, which was changed from check and change every 3 hours due to a new area of impaired skin integrity. Residents who sat in soiled incontinent briefs had an increased chance of skin breakdown and should be checked and changed frequently. During an interview on 1/16/25 at 9:55 a.m., the director of nursing (DON) stated it was the expectation staff would have followed resident care plan related to check and change of incontinent briefs to ensure R8's care was done. The facility's Urinary Incontinence Program policy dated 4/6/15, identified each resident will receive the appropriate care and services to prevent incontinence related complications to the extent possible. SUGGESTED METHOD OF CORRECTION: The DON and/or designee could review policies and procedures, revise as needed, train staff, assess the system, evaluate to assure residents who are incontinent of urine, receive the necessary services and care following each episode of incontinence. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by assessments and the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		

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2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 2 residents (R8) reviewed for pressure ulcers. Findings include: R8's significant change Minimum Data Set (MDS) dated 10/21/24, identified severe cognitive impairment. R8 required substantial/maximal assistance with turning and repositioning and toileting. R8 was at risk for pressure ulcers, currently did not have any skin issues. Diagnoses included Alzheimer's disease and non-Alzheimer's dementia. R8's Braden Risk Assessment (a tool used to assess a patient's risk of developing pressure ulcers) dated 11/1/24, identified R8 was at moderate risk of developing a pressure ulcer. R8's care plan dated 11/12/24, identified R8 should be repositioned every three hours as R8 had a potential for skin impairment.	2 905	Corrected	2/19/25

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2 905	Continued From page 14 R8's Tissue Tolerance-Repositioning Observation dated 1/6/25, identified after R8 was in sitting or lying in same position after two hours redness was observed in areas of pressure. It identified R8 was to be repositioned every two hours. R8's progress note dated 1/6/25 identified a new skin issue located on the inside of R8's right buttock. The area was 1.5 centimeters (cm) x 1.5 cm with 100% granulation tissue (a new, pink or red, moist tissue that forms at the site of a wound as it heals.). Primary care provider notified. Tissue tolerance identified to turn every 2 hours. Continuous observations were completed on 1/15/25 at 7:18 a.m. through 11:13 a.m. and identfied the following - At 7:18 a.m. R8 was seated in her wheelchair and wheeling herself down the hall heading to the common area - At 8:08 a.m. R8 was in dining room for breakfast. She was seated in her wheel chair and had not been repositioned or offered respositioning. - At 9:24 a.m. R8 was taken by unidentified activity staff to an activity in the common area of the nursing home. R8 remained seated in her wheelchair and had not been repositioned or offered respositioning. - At 9:40 a.m. R8 was brought to the common area when activity was completed and was watching TV. R8 remained in common area seated in the wheelchair and had not been repositioned or offered repositioning. - At 10:40 a.m. R8 remained in the common area and participated a bible study that finished at 10:50 a.m. . R8 had not been repositioned or offered to be repositioned. - At 11:00 a.m. R8 remained in her wheelchair seated in the same position. R8 had not been	2 905		

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2 905	Continued From page 15 repositioned or offered to be repositioned. During an interview on 1/15/25 at 11:06 a.m. nursing assistant (NA)-G stated they were assigned to care for R8 today. NA-G stated R8's care plan was recently updated and R8 was supposed to be repositioned every two hours, because R8 had a new area of impaired skin integrity on the identified R8's buttocks. NA-G was not sure when the last time R8 was repositioned. The aids usually repositioned R8 right after breakfast, but NA-G did not do it today and was unsure if it was done. The last time NA-G knew R8 was repositioned was when she got R8 up this morning. NA-G then went to bring R8 to the bathroom and reposition her. During observation on 1/15/25 at 11:13 a.m., nursing assistant (NA)-G assisted R8 to the bathroom. When R8's incontinent brief was removed there was a small amount of feces in the brief and smeared on her buttocks and the brief had a small amount of urine. There was a scabbed area on R8's inner right buttocks that looked one cm in size, the skin around the area was intact. During an interview on 1/15/25 at 3:00 p.m., registered nurse (RN)-C stated R8 had developed a new area on her inner right buttocks and were doing dressing changes every three days and as needed. R8 was also to be repositioned every two hours to keep pressure off the wound. The updates with repositioning R8 had been communicated with nursing staff and the nursing assistants. R8 should not have gone more than two hours without repositioning as her ulcer could worsen. During an interview on 1/16/25 at 9:55 a.m., the	2 905		

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2 905	Continued From page 16 director of nursing (DON) stated it is the expectation staff followed the care plan related to resident with impaired skin integrity and/or pressure sores. Which included timely repositioning of R8. A policy for pressure ulcers was request, but not received. The facility's Tissue Tolerance Repositioning Observation policy dated 11/26/24, identified it was to establish and adjust individualized repositioning schedules based on skin assessments. To provide guidelines to staff on the ability of the resident's skin and its supporting structures to endure the effects of pressure without adverse effects. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures related to ensuring turning and repositioning for each individual resident is followed. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by assessments and the written plan of care. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 905		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming,	2 920		2/19/25

