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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OOTB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00448

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

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

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

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

6. DATE OF SURVEY **11/05/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
04/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 01/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/05/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
11/13/2015 (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

CMS Certification Number (CCN): 245252

January 5, 2016

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

Dear Ms. Halvorson:

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

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

Effective November 17, 2015 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

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

Minnesota Department of Health

Electronically delivered
November 28, 2015

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

RE: Project Number S5252025

Dear Ms. Halvorson:

On October 2, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 17, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On November 5, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 20, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 17, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 17, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 17, 2015, effective November 17, 2015 and therefore remedies outlined in our letter to you dated October 2, 2015, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245252	A. Building B. Wing	11/5/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **10/16/2015**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **10/16/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **10/16/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **10/09/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **10/09/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	11/30/2015	28035	11/05/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/17/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245252	A. Building B. Wing **02 - THEIF RIVER CARE CENTER NEW BLDG**	11/20/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0038	Correction Completed **11/17/2015**	ID Prefix Reg. # **NFPA 101** LSC K0052	Correction Completed **10/16/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** TL/mm	**Date:** 11/30/2015	**Signature of Surveyor:** 27200	**Date:** 11/20/2015`
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 9/15/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: OOTB

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

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

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(L3) **THIEF RIVER CARE CENTER**
(L4) **2001 EASTWOOD DRIVE**
(L5) **THIEF RIVER FALLS, MN** (L6) **56701**

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

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

6. DATE OF SURVEY **09/17/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
04/30

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

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

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

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

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

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

* Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Debra Vincent, HFE NE II 10/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 11/12/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 2, 2015

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

RE: Project Number S5252025

Dear Ms. Halvorson:

On September 17, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Gloria.derfus@state.mn.us

Phone: (651) 201-3792
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 27, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 17, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 17, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Gary Schroeder, Interim Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: gary.schroeder@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate monitoring and assessment for 1 of 1 resident (R63) who was reviewed with high blood glucose levels. Findings include: R63's Face Sheet dated 7/23/14, indicated R63's diagnoses included chronic airway obstruction	F 309	R63s Diabetic care was reviewed with her Physician and her POC was revised, R63 will be followed by the Diabetic educator for insulin management. We will be updating the Diabetic educator every 2 weeks until blood sugars are stable between 200 and 300. Staff is to monitor and record for signs/symptoms of hyperglycemic responses when she is having high blood sugars.	10/16/15

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

Electronically Signed | 10/12/2015

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	245252	A. BUILDING _____ B. WING _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 1 (difficulty breathing), diabetes, congested heart failure (decrease in heart function to pump blood), anxiety, renal failure (kidney failure), macular degeneration (poor vision), peripheral autonomic neuropathy (peripheral nerve damage often caused by diabetes). R63's care plan dated 8/29/14, indicated R63 was diabetic and directed staff to conduct glucose monitoring as ordered and to monitor for signs and symptoms of hypoglycemia (low blood glucose levels) and hyperglycemia (high blood glucose levels). R63's quarterly Minimum Data Set (MDS) dated 8/28/15, indicated R63 had no cognitive impairment and was on insulin daily. R63's Physician Order Sheet dated 9/1/15, indicated R63 was scheduled to receive the following medication for her diabetes: - Lantus (insulin) 12 units subcutaneous (injection into the subcutaneous tissue - SQ) every 8:00 a.m. - Lantus 4 units SQ every 8:00 p.m. - Humalog (insulin) 2 units SQ every 5:00 p.m. - Humalog sliding scale (scale utilized to determine the amount of insulin to be given depending on the blood glucose level at the time) twice a day before meals at 8:00 a.m. and 12:00 noon: o Hold if blood sugar is less than 200 milligrams per deciliter (mg/dL) o Give 2 units if blood sugar between 201-250 mg/dL o Give 4 units if blood sugar between 251-300 mg/dL o Give 6 units if blood sugar between 301-350	F 309	The facility Blood Glucose Policy was reviewed and revised to include direction on what to do if a resident is hypoglycemic or hyperglycemic. Nursing staff were reeducated on the revised Glucose Testing Policy and on R63¿s revised Diabetic POC will be completed by 10/16/2015. All residents with Glucose monitoring were assessed to ensure appropriate monitoring and assessment for high and/or low blood sugars is in place by 10/9/2015. (Directions and documentation present in EMR) Random audits of documentation of blood glucose monitoring and follow up as needed will be conducted by the DON/designee 2Xwk X3, then weekly x4. Audit results will be brought to the QAPI committee for review and further recommendations. Completion date: 10/16/15	

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F 309	Continued From page 2 mg/dL o Give 7 units if blood sugar is greater than 7 units mg/dL - Humalog 2 units SQ if blood sugar greater than 500 mg/dL On 9/16/15, at 7:48 a.m. R63 was observed walking to the dining room for breakfast. On 9/16/15, at 10:51 a.m. licensed practical nurse (LPN)-D conducted a blood glucose check on R63. R63's blood glucose level reading at this time was 404 mg/dL. R63's A1C (blood test which indicated how well blood glucose levels have been controlled over the last 2-3 months) results were: - 6/4/15, 13.0 - value identified as being high (reference range 4.3-5.7) - 4/9/15, 12.6 - value identified as being high (reference range 4.3-5.7) On 9/17/15, at 11:23 a.m. registered nurse (RN)-B stated R63 was to have her blood sugar level checked four times a day (before each meal and at bedtime). RN-B confirmed R63's last three months of blood sugar reading results as listed below and verified R63's medical record lacked documentation of a recheck on any of these high readings: - 9/11/15, at 9:03 p.m. blood glucose result = 548 mg/dL - 9/10/15, at 9:23 p.m. blood glucose result = 560 mg/dL - 8/30/15, at 9:01 p.m. blood glucose result = 555 mg/dL - 8/30/15, at 5:15 p.m. blood glucose result = 595 mg/dL	F 309		