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2 920	Continued From page 17 and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely assistance with toileting/incontinence care for 1 of 3 residents (R8) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. Findings include: R8's significant change Minimum Data Set (MDS) dated 10/21/24, identified R8 had severe cognitive impairment and was dependent on staff for her ADLs. R8 was incontinent of bowel and bladder. The MDS included diagnoses of Alzheimer's disease, and non-Alzheimer's dementia. R8's Bowel and Bladder Risk Assessment dated 10/21/24, identified R8 was incontinent of bowel and bladder. R8's care plan dated 11/12/24, identified R8 required extensive assist of one for toileting and incontinence care every three hours and as needed. Continuous observations were completed on 1/15/25 at 7:18 a.m. through 11:13 a.m. and identfied the following: - At 7:18 a.m. R8 was seated in her wheelchair and wheeling herself down the hall heading to the common area. - At 8:08 a.m. R8 was in dining room for breakfast. She was seated in her wheel chair and had not been toileted or offered toileting.	2 920	Corrected	

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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) COMPLETE DATE
2 920	Continued From page 18 - At 9:24 a.m. R8 was taken by an unidentified activity staff to an activity in the common area of the nursing home. R8 had not been toileted or offered toileting. - At 9:40 a.m. R8 was brought to the common area when activity was completed and was watching TV. R8 remained in common area seated in the wheelchair and had not been toileted or offered toileting. - At 10:40 a.m. R8 remained in the common area and participated in a bible study that finished at 10:50 a.m. - At 11:00 a.m. R8 continued in her wheelchair and had not been toileted or offered toileting. During an interview on 1/15/25 at 11:06 a.m. nursing assistant (NA)-G stated they were assigned to care for R8 today. NA-G was not sure when the last time R8 was toileted. NA-G then went to bring R8 to the bathroom. During observation on 1/15/25 at 11:13 a.m., nursing assistant (NA)-G assisted R8 to the bathroom. When R8's incontinent brief was removed there was a small amount of feces in the brief and smeared on her buttocks and the brief had a small amount of urine. There was a scabbed area on R8's inner right buttocks that looked one cm in size, the skin around the area was intact. During an interview on 1/15/25 at 11:04 a.m., NA-F stated staff reviewed the communication board or it would be passed on in report when a resident was to be assisted with toileting and/or have their brief checked. The facility recently updated their electronic charting system and staff could also see the care planned interventions in the Kardex . NA-F stated she had not worked with R8 and did not know when she needed to be	2 920		

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2 920	Continued From page 19 checked. During an interview on 1/15/2 at 11:07 a.m., NA-G stated they were assigned care of R8. R8's care plan was recently updated and was supposed to be offered toileting and check and change every 2 hours because an area of impaired skin integrity was identified on her buttocks. NA-G was not sure of when the last time R8 was checked or offered toileting assistance. NA-G stated they usually checked her right after breakfast, but did not do it today and was unsure if it was done. The last time NA-G knew R8 was checked was when she got up this morning and NA-G brought R8 to the bathroom. During an interview on 1/15/25 at 3:00 p.m., registered nurse (RN)-C stated R8 was to be checked and changed every 2 hours, which was changed from check and change every 3 hours due to a new area of impaired skin integrity. Residents who sat in soiled incontinent briefs had an increased chance of skin breakdown and should be checked and changed frequently. During an interview on 1/16/25 at 9:55 a.m., the director of nursing (DON) stated it was the expectation staff would have followed resident care plan related to check and change of incontinent briefs to ensure R8's care was done. The facility's Urinary Incontinence Program policy dated 4/6/15, identified each resident will receive the appropriate care and services to prevent incontinence related complications to the extent possible. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures related to ensuring	2 920		

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2 920	Continued From page 20 toileting and/or check and change for each individual resident is followed. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by assessments and the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served at warm, palatable temperatures for 5 of 5 residents (R30, R4, R32, R11,R18) who received meal trays out of temperature range. Findings include: R30's significant change MDS dated 11/18/24, identified R30 had intact cognition and was independent with eating. On 1/14/25, at 2:00 p.m. R30 stated he ate his meals in his room and the meal trays served were almost always cold. R30 stated this occurred with all the meals served in his room and it did not matter if was breakfast, lunch or supper. On 1/14/25, at 4:56 p.m. the supper meal	2 960	Corrected	2/19/25

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2 960	Continued From page 21 services were observed on the "Blueberry" unit where several residents were seated in the dining area waiting for the supper meal. Residents were served a meal of hot dogs and tater tots in the dining room. The supper trays were on an open metal cart with three shelves. Each tray was covered with a dish cover over the plate of food. At 5:18 p.m. nursing assistant (NA)-O began delivering supper trays to the residents in their rooms. At 5:19 p.m. NA-O delivered a supper tray to R30's room. At 5:20 p.m. NA-O delivered a supper tray to R4's room. At 5:20 p.m. NA-O delivered a supper tray to R32's room. At 5:21 p.m. NA-O delivered a supper tray to R11's room. At 5:23 p.m. NA-O delivered a supper tray to R18's room. At 5:25 p.m. a test tray was removed from the resident cart and cook (CK)-A tested the hotdog and tater tots for temperature. The hot dog measured 99.5 degrees, and the tater tots measured 94 degrees. CK-A stated the food was cold and should temp around 145 degrees. On 1/14/25, at 5:40 p.m. CK-A stated the food had been hot when leaving the kitchen area and he thought the problem with the food cooling off so quickly was the dietary aide had not allowed the steam table to warm up adequately prior to meal service. The dietary aide had also not been trained on using the plate warmer function of the steamer table and that may have contributed to the cold food as well. When interviewed on 1/15/25, at 1:28 p.m. the director of nursing (DON) stated the food temperatures at supper service was not acceptable and should have been warmer. The cold food did not taste very palatable and was unappetizing.	2 960		

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2 960	Continued From page 22 During interview on 1/15/25, at 2:16 p.m. the director of dietary services (DODS) stated she observed food service at the facility in the past and could recall the facility used an open tray cart, which could contribute to the food cooling off quickly. Food was not safe if the temperature was dropped below 135 degrees and cold food was just not palatable. The facility policy General Food Preparation and Handling dated 10/23, identified all meats were to be heated to a safe minimum internal temperature. Staff were to refer to the charts Minimum Cooking Food Temperatures and Holding Times and Suggested Food Cooking Temperatures and Holding Times, which identified hot holding temperature of 135 degrees. SUGGESTED METHOD OF CORRECTION: The director of nutrition services, or designee, could review applicable policies and procedures to ensure resident meal trays were served at palatable temperatures; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 960		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by:	21015		2/19/25

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21015	Continued From page 23 Based on observation, interview and document review, the facility failed to ensure the final rinse on the dishwasher reached 180 degrees Fahrenheit (F) to sanitize dishes. This had the potential to affect 61 of 62 residents who consumed food from the main production kitchen. Findings include: On 1/13/25, at 11:58 a.m., an initial kitchen tour was completed with dietary aide (DA)-A. A single commercial dishwasher was observed along the wall with several hard plastic racks on the conveyor belt in front of machine. DA-A loaded several plate covers onto a hard plastic rack and placed them into the dishwasher. Two gauges were located on the top front of the dishwasher. One gauge was labeled wash and on the gauge next to the 150 F degrees there was black marker identifying the temperature. A second gauge was labeled rinse, and the black marker was marked at 180 F next to the gauge. DA-A identified the temperatures were the minimum required for the dishwasher to reach when monitoring the temperatures. DA-A ran the rack with plate covers through the dishwasher machine three times. On the first run, the rinse temperature registered 160 F., on the second run the rinse temperature registered 172 F, and on the third run, the rinse temperature registered 180 F just after the dish tray exited the dishwasher and the cycle was completed. DA-A stated the third tray had not reached the rinse temperature of 180 when in the dishwasher. The Dishwashing Machine Temp Sheet for the month of January 2025, identified from January 25 through January 29, 2025, the dishwasher rinse temperature was recorded between 150 degrees and 160 degrees for the am shift/meal.	21015	Corrected	

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21015	Continued From page 24 The Dishwashing Machine Temp Sheet for the month of December 2024, identified 12 of 49 recorded dishwasher rinse temperatures were recorded below 180 degrees when monitored for the three meals. During interview on 1/13/25, at 12:00 p.m. cook (CK)-B stated the dishwasher repair person had told dietary staff to shut off and drain the washer every shift to help it to reach adequate temperatures and she was not sure that was being done. The dishes would not be rinsed properly if the rinse temperature did not reach the required 180 degrees. When it was identified the dishwasher was not reaching adequate temperatures, staff were to call the dishwasher repair person. Staff were to keep running the dishes through the dishwasher until it reached the adequate rinsing temperature to ensure the dishes were sanitized and she would let maintenance know they were having problems with the dishwasher. During interview on 1/13/25, at 12:32 p.m. maintenance (MAINT)-A observed the dishwasher cycle with rinse temperature at 160 degrees. MAINT-A stated he had never been notified the dishwasher was not working properly. He did not work on the dishwasher but would call the repair person to come. A joint interview was completed with DA-A and CK-B on 1/13/25, at 12:40 p.m. CK-B stated they never manually sanitized dishes in the sink. CK-B could only remember hand washing dishes one time when the dishwasher was being replaced. CK-B stated currently the dishwasher was not working properly if the rinse did not reach 180 degrees. DA-A stated maybe they should be hand	21015		