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F 309	Continued From page 3 - 8/24/15, at 8:54 p.m. blood glucose result = 600 mg/dL - 8/18/15, at 8:31 p.m. blood glucose result = 561 mg/dL - 8/17/15, at 7:31 p.m. blood glucose result = 562 mg/dL - 8/17/15, at 8:47 p.m. blood glucose result = 562 mg/dL - 8/15/15, at 7:22 p.m. blood glucose result = 600 mg/dL - 8/2/15, at 9:37 p.m. blood glucose result = 541 mg/dL - 7/28/15, at 10:14 p.m. blood glucose result = 513 mg/dL - 7/28/15, at 8:23 p.m. blood glucose result = 556 mg/dL - 7/18/15, 3:53 p.m. blood glucose result = 530 mg/dL - 7/14/15, at 7:24 p.m. blood glucose result = 554 mg/dL - 7/7/15, at 9:36 p.m. blood glucose result = 511 mg/dL - 7/7/15, at 11:59 a.m. blood glucose result = 557 mg/dL - 7/2/15, at 8:40 p.m. blood glucose result = 517 mg/dL - 7/1/15, at 5:23 p.m. blood glucose result = 554 mg/dL - 6/29/15, at 8:13 p.m. blood glucose result = 531 mg/dL - 6/28/15, at 9:12 p.m. blood glucose result = 541 mg/dL - 6/25/15, at 9:04 p.m. blood glucose result = 531 mg/dL - 6/24/15, at 3:37 p.m. blood glucose result = 562 mg/dL - 6/23/15, at 9:43 p.m. blood glucose result = 600 mg/dL	F 309		

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R63's progress note dated 7/28/15, at 10:14 p.m. indicated R63 was hyperglycemic and had no odor or acetone on her breath. However, R63's progress notes for the other dates and times of the high blood glucose readings noted above lacked documentation related to an assessment for signs and symptoms of hyperglycemia.

The Consultant Pharmacist's Medication Review for R63 dated 5/28/2015, indicated R63's A1C was up to 12 from 10 and the suggested course of action indicated R63 was a brittle diabetic and the past recommendation for insulin adjustment had been declined as R63 had a history of falls from hypoglycemia. The pharmacist recommended a need to identify A1C and blood sugar goals for R63. The follow up action indicated by medical doctor (MD)-A was that an A1C had been done. No goals had been recommended by the MD.

The Nurse Communication to Physician Order dated 4/8/15, indicated R63 had been hyperglycemic with symptoms and requested any changes. MD-A's response dated 4/9/15, indicated no changes as R63 was brittle and to give 2 units insulin for blood sugars greater than 500 mg/dL.

R63's physician progress note dated 8/22/15, indicated R63 was receiving Lantus 12 units in the morning and 4 units at night and sliding scale Humalog. In addition, acknowledgement of R63's blood glucose level being over 600 mg/dL and that R63 was a brittle diabetic with past episodes of hypoglycemia.

On 9/17/15, at 9:21 a.m. RN-B stated for blood glucose levels over 500 she would normally notify

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the physician and would recheck the blood glucose level in 30 minutes. RN-B stated she would especially recheck R63's blood sugar level within 30 minutes if R63's blood sugar levels were over 500.

On 9/17/15, at 2:32 p.m. the director of nursing (DON) stated R63 used to have an order for nursing to give an additional 2 units of Humalog insulin every one hour until 8:00 p.m. or until R63's blood glucose level went below 500.

On 9/17/15, at 3:45 p.m. the DON stated she would not expect staff to recheck R63's blood glucose level even if it read "high", nor would it be an expectation of staff to notify the physician if R63's blood glucose level was over 500 because they (physician) would ask what we wanted them to do about it. The DON stated she would expect staff to document if R63 was having any signs and symptoms of hyperglycemia. The DON stated the goal was to maintain R63's blood glucose levels between 200-300 mg/dL. The DON verified R63's 600 mg/dL readings could have been higher than 600 as the glucose machine only read "high" when a blood sugar was above 600 mg/dl. The DON also stated staff were unable to document "high" on the monitoring form so they wrote 600 mg/dL as that was the highest reading the machine read. The DON also confirmed it had been a long time ago since R63 had been hospitalized for a hypoglycemic episode.