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21015	Continued From page 25 washing the dishes to sanitize them. During a second tour of the kitchen on 1/13/25, at 1:05 p.m. DA-A was observed hand washing cooking equipment, pots and utensils in a sink with soapy water. DA-A put the hand washed equipment into a hard plastic rack and ran three racks of hand washed pots, equipment and utensils through the dishwasher. The dishwasher rinse gauge registered 175 degrees. DA-A stated she ran the dishes through the dishwasher after hand washing them in order to sanitize the dishes. DA-A stated the dishes were not getting properly sanitized since the rinse temperature did not reach 180 degrees, but she did not know what else she could do. At 1:24 p.m. DA-A completed washing all the lunch dishes through the dishwasher and the rinse temperature reached 180 degrees and greater. DA-A stated it was just the first few trays that were run through that the rinse was below 180 degrees. DA-A was watching all the trays going through now to make sure the rinse reached 180 degrees or more. During interview on 1/14/25, at 10:30 a.m. MAINT-A stated the dishwasher repair person checked the dishwasher, and it was working properly. The repair person indicated the surface temperature needed to be 160 degrees and was reaching 168 degrees. The staff needed to run a holding thermometer or test strip or plate through the machine to get the most accurate readings. During observation of dishwasher on 1/14/25, at 4:29 p.m. DA-B ran a rack of plastic glasses through the dishwasher. The rinse temperature registered 160 degrees. DA-B stated she always ran resident glasses through two times. DA-B ran the glasses through the dishwasher a second time. The rinse temperature registered 178	21015		

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21015	Continued From page 26 degrees. DA-B stated she did not know where to locate or how to run a thermometer or temperature plate through the dishwasher, as she had never been taught. DA-B stated she only looked at the front gauges to record the dishwasher temperatures and had never been told or taught to do it any other way. During interview on 1/14/25, at 5:35 p.m. MAINT-A stated the dishwasher took a while to heat up to the 180 degree rinse. MAINT-A was not aware the dietary staff were not trained on how to check dishwasher temperatures other than to read the front gauges. The dishwasher repair technician who checked the machine earlier that day had not trained the dietary staff on alternative methods to check dishwasher temperatures. During interview on 1/15/25, at 1:11 p.m. CK-A stated he thought he had figured out the problem with the facility's dishwasher. The dishwasher took a while to heat up to the required 180-degree rinse temperature. CK-A instructed all the dietary staff to run a tray through the dishwasher several times until the rinse temperature reached 180 degrees before washing any dishes with the dishwasher. Staff had not been getting the dishwasher up to the required temperature before washing dishes. The staff would just run the dishes through right away in order to get done for the day quickly. The staff have been instructed now to get the dishwasher up to required temperature prior to starting to wash any dishes. When interviewed on 1/15/25, at 1:28 p.m. the director of nursing (DON) stated if dietary staff were not running dishes through a properly working dishwasher, they ran the risk of the	21015		

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21015	Continued From page 27 dishes not being sanitized properly. The DON would expect the dietary staff to try to problem solve and find out the reason the dishwasher was not reaching the required temperature and to reach to the dietary manager or maintence when equipment was not working properly. During telephone interview on 1/15/25, at 2:16 p.m. the director of dietary services (DODS) stated running dishes through the dishwasher at low rinse temperatures meant the dishes were not being sanitized, which was not appropriate. DODS stated it was an area staff would need training on. The facility policy Cleaning Dishes/Dish Machine dated 4/20/22, identified the facility used a high temperature dishwasher which used heat for sanitization. Minimum wash temperatures were 150 degrees and minimum rinse temperature was 180 degrees. If minimum temperatures were not obtained, staff were to utilize sanitation process and indicate on the temperature log the corrective action used to ensure dishes were sanitized. SUGGESTED METHOD OF CORRECTION: The dietary manager or desigee could review policies and procedures for sanitizinf dishes, and educate the staff on the dishwasher tempurature reuirements and correct procedures when the dishwasher is not brought up to the appropriate tempuratures. The dietary manager or desigee could develop a monitoring system and bring the results to the quality assurance team. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		

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21390	Continued From page 28	21390		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to expand COVID-19 testing/ and or contact tracing of staff and residents on other units after residents tested positive for COVID19 per Centers for Disease Control (CDC) guidelines. In addition, the facility	21390	Corrected	2/19/25

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21390	Continued From page 29 failed to implement enhanced barrier precautions (EBP) for 1 of 3 residents (R53) reviewed for activities of daily living (ADLs). This had the potential to affect all 60 residents residing in the facility. Findings include: COVID-19 Testing: The current CDC guidance on COVID-19 in the Nursing Home dated June 2024 included : "Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated. Empiric use of Transmission-Based Precautions for residents and work restriction for HCP who met criteria can be discontinued as described in Section 2 and the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, respectively. If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days. If antigen testing is used, more frequent testing	21390		

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21390	Continued From page 30 (every 3 days), should be considered." On 1/13/25 at 1:25 p.m., R10 stated she was waiting for her shower because the NA that was supposed to help her was pulled to the other unit (Evergreen) to work. On 1/15/25 at 2:37 p.m., maintenance worker-A stated there was a potential that housekeeping staff would be pulled to work from one unit to the other during the same shift. Review of the facility covid outbreak document dated 1/7/25, identified the following: - NA-E worked the night shift (10:00 p.m. - 6:30 a.m.) on 1/6/25 and evening shift on 1/7/25 on Evergreen unit. Throughout the evening on 1/7/25, NA-E developed symptoms (not listed) and at 9:00 p.m. tested positive for COVID-19. NA-E immediately left the facility. The morning of 1/8/25, infection surveillance and tracking was initiated. The document identified NA-E had high risk contact with all 29 residents on Evergreen Unit and 16 staff (RN-C, RN-G, RN-H, LPN-C, TMA-A, NA-R, NA-S, NA-T, NA-U, NA-V, NA-W, NA-X, NA-Y, NA-Z, Hsk-C, Scheduler) that worked in the facility. - On 1/8/25, 4 residents (R3, R17, R36 and R43) tested positive for COVID-19 and were immediately placed on droplet precautions and were quarantined to their rooms. R3's symptoms included cough, congestion and sore throat. R17's symptoms included cough and congestion. R36 and R43 were asymptomatic. - On 1/10/25, all residents on Evergreen unit were tested for day 3 outbreak testing. One additional resident, R46, tested positive for COVID-19. R46	21390		

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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) COMPLETE DATE
21390	Continued From page 31 had symptoms including cough and runny nose and was immediately placed on droplet precautions and quarantined to the room. The previously identified high risk staff all tested negative for COVID-19. - On 1/12/25, all residents on Evergreen unit and previously identified high risk staff were tested and were negative for COVID-19. The facility staff schedules identified 19 staff, including 11 nursing staff (RN-B, RN-E, RN-F, LPN-A, LPN-B, NA-B, NA-H, NA-I, NA-J, NA-K, NA-L, NA-M, NA-O, NA-P, NA-Q), 5 dietary aides (DA-A, DA-B, DA-C, DA-D), 2 activity aides (AA-A, AA-B) and 1 housekeeping staff (HSK-A), worked on 1/8/25, and were not tested for COVID-19. The schedules did not identify if staff were pulled to the other unit during their shift. During joint interview on 1/15/25 at 1:02 p.m., registered nurse (RN)-C and RN-D identified the on 1/7/25, nursing assistant (NA)-E was working the evening shift (2:00 p.m.-10:30 p.m.). Throughout the shift NA-E developed body aches and congestion. At 9:00 p.m., NA-E tested positive for COVID-19 and was immediately sent home by the nurse. The morning of 1/8/25, RN-C and RN-D were notified of NA-E's positive COVID-19 result and started employee contact tracing. All high risk staff identified through, contact tracing, and all residents on Evergreen unit were tested for COVID-19. Of those tested, zero staff tested positive; however, four residents tested positive. The positive residents were immediately placed in droplet precautions and a mass text was sent to inform all other employees of the positive cases. - The facility continued to test the originally	21390		

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	00448	A. BUILDING: _____ B. WING _____	C 01/16/2025

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

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21390	Continued From page 32 identified high risk staff and all residents on Evergreen unit on day 3 (1/10/25), day 5 (1/12/25), day 7 (1/14/25) and planned to test on 1/17/25. The facility failed to expand the contact tracing, to include staff/residents exposed to the positive residents; or complete broad-based testing of all staff and residents after continued positive cases of COVID-19 were identified. Staff continued to worked in close proximity with residents and other staff from both units throughout their workday. The facility tried to keep staff, (including nursing, dietary, and housekeeping staff) on one unit or the other during their shift, although there was a potential for staff to be pulled from one unit to the other during, as well as residents from either unit to co-mingle during times including meals and activities. The facility failed to complete additional employee contact tracing and failed to consider broad-based testing for all staff and residents even after the facility continued to have positive COVID-19 test results. On 1/16/25 at 10:33 a.m., RN-C stated she was monitoring the residents on Blueberry unit for symptoms of COVID-19 by reviewing their progress notes and receiving verbal report from nursing staff. She had not tested the residents on Blueberry because she thought symptom monitoring was sufficient. Additional staff were not tested because staff were monitoring their own symptoms. In addition, RN-C stated there was a potential for staff, including nursing, housekeeping, activities and dietary staff, to work on both units during the same shift, as well as residents from either unit to come into contact with each other during facility activities. On 1/16/25 at 10:53 a.m., the director of nursing (DON) stated the facility dropped the ball on	21390		

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21390	Continued From page 33 testing staff and residents for COVID-19. Once there were additional cases of COVID-19 they should have tested the entire facility because staff work back/forth on both units and there was a risk that the staff were exposed and worked with other residents and/or staff when they had not been tested. The DON stated the risk of not testing appropriately is the risk of spreading the illness to other residents, staff or visitors. The facility Coronavirus Prevention, Screening, and Identification policy reviewed/revised 10//11/23, included the following: The facility will assess and identify the potential staff risk. Low risk includes when there is no direct exposure to a COVID-19 infected person. Contact risk is identified as close (within 6 feet for 15 minutes or more, or within same living space) contact of person(s) with COVID-19 within 48 hours. The facility will communicate the risk level and recommendations to staff. Care center wide testing includes: if the care center becomes aware of a COVID-19 positive case among staff who have worked within the past 2 days and/or residents, an assessment to determine exposure will begin immediately. Residents and staff with close contact with someone with COVID-19 will begin testing 24 hours after exposure. If unable to determine close exposure to the COVID-19 positive individual broad testing of all staff and residents (regardless of vaccination status) will occur. The facility Suspected (or Confirmed) Coronavirus (COVID-9) Outbreak policy reviewed/revised 7/25/23, identified the purpose was to provide guidance for care center staff on handling suspected or confirmed Corona virus (COVID-19) disease. During an outbreak of COVID-19 disease the facility would begin testing	21390		