On 9/17/15, at 4:38 a.m. the consulting pharmacist confirmed nursing staff should have been monitoring R63 for signs and symptoms of hyperglycemia and rechecking R63's blood glucose levels when they were reading over 500

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F 309	Continued From page 6 mg/dL. The Assure Platinum blood glucose monitoring system manufacture instructions indicated if blood glucose levels are above 600 mg/dL, the machine will read "Hi". The test should be repeated with a new test strip and if this message showed again, contact the healthcare professional immediately! Contact the physician for advice if test results are very high and/or show symptoms of high blood glucose. The Blood Glucose Testing policy dated 4/13, provided instructions on how to obtain a blood glucose sample, however did not give direction on what to do if a resident was hypoglycemic or hyperglycemic. No policy on critical value reporting or notification of clinical change to the provider were provided.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by:	F 325		10/16/15

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F 325	Continued From page 7 Based on observation, interview and document review, the facility failed to comprehensively assess nutritional risk and implement appropriate interventions in order to minimize the risk of weight loss for 1 of 3 residents (R63) reviewed who was underweight. Findings include: R63 was underweight and continued to slowly lose weight and facility failed to complete a comprehensive nutritional assessment and implement appropriate interventions to address weight loss. R63's Face Sheet dated 7/23/14, indicated R63's diagnoses included chronic airway obstruction (difficulty breathing), diabetes, congested heart failure (decrease in heart function to pump blood), anxiety, renal failure (kidney failure) and underweight. R63's quarterly Minimum Data Set (MDS) dated 8/28/15, indicated R63 had no cognitive impairment, had feelings of being tired and having little energy, required set up assistance only with meals and was on a therapeutic diet. R63's care plan dated 2/23/15, indicated R63 had a potential for weight loss. Interventions included to provide R63 with nutritional extra calories for weight maintenance or weight gain and to provide R63 sugar free hot chocolate and whole milk.	F 325	R63 was seen by RD on 9-17-15. R63 stated she doesn't want supplements and feels this is a good weight for her. DM spoke with R63 and R63 feels that 97# is her ideal body weight and would only be concerned about her weight if is fell below 95#. R63 weight range will be from 95 to 105# per input from R63, IDT and consult DM. All residents with a BMI < 18.5 will have identified ideal body weights and weight range goals, unless the resident's clinical condition demonstrates that it is not possible. Residents will be assessed for appropriate interventions to maintain and increase weight as needed. DM will make notes with the identified information and adjust the care plan on identified residents. DM will refer all residents whose BMI drops below 18.5 to the RD for review and recommendations. Random audits of documentation of nutritional assessment will be conducted by the DON/designee 2Xwk X3, then weekly x4. Audit results will be brought to the QAPI committee for review and further recommendations. Completion date: 10/16/2015	

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R63's dietary risk assessment conducted on 8/27/15, indicated R63 was a moderate dietary risk.

Nurse communication note to the physician dated 8/27/15, indicated R63 was currently on an 1800 calorie diet and that R63 never met this caloric intake goal.

R63's resident dietary assessment dated 8/27/15, indicated R63 was on a therapeutic diet and was not on a planned weight loss program.

R63's physician orders dated 9/1/15, directed staff to provide R63 with a cup of hot chocolate with whole milk once a day at 9:00 a.m.

On 9/16/15 at 7:48 a.m. R63 was served her breakfast in the dining area which consisted of a cup of coffee, glass of tomato juice, toast and a bowl of peaches (no hot chocolate with whole milk).

On 9/17/15, at 8:37 a.m. R63 confirmed she had coffee to drink for breakfast and no hot chocolate with whole milk.

R63's weight history was:
- 9/15/15 - 97.8 pounds
- 8/14/15 - 97.8 pounds
- 7/17/15 - 98.6 pounds
- 6/19/15 - 99.2 pounds

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F 325	Continued From page 9 - 6/8/15 - 103.8 pounds Dietary note dated 9/15/15, indicated R63 was on a consistent carb diet (diabetic diet) and had a supplement ordered which was whole milk with no sugar added hot chocolate. In addition, R63's weight had been stable with a slight weight loss. R63's body mass index (BMI - (index utilized to assess when a person is overweight or underweight) was 16.2, which indicated R63 was underweight. R63 had tried other supplements in the past, but didn't like them or they affected her blood sugar too much. R63 liked the whole milk with no sugar added hot chocolate, however, refused it during the summer months on some days. R63 ate small portions of food, but usually consumed 50-100% of her meals. Most current registered dietician (RD) note dated 8/23/14, indicated R63 had had some weight loss. It was suggested for R63 to have protein and fat through her food with every meal. In addition, it was recommended R63 be on a nutritional supplement to help stop continued weight loss. Recommendation was to provide R63 with Glucerna (nutritional supplement) twice a day. Contact the RD with any further nutritional questions or concerns. RD will follow as needed. R63's medication administration record for August and September 2015, lacked documentation that R63 had been provided hot chocolate and whole milk daily.	F 325		

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On 9/16/15, at 11:00 a.m. R63 stated she had tried ensure and boost (both nutritional supplements) and she didn't like them. R63 stated the hot chocolate and whole milk was okay. R63 stated she liked ice cream and malts.

On 9/17/15, at 11:18 a.m. registered nurse (RN)-B confirmed R63 was weighed weekly and verified R63 had continued to lose weight.

On 8/27/15, at 11:38 a.m. dietary manager (DM) confirmed R63 had been on Glucerna (nutritional supplement), however that had been discontinued on 10/29/14. The DM confirmed R63 was slowly still losing weight. The DM stated R63 did have a slight weight gain when R63 was drinking the hot chocolate and whole milk, however, when summer came R63 didn't want it because of the heat. The DM verified R63's BMI was 16.2 on 9/15/15, which indicated R63 was underweight. The DM verified the RD had not been involved with R63's care in at least the past six months. The DM confirmed she would refer any resident who had significant weight loss or gain to the RD for further assessment and would definitely refer a resident who was underweight like R63 or if the DM was having a difficult time finding supplements which met the preferences of the resident.