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21390	Continued From page 34 all exposed staff and residents immediately day one, (two days after exposure) day three, and day five after exposure, and 5-7 days after testing until 14 days of no further positive results. Enhanced Barrier Precautions: R53's quarterly Minimum Data Set (MDS) dated 12/17/24, identified R53 had severely impaired cognition and was dependent on staff for all activities of daily living (ADLs). R53 was incontinent of bowel and had an indwelling catheter and a feeding tube. Diagnosis included spastic quadriplegic cerebral palsy. On 1/14/25, at 8:55 a.m. a personal protective equipment (PPE) cart was observed in the hall beside R53's room door. The PPE cart's drawers contained disposable hospital gowns, disposable gloves and masks. A sign was posted above the cart which identified enhanced barrier precautions were required when providing high contact care with resident residing in the room. The poster identified when and what staff were required to don prior to entering the room. During observation on 1/14/25, at 9:02 a.m. nursing assistant (NA)-Q entered R53's room to assist her with her morning care. NA-Q was wearing a surgical mask and put on gloves. NA-Q removed R53's brief and washed up R53's peri area with disposable wipes. NA-Q turned R53 away and then rolled her back toward her, leaning over R53 to perform the peri care. NA-Q changed her gloves after performing incontinence care and rolled R53 from side to side to secure the clean brief. R53's body would lean against NA-Q uniform at times, when rolling R53 toward her. NA-B entered the room wearing a face mask, gloves and disposable gown. NA-B and NA-Q placed a Hoyer (full lift) lift sheet underneath	21390		

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21390	Continued From page 35 R53's body, again rolling her from side to side and at times leaning into NA-Q's uniform. Both aides utilized the Hoyer lift to transfer R53 into her wheelchair and secured her catheter bag to the side of the wheelchair and adjusted R53's feeding tube lines to ensure placement was appropriate. When interviewed on 1/14/25, at 9:14 a.m. NA-Q stated she wore a disposable gown in the moring when she got R53 dressed. It was especially important to wear a gown and gloves when working with R53's indwelling catheter. NA-Q had not worn a gown when assisting with incontinent peri care, as she was just getting the resident up in her wheelchair and not emptying her catheter or anything like that. R53 had touched NA-Q's uniform when she was assisting her, and NA-Q had provided bowel incontinent peri care without a gown on. NA-Q should have worn a gown before assisting R53 with personal care. During interview on 1/14/25, at 9:18 a.m. NA-B stated staff were suppose to a wear gown and gloves with any residents who had a catheter or open wounds. Staff were to wear the PPE whenever providing care to those type of residents; however, were not required to wear the PPE when just passing water or going in room to speak with them. During joint interview with infection preventionist registered nurse (RN)-C and RN-D on 1/16/25, at 10:15 a.m. RN-C stated R53 was on enhanced barrier precautions and staff should wear the appropriate PPE of gown, mask and gloves to perform peri care. Staff were educated on the use of PPE with enhanced barrier precautions (EBP) in April 2024, and were to wear PPE whenever providing care, transfers, or toileting.	21390		

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21390	Continued From page 36 The resident's that required EBP had PPE carts outside of their room doors and EBP posters on their doors to direct staff. The facility policy Enhanced Barrier Precautions dated 8/20/24, identified EBP were to be used when providing high contact care to residents who were colonized or infected with a multi-drug-resistant organism. EBP would also be used for residents with chronic wounds and/or indwelling medical devices. EBP was to be employed when performing high contact resident care activities such as dressing, bathing, changing linen, transferring, hygiene care, toileting, peri care, emptying catheter bag, wound care, indwelling medical device care and therapy treatment. The CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multi-drug-resistant Organisms (MDROs) manual, dated 7/2022, identified MDRO transmission within a nursing home was common and contributed to substantial resident morbidity and mortality. The feature outlined EBP were defined as, " ... expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing ... MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities ... residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs." The feature identified several examples of high-contact resident care activities including dressing, bathing, providing hygiene, transferring, changing linens or briefs, and wound care. SUGGESTED METHOD OF CORRECTION: The	21390		

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21390	Continued From page 37 director of nursing (DON) or designee could review and revise policy's for COVID-19 testing and EBP to ensure it meets the CDC guidelines. Then educate staff on the requirements, monitor and audit and bring the results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21390		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an assessment was completed for an electric scooter to increase mobility for 1 of 1 residents (R57) reviewed for accomadation of needs. Findings include: R57's significant change Minimum Data Set (MDS) dated 12/30/24, identified R57 was cognitively intact, was independent with bed mobility, no functional limitation in range of motion of upper or lower extremities, and used a	21810	Corrected	2/19/25

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21810	Continued From page 38 walker and wheelchair for mobility. R57 participated in physical and occupational therapy during the assessment period. R57's care plan revised on 11/14/24, identified R57 was independent with bed mobility, required assistance of one staff and gait belt to transfer between surfaces, and required stand-by assistance while walking with a walker. The plan failed to identify use of an electric scooter. On 1/13/25 at 6:20 p.m., R57 stated she had an electric scooter at home and talked to staff about it. R57's son brought the scooter to the facility; however, R57 stated she had not received any follow-up from staff. R57 stated she received therapy every day and had not had any discussion or assessments related to use of the scooter. R57's care conference notes from 11/27/24 were reviewed; however, the notes did not identify any discussion regarding the electric scooter use. R57's medical record lacked any assessment or referral for the use of the electric scooter. On 1/16/25 at 9:13 a.m., social services (SS)-A stated R57's electric scooter was in the building by the front entrance and was under the impression R57 was assessed by occupational therapy but was not strong enough to drive the scooter independently. SS-A stated she was uncertain what R57 had been told regarding using the scooter. On 1/16/25 at 12:13 p.m., physical therapy assistant (PTA)-A stated therapy had not received a referral to assess R57 for use of the electric scooter.	21810		

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21810	Continued From page 39 On 1/16/25 at 12:13 p.m., SS-A provided an undated and untitled document with R57's name and written notes that identified "scooter eval. - key in top drawer." SS-A stated the document was notes she made to herself, although she failed to pass the information onto nursing staff. A policy regarding following up on resident's requests was requested but not provided. SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review, and /or revise policies and procedures related to accomation of resident needs. The administrator or designee could audit residents to ensure they have the appopriate devices for the greatest independance and then make any changes needed, then educate all appropriate staff. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		

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	245252	A. BUILDING **02 - THEIF RIVER CARE CENTER NEW BLDG** B. WING _____	**01/16/2025**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/16/2025. 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/11/2025

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Thief River Care Center is a 1-story building with no basement that was built in 2011 and was determined to be of Type II(000) construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is monitored for automatic fire department notification. The facility is protected throughout by a complete	K 000		

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K 000	Continued From page 2 fire sprinkler system. The facility also has smoke detection throughout the corridors and spaces open to the corridors. The facility has a capacity of 70 beds and had a census of 67 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 163 SS=E	Interior Nonbearing Wall Construction CFR(s): NFPA 101 Interior Nonbearing Wall Construction Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 19.1.6.4, 19.1.6.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain non-combustible ceiling in accordance with the NFPA Life Safety Code 101 2012 edition section 19.1.6.3 subsection 1 and 3. This deficient practice could have a patterned impact on the residents within the facility. Findings include: 01/16/2025, between 9:30am and 1:30pm, It was revealed by observation that there are missing	K 163	In order to comply with NFPA Life Safety Code 101 2012 edition, section 19.1.6.3 subsection 1 and 3, the following corrections will occur: • Ceiling Tiles were put in place in the Therapy Room and West Wing Soiled Utility Room. • An inspection of all rooms will be conducted and if any ceiling tiles are missing, they will be installed. • The Environmental Services Director	2/19/25

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K 163	Continued From page 3 ceiling tiles in the following areas: 1) Therapy room 2) West wing soiled Utility Room An interview with the Assistant Maintenance Director verified this deficient finding at the time of discovery.	K 163	and Maintenance Assistant received education on K163 and to have ceiling tiles installed to maintain a 2-hour fire rating . • The Environmental Services Director is responsible for compliance with K163.	
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clear path of egress system per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1 and 7.1.10.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: 01/16/2025, between 9:30am and 1:30pm, it was revealed by observation that there is uneven and/or missing concrete outside of emergency exit located at the Northwest Corridor Exit. An interview with the Assistant Maintenance Director verified this deficient finding at the time of discovery.	K 211	In order to comply with NFPA Life Safety Code 101 2012 edition, section 19.2.1 the following corrections will occur: • A mixture of Sand and “Quickcrete” will be applied to the Northwest Corridor Exit to provide a temporary solution for a means of egress free of obstructions. • All other exits will be inspected and the above solution will be used for those means of egress. • The Environmental Services Director will monitor the exits for any further movement due to frost heaving. • The Environmental Services Director is responsible for compliance with K211.	2/19/25

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	245252	A. BUILDING **02 - THEIF RIVER CARE CENTER NEW BLDG** B. WING _____	**01/16/2025**

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 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		2/19/25