On 9/17/15, at 1:46 p.m. an attempt to contact the RD was made. The RD was unable to return a call during this survey time.

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F 325	Continued From page 11 The job description for the consulting dietician indicated the RD would review and chart on residents that were at high risk, weight loss/change, wounds, new admissions, annual MDS's or that required assessments and charting for a variety of reasons. The job description for the DM included under the nutritional and clinical management portion: - determine residents' diet needs and develop appropriate plan in cooperation with the RD - review, revise, and implement the nutrition assessment and plan of care No policy on nutritional risk and assessment was provided.	F 325		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		10/16/15

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F 329	Continued From page 12 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify target behaviors and implement non-pharmacological interventions for 3 of 3 residents (R14, R47, R63) who received an as needed (PRN) antipsychotic medication or a PRN or scheduled antidepressant medication. In addition, the facility failed to ensure non-pharmacological interventions were attempted prior to the administration of a PRN antianxiety/antidepressant medication for 2 of 2 residents (R14, R22). Findings include: Target behaviors and non-pharmacological interventions to address the use of a PRN Zyprexa (antipsychotic medication) were not identified for R14. In addition, non-pharmacological interventions were not implemented prior to the use of a PRN clonazepam (antianxiety medication) for R14. R14's Disease Diagnosis and Allergies sheet dated 9/17/15, indicated R14 had diagnoses that	F 329	R63 target behaviors and non-pharmacological have been added to her prn medication order. R14 prn Zyprexia was discontinued by Dr. K on 9-18-15. R22 and R47 target behaviors added to medication order and care plan was updated to include her target behaviors and non-pharmacological interventions. All licensed nursing staff and TMSs educated on order entry for psychotropic medication. Orders must contain proper diagnosis, target behaviors, and non-pharmacological interventions in the order for prn medications and target behaviors for scheduled medications. Staff also educated on when providing prn medication they must try non-pharm intervention prior to providing the medication. Their behavior note needs to include the behavior and non-pharm intervention, as well as follow-up after administering the medication. Education provided on 10-1-15 All residents with scheduled psychotropic	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 13 included anxiety, depression, hypertension and muscle weakness. R14's quarterly Minimum Data Set (MDS) dated 7/7/15, indicated R14 had no cognitive impairment and had trouble sleeping. R14's care plan identified R14 received an antianxiety medication. Approaches identified to address this problem area included encourage resident to ventilate feelings, explore reasons for resident's distress, environmental stressors, psychosocial stressors and treatable medical conditions. R14' s PRN Medication Administration Report dated 7/1/15 - 9/16/15, indicated the physician had ordered that R14 could be given Zyprexa 2.5 milligrams (mg) (antipsychotic medication) once a day PRN. Target behaviors and non-pharmacological interventions had not been identified for the use of the Zyprexa. In addition, the physician had ordered that R14 could be given clonazepam 0.5 mg (antianxiety medication) once a day PRN. Target behaviors identified for the use of the clonazepam were repetitive complaints, nervous statements, paranoia and feeling uneasy. Non-pharmacological interventions identified to be used prior to the administration of the PRN clonazepam included 1:1 time, playing cards, movie and bring R14 to her room. R14's progress note dated 8/21/15, at 2:56 p.m., indicated the provider had made rounds and had	F 329	medications will have identified target behaviors and care plans that reflect their target behaviors, non-pharmacological interventions and potential side effects noted. All residents with prn psychotropic medications will have identified target behaviors and non-pharmacological intervention in their order as well as care plan. Care plan will also indicate potential side effects of the medication. To be completed by 10-16-15 Random audits of PRN psychotropic medication documentation will be conducted by the DON/designee 2Xwk X3, then weekly x4. Audit results will be brought to the QAPI committee for review and further recommendations. Completion date 10-16-15	

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F 329	Continued From page 14	F 329		

made a change in R14's Zyprexa medication. The provider had ordered for R14's Zyprexa medication to be decreased to 2.5 mg twice a day for one week, then Zyprexa 2.5 mg nightly for three days then Zyprexa 2.5 mg once a day PRN.

R14's PRN Medication Administration Report dated 7/1/15-9/16/15, indicated R14 had been administered clonazepam 0.5 mg on 7/6/15, 7/11/15, 7/18/15, 7/22/15, 8/5/15, 8/8/15, 8/13/15, 8/16/15, 8/17/15, 8/19/15, 8/21/15, 8/25/15, and 9/5/15. The documentation lacked non-pharmacological interventions attempted prior to the administration of these doses of clonazepam. In addition, R14 received Zyprexa 2.5 mg on 9/7/15. The documentation lacked identification of target behaviors for giving this medication and non-pharmacological interventions which had been attempted prior to the administration of the Zyprexa.

On 9/16/15, at 1:21 p.m. the assistant director of nursing (ADON) confirmed R14 had ordered Zyprexa 2.5 mg PRN and clonazepam PRN for anxiety. The ADON verified the Zyprexa lacked the identification of target behaviors and non-pharmacological interventions which should be attempted prior to the administration of the Zyprexa. The ADON was unable to find the documentation of the non-pharmacological interventions attempted prior to the administration of the above noted doses of clonazepam.

On 9/17/15, at 2:16 p.m. the director of nursing (DON) confirmed the above administration dates/times for R14's medical record lacked

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F 329	Continued From page 15 documentation of non-pharmacological interventions attempted prior the administration of the clonazepam medication being given. On 9/17/15, at 4:19 p.m. the consulting pharmacist (CP) stated staff should have been identifying target behaviors and non-pharmacological interventions for residents on an antipsychotic and antianxiety medication. The CP stated each month she has reiterated to the leadership staff that they needed to improve upon their documentation of target behaviors and non-pharmacological interventions. The CP stated it was a system's problem throughout the facility so she has not written this as a recommendation for each individual resident. Target behaviors and non-pharmacological interventions to address the use of a PRN trazodone (antidepressant medication) were not identified for R63. R63's Face Sheet dated 7/23/14, indicated R63's diagnoses to include chronic airway obstruction (difficulty breathing), diabetes, congested heart failure (decrease in heart function to pump blood), anxiety and insomnia. R63's quarterly MDS dated 8/28/15, indicated R63 had no cognitive impairment and had feelings of being tired and having little energy two out of six days during the observation period, and was receiving an antidepressant medication. R63's Physician Order Sheet dated 9/1/15,	F 329		

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indicated R63 had trazodone 12.5 mg (antidepressant medication) ordered to be administered PRN. Target behaviors and non-pharmacological interventions had not been identified for the use of the trazodone.

R63's PRN Medication Administration Report from 7/1/15 - 9/16/15, indicated R63 had received 0.25 mg of trazodone on 8/23/15, 8/24/15, 8/26/15, 8/27/15, 8/31/15, 9/1/15, 9/2/15, 9/3/15, 9/4/15, 9/13/15, and 9/15/15. The documentation lacked identification of target behaviors for giving this medication and non-pharmacological interventions which had been attempted prior to the administration of the trazodone.

On 9/17/15, at 2:53 p.m. the DON confirmed prior to 9/17/15, R63's medical record lacked documentation of target behaviors and non-pharmacological interventions for the use of the PRN trazodone.

R22 was administered PRN antianxiety medication and the facility failed to attempt non pharmacological interventions prior to the administration of the medication.

R22's Face Sheet as of 9/17/15, indicated R22 was diagnosed with schizoaffective disorder, bipolar disorder, generalized anxiety disorder, depressive disorder and end stage renal disease.

R22's quarterly MDS, dated 7/2/15, indicated R22 had intact cognition, felt down and depressed and received antianxiety/antipsychotic medications.

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F 329	Continued From page 17 R22's current Physicians Order Sheet in the electronic record, indicated an order for Lorazepam (Ativan) (antianxiety), tablet, 0.5 milligrams (mg) give one tablet by mouth, as needed (PRN) two times per day for generalized anxiety disorder. Special instructions section indicated nonpharmacological to be attempted prior to the administration of Lorazepam were 1) Redirection 2) One on One and directed staff to chart on nonpharmacological interventions attempted prior to giving the PRN medication. R22's PRN Medication Administration Report from 6/1/15, to 9/15/15, indicated R22 received 20 doses of PRN Lorazepam (Ativan) 0.5 mg and only 5 doses had non-pharmacological interventions documented prior to the administration of the medication. R22's Registered Nurse progress noted dated 7/1/15, indicated R22 received the following psychoactive meds: Zyprexa, Celexa, Ativan, Ambien, Trazadone and Depakote and had diagnoses of bipolar disorder and schizoaffective disorder. The note also indicated R22 had history of screaming, clapping and yelling at staff and would sometimes make irrational requests and get angry if needs or requests were not fulfilled immediately. The note also indicated these behaviors occurred 1-3 times per week and non pharmacological's were sometimes effective in reducing the behaviors and would sometimes respond to a calm approach and empathy. R22's care plan dated 7/1/15, directed staff to	F 329		

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F 329	Continued From page 18 implement the following behavioral interventions -1:1 time when available to help her relax. -Answer call light timely. -Ask resident if there was anything she needed/reason for calling out/disruptive noises. -Attempt to meet residents needs when calling out. -Reapproach as needed -Ask R22 to go back to her room to calm her down, remove from situation should behavior be disruptive for others. -Try to answer resident needs immediately. -Behavior would increase if staff tell her they would be back shortly. -Use distraction and/or redirection -offer activity, food or beverage. The care plan care plan further identified psychotropic drug use with interventions that included to monitor for side effects, allow ample time to make needs known, assess environmental factors, encourage activity attendance, venting of feelings and a calm environment. On 9/16/15, at 1:03 p.m. licensed practical nurse (LPN)-A stated she did not see "a lot" of R22's behaviors during the day, rather the majority of her behaviors occurred in the evening. In addition, LPN-A stated if staff administered the PRN ativan to R22, they would document the use of any nonpharmacological interventions attempted on the PRN Medication Administration Report or in the progress notes. Upon review of the Ativan doses given on 8/25/15, at 6:14 a.m. 8/25/15, at 1:48 p.m., 9/3/15, at 5:44 p.m., 9/13/15, at 11:25 p.m., and 9/15/15, at 9:53 p.m.	F 329		

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F 329	Continued From page 19 LPN-A verified there was no documentation in the record showing that non-pharmacological interventions were attempted or documented prior to the administration of the PRN Ativan and stated, "I don't know why they are not there." On 09/17/2015, at 12:14 p.m. registered nurse (RN)-A verified non-pharmacological interventions were to be attempted and documented prior to administering any prn medication. RN-A stated the documentation should be on the PRN medication form, in the progress notes or in the behavior notes. RN-A verified only 5 doses of R22's PRN Ativan administration had non-pharmacological interventions attempted and documented and the remaining 15 did not have any documentation. RN-A stated " the expectation is for the documentation to be done." ON 9/17/2015, at 12:22 p.m. the DON verified non-pharmacological interventions were to be attempted and documented prior to administering the Ativan or any psychoactive medication. The DON stated during the nurse's meeting, staff had been trained on this requirement and it was expected that staff documented the use of non-pharmacological interventions. R47 was administered antianxiety medication and the facility failed to identify target symptoms of anxiety and non-pharmacological interventions to be attempted prior to the administration of the medicaiton. R47's Face Sheet dated 9/17/15, indicated R47 had diagnoses that included major depressive disorder, hypertension and diabetes.	F 329		

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R47's quarterly MDS dated 8/21/15, indicated R47 had severe cognitive impairment and received antidepressant medication daily. The MDS indicated R47 experienced mood symptoms of feeling tired or having little energy half or more of the days of the assessment period.

R47's Psychotropic Drug Use Care Area Assessment (CAA) dated 6/15/15, indicated R47 received Zoloft 25 milligrams (mg) (an antidepressant medication) once daily. The CAA indicated R47 had reported she had taken it for awhile and had no obvious side effects. The CAA also indicated R47 was a short term resident, the facility would not make any changes to the medication, and would continue to observe for any side effects from the medication.

R47's Physicians Order Sheet dated 9/17/15, included an order for sertraline hcl (Zoloft) 25 mg give 1 tablet by mouth 1 time per day for anxiety.

R47's EMAR Monthly Reports for June, July, August, and September 2015, indicated R47 received sertraline (Zoloft) 25 mg once daily for anxiety from 6/2/15 through 9/17/15 while in the facility.

R47's undated current care plan indicated R47 received antidepressant medication and directed staff to encourage daily activity attendance, observe for common symptoms of dry mouth/dry mucous membranes and review medications on

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rounds with physician. The care plan lacked target symptoms of anxiety and non-pharmacological interventions for anxiety.

On 9/14/15, at 6:10 p.m. R47 was observed attending an activity in the Evergreen common area. No behaviors were observed.

On 9/16/15, at 7:10 a.m. R47 was up and dressed seated in a wheelchair in her room. No behaviors were observed.
-at 11:18 a.m. R47 was seated in a wheelchair at a table in the dining room. No behaviors observed.
-at 12:49 p.m. R47 was seated in a wheelchair in her room. R47 responded pleasantly when greeted and made eye contact. She stated she was doing well and indicated was satisfied with her medication regime.

On 9/17/15, at 3:01 p.m. the DON verified the indication for use of the Zoloft was anxiety and depression and confirmed there were no target symptoms of anxiety identified for R47. There DON also confirmed there were no non-pharmacological interventions identified for R47's anxiety.

On 9/17/2015, at 4:19 p.m. the CP stated the facility should have identified target symptoms of R47's anxiety and should have developed non-pharmacological interventions for the anxiety. The CP stated she provided the facility monthly reports on individual resident issues as well as an executive summary of issues identified at a

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F 329	Continued From page 22 facility level. The CP indicated she had identified and communicated both verbally and in writing multiple times her recommendation to identify target behaviors and non-pharmacological interventions for residents receiving psychotropic medications. The CP indicated she had last addressed this issue as a system problem with the facility in August. Upon request, on 9/17/15, at 4:30 p.m. the DON provided the Nursing Report July 2015, and Nursing Report August 2015. Both reports identified facility irregularities for nursing staff to address and recommended the facility needed to be sure target behaviors and non-pharmacological interventions were on the care plan/medication administration record for all psychotropic medications. The reports identified these items were missing occasionally. The undated Psychotropic Medication policy indicated the facility supported the goal of determining the underlying causes of behavioral symptoms so the appropriate treatment of environmental, medical, and/or behavioral interventions could be utilized to meet the needs of the resident and identified psychotropic medications to include anti-anxiety/hypnotic, antipsychotic and antidepressant classes of drugs. The policy indicated actions required included identification of target symptoms and orders for PRN psychotropic medications would be time limited (i.e. times 2 weeks) and only for specific clearly documented circumstances.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		10/9/15

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F 371	Continued From page 23 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the meat slicer was cleaned and sanitized after use in order to prevent the contamination of food. This had the potential to affect 62 of 64 residents who received their meals from the kitchen. Findings include: On 9/14/15, at 2:00 p.m. during the initial kitchen tour with the dietary manager (DM), the facility meat slicer was observed to have pieces of dried meat and residue on the blades and on the base of the machine. The DM verified the findings and stated the meat slicer was not clean, however, also stated it had just been used that day. At this time, the DM asked the evening cook to clean it. When asked how staff cleaned and sanitized the meat slicer, the DM stated it had to be cleaned in the three compartment sink because it would not fit inside the dishwasher. The DM stated staff used sanitation chemicals in the three compartment sink and staff used chemical paper	F 371	The meat slicer was cleaned and sanitized 9/17/2015. No further debris/residue on meat slicer noted after cleaning by Dietary Manager. All Dietary Staff were educated on cleaning the meat slicer on 9/21/2015. Meat slicer must be cleaned and sanitized after each use. Documentation of chemical sanitizer will be documented on new form when 3 compartment sink is used. Staff has been educated on 10/9/2015 on how to document chemical sanitizer test strips. Audits will be completed for the first four uses every time the slicer is used. Staff will notify Dietary Manager or designee when used. Then audits will be completed randomly for twelve months to ensure meat slicer is clean and documentation completed. All audits will come quarterly to the QAPI committee meeting.	

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F 371	Continued From page 24 testing strips to ensure the chemical sanitizer was within the recommended sanitizing solution. When asked to see the logs to verify the appropriate sanitization method was utilized in the sink, the DM stated the facility had not logged / documented any of the test strip results because the three compartment sink was not used that often as everything else went in the dishwasher. On 9/16/15, at 1:10 p.m. the DM lifted the cover off the meat slicer and it was again observed to be unclean with pieces of dried debris / residue on the blades and the base of the machine. The DM confirmed it was not cleaned. The DM stated she was unsure if the staff person had utilized the three compartment sink to clean the meat slicer or not. On 9/17/1,5 at 11:44 a.m. the administrator stated if cooking equipment was not cleaned or sanitized properly it had the potential to effect all residents that received food from the kitchen. The facility undated Dietary Policy for: Pots and Pans included Three compartment sink washing. The policy indicated utensils and dishes washed by hand will be clean and sanitized. The Procedure included: Check chemical sanitizer with Hydrion PapersQT-40. Immerse for 30 seconds. Compare when wet to 150-400 parts per million.	F 371	Completed 10/9/15	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		10/9/15

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F 431	Continued From page 25 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper medication storage and security for 1 of 4 medication/treatment carts (Evergreen unit) was	F 431	All licensed staffed and TMAs were educated on locking of the medications carts when not in direct view of the medication cart on 10-1-15	

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F 431	Continued From page 26 maintained. In addition, the facility failed to ensure expired medications were removed from 2 of 4 carts that stored medications Findings include: The Evergreen unit medication cart was left unlocked and unattended. On 9/15/15, at 2:22 p.m. the medication cart on the Evergreen unit was observed unlocked and parked outside and to the left of the nurses station. Licensed practical nurse (LPN)-A was seated behind the nurses station with her back to the medication cart working on the computer. The cart was continuously observed to be unattended until 2:27 p.m. -at 2:27 p.m. LPN-E returned to the cart with plastic cups. -at 2:29 p.m. LPN-E confirmed the cart should be locked if left unattended. On 09/17/2015, at 3:18 p.m. the director of nursing (DON) stated the medication cart should have been locked when unattended. The Medication Administration policy dated 8/15, indicated med carts were to be locked at all times when not giving medications and at any time the cart was unattended by the medication nurse. The medication and treatment carts on the Evergreen unit contained expired medications. On 9/17/15, at 1:48 p.m. the Evergreen medication cart was reviewed with LPN-D. The medication cart was found to have one bottle of latanoprost 0.005% eye drops with no open date	F 431	All residents with Xalatan eye drops have an order in the computer to order a new bottle on day 38 and when new bottle arrives to discard the old bottle and use new bottle. The date of dispense will be used as the date of opening. This order will also be used for all new admissions that enters the building with Xalatan eye drops. All licensed staff and TMAs were educated on 10-1-15 about the new ordering process for Xalatan eye drops as well as discarding the old bottle and opening the new bottle when it arrives. Residents should only have one bottle of eye drops in the med/tx cart. Random audits will be completed to ensure med/tx carts are locked when staff are not in director view of the med/tx carts 2x per week for 2 weeks and weekly for 4 weeks. Random audits of the med/tx cart will be done to ensure staff are ordering and using the new eye drop bottle will be conducted by the DON/designee weekly x4. Audit results will be brought to the QAPI committee for review and further recommendations. Completion date: 10/9/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	09/17/2015

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 431	Continued From page 27	F 431		

identified and a dispense date of 7/27/15, another bottle of latanoprost 0.005% eye drops with no open date identified and a dispense date of 5/14/15, and a third bottle of latanoprost 0.005% eye drops with no open date identified and a dispense date of 4/11/15. LPN-D verified the findings.

On 9/17/15, at 2:33 p.m. the Evergreen unit treatment cart was reviewed with LPN-A. The treatment cart was found to have one bottle of latanoprost 0.005% eye drops with an open date identified as 5/14/15. LPN-A verified the eye drops were expired. The treatment cart was also found to have a second bottle of latanoprost 0.05% eye drops with no open date identified. The eye drop bottle was stored in a pill bottle with a pharmacy label identifying the dispense date at 5/4/15. LPN-C verified the findings.

An undated, two page form titled "Medications with Shortened Expiration Dates" with a Thrifty White Pharmacy logo was provided as the facility guidelines for medications. The form indicated Xalatan (generic name: latanoprost) Ophthalmic solution was to be discarded after 42 days. General guidelines indicated the date of opening should be noted on each medication and if a medication was not dated when opened, the date of dispensing from the pharmacy was to be used as the date of opening.

On 9/17/2015, at 3:23 p.m. the director of nursing (DON) confirmed the "Medications with Shortened Expiration Dates" provided by Thrifty White Pharmacy was the facility policy regarding medications. The DON confirmed eye drops should have been dated when opened and verified the latanoprost eye drops were expired.

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F 431	Continued From page 28 The DON confirmed the expired medications should have been removed from use / carts.	F 431		

Thief River Care Center

9/17/2015

Draft

F272- D Based on observation, interview, and document review the facility failed to complete a comprehensive accurate dental assessment for 1 of 1 resident (R30) reviewed for dental problems.

F309 –D Based on interview and document review, the facility failed to provide appropriate monitoring and assessment for 1 of 1 resident (R63) who was reviewed displaying high blood glucose levels.

F325-D Based on observation, interview, and document review the facility failed to comprehensively assess nutritional risk and develop interventions to minimize the risk of weight loss for 2 of 3 residents (R41, R63) reviewed for nutrition.

F329- E Based on interview and document review, the facility failed to identify target behaviors and implement non-pharmacological interventions for 2 of 2 resident (R14, R47) who was receiving an as needed (PRN) antipsychotic medication or scheduled antidepressant medication. In addition, the facility failed to ensure non-pharmacological interventions were attempted prior to the administration of an as needed (PRN) antianxiety/antidepressant medications for 3 of 3 residents (R14, R22, R63) whose medication regimes were reviewed.

F371-E Based on observation, interview and document review the facility failed to provide sanitary conditions in the kitchen, and prevent the contamination of food. This would have the potential to affect 62 of 64 residents who received their meals from the kitchen.

F431-E Based on observation, interview and document review, the facility failed to ensure proper medication storage and security for 1 of 4 medication/treatment carts (Evergreen unit) were maintained. In addition, the facility failed to properly label insulin pens/vial when opened for 2 of 4 residents (R49 , R43) reviewed who received insulin and properly label eye drops when opened for 5 of 11 residents (R71, R11, R38, R78, R22) who received eye drops.

MN LIC: 4658.0810 – Based on interview, and document review the facility failed to ensure an Annual TB risk assessment was completed.

MN LIC: 4658.1426 the facility failed to ensure 2 of 5 staff and 1 of 5 (R73) residents two step TST were completed.

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	245252	A. BUILDING **02 - THEIF RIVER CARE CENTER NEW BLDG** B. WING _____	**09/15/2015**

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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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Thief River Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

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

Electronically Signed | 10/12/2015

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

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	245252	A. BUILDING **02 - THEIF RIVER CARE CENTER NEW BLDG** B. WING _____	**09/15/2015**

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Thief River Care Center building was constructed in 2011 is 1-story, without a basement and was determined to be of a Type II (000) construction. The building is divided into three smoke zones by 90-minute fire barriers. The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems 1999 edition. The facility has a fire alarm system with automatic smoke detection in the all corridors and in all common use spaces in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have smoke detection with other hazardous areas have automatic fire detectors, that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm is monitored for automatic fire department notification.	K 000		

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	245252	A. BUILDING **02 - THEIF RIVER CARE CENTER NEW BLDG** B. WING _____	**09/15/2015**

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K 000	Continued From page 2 The facility has a capacity of 70 beds and had a census of 68 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to provide 1 of several exit discharge walking surfaces in accordance with NFPA 101 Life Safety Code (00) edition, Sections 19.2.7, and 7.1.6.2. This deficient practice could affect residents, staff and visitors if emergency evacuation via this discharge was necessary. Findings include: On facility tour between 10:30 AM to 1:30 PM on 09/15/2015, it was observed that there were 7 of 9 required exterior exit discharge paths that had a 1/2 inch change in elevation due to the cement sidewalk settling at the first expansion joint that is located 48 inches from the exit door. These deficient practices were confirmed by the Maintenance Supervisor (LL).	K 038	For 7 of the 9 required exterior exit discharge paths that have an half inch change in elevation due to the cement sidewalk settling at the first expansion joint that is located 48 inches from the exit door we are having contractors to remove or replace the mud jacks of the sinking paths back to the proper level. The maintenance staff has been educated on what our plan is for the exit discharge paths on 9/15/15. There will be quarterly audits that will occur during the maintenance facility inspection event that has been added to the current inspection check lists. All results will be brought to the QAPI committee meeting on a quarterly basis.	11/17/15

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K 038	Continued From page 3	K 038	Completion date 11/17/15.	
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting residents, staff, and visitors of the facility. Findings include: On facility tour between 10:30 AM to 1:30 PM on 09/15/2015, observations revealed that there was a smoke detectors that is located within 36 inches of a HVAC diffusers located in the Laundry room near the bank of dryers.	K 052	The smoke diffusers that was located within 36 inches of the HVAC system in the laundry room by the bank of dryers was moved on 9/15/15 over one complete 2' X 2' ceiling tile making it more than the 36" minimum distance from the air diffuser. All other smoke diffusers located throughout the building have been audited. Quarterly audits will be done on the smoke diffusers throughout the building for one year by the Environmental Services Director or the Maintenance employee. Maintenance staff was educated on 9/15/15 to help ensure that smoke