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K 363	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: 01/16/2025, between 9:30am and 1:30pm, it was revealed by observation that the Mechanical Room in kitchen did not latch. An interview with the Assistant Maintenance Director verified this deficient finding at the time of discovery.	K 363	In order to comply with NFPA Life Safety Code 101 2012 edition, section 19.3.6.3.5 the following corrections will occur: • A new strike plate was installed on the Mechanical room Kitchen door. • An inspection of all corridor doors will be conducted and if any are found not to latch, they will be adjusted/repaired. • The door inspection checklist will be updated to inspect for non-latching corridor doors. • The Environmental Services Director is responsible for compliance with K363.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per	K 372	In order to comply with NFPA Life Safety Code 101 2012 edition, section 19.3.7.1,	2/19/25

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K 372	Continued From page 6 NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 01/16/2025, between 9:30am and 1:30pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above ceiling in west wing fire door area. An interview with the Assistant Maintenance Director verified this deficient finding at the time of discovery.	K 372	19.3.7.3 and 8.5.6.5 the following corrections will occur: • The penetration revealed above the ceiling in the West Wing fire door area was sealed with fire caulking. • The Environmental Services Director will inspect other areas above the fire doors to ensure that any penetrations are fire caulked. • The Environmental Services Director and Maintenance assistant were educated on monitoring for any penetrations during any work where wire and/or conduit is run during construction or repairs. • The Environmental Services Director is responsible for compliance with K363.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This	K 712	In order to comply with NFPA Life Safety Code 101 2012 edition, section 19.7.1.6, 4.7.4 and 4.6.1.1, the following corrections will occur: • Fire Drills will be conducted under	2/19/25

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K 712	Continued From page 7 deficient finding could have a widespread impact on the residents within the facility. Findings include: 01/16/2025, between 9:30am and 1:30pm, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: first shift, first quarter and second quarter have same time. second shift first quarter, second quarter and fourth quarter all drills within 15 minutes of each other. An interview with the Assistant Maintenance Director verified this deficient finding at the time of discovery.	K 712	varied times to comply with K712. • The checklist provided by the parent corporation will be followed for future fire drills that varies the time of fire drills. • The Environmental Services Director is responsible for compliance with K712.	
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by:	K 753		2/19/25

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K 753	Continued From page 8 Based on observation or a review of available documentation and staff interview, the facility failed to prohibit combustible decorations per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.5.6 and 19.7.5.6 (4). These deficient findings could have an isolated impact on the residents within the facility. Findings include: 01/16/2025, between 9:30am and 1:30pm, it was revealed by observation that a candle was located on the wooden alter in the chapel. An interview with the Assistant Maintenance Director verified this deficient finding at the time of discovery.	K 753	In order to comply with NFPA Life Safety Code 101 2012 edition, section 19.7.5.6 and 19.7.5.6 (4), the following corrections will occur: • The candle noted in the inspection on 1/16/2025 was a mechanical candle that is non-combustible. • The Maintenance Assistant looked at all candles in the Chapel and verified they are all mechanical candles. • Office areas and resident rooms will be inspected for any actual candles and ensure they are either removed or the candle wick will be removed. The requirement to not have candles in the office areas was communicated to office staff. • The Environmental Services Director is responsible for compliance with K753.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80)	K 761		2/19/25

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K 761	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 01/16/2025, between 9:30am and 1:30pm, it was revealed by review of available documentation the required annual door inspection documentation did not show the required completion of found door issues. Form must indicate when and by whom the repairs completed. Findings include: 01/16/2025, between 9:30am and 1:30pm, it was revealed by observation that the mechanical room in the kitchen has a painted door label. This deficient finding could have an isolated impact on the residents within the facility. An interview with the Assistant Maintenance Director verified this deficient finding at the time of discovery.	K 761	In order to comply with NFPA Life Safety Code 101 2012 edition, section 8.3.3.1 and NFPA 80 (2010 edition) Section 5.2.1, the following corrections will occur: • The Maintenance Assistant will follow the instructions on completing the Annual Door Inspection Checklist provided by the parent corporation. • Education was provided on the requirements of the annual Door Inspection. • The Environmental Services Director is responsible for compliance with K761.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only	K 920		2/19/25

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K 920	Continued From page 10 used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: 01/16/2025, between 9:30am and 1:30pm, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following areas;	K 920	In order to comply with NFPA Life Safety Code 99 2012 edition, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70 (2011 edition) National Electrical Code, sections 400-8 and UL 1363, the following corrections will occur: • The power-strip in the Rehabilitation office was removed and the appliance was plugged directly into the wall receptacle. • The 6 lug outlet cover in the Human Resource Office was removed and power cords are now plugged directly into the wall receptacle. • An inspection will be conducted for compliance with K920.	

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K 920	Continued From page 11 1) Rehabilitation Office (appliances power-strip 2) Human Resource Office (6 Lug Outlet Cover) An interview with the Assistant Maintenance Director verified this deficient finding at the time of discovery.	K 920	• Non-compliance with K920 will be reviewed during the annual electrical receptacle inspection and will be expanded to include office areas for non-compliance with K90. • The Environmental Services Director is responsible for compliance with K761.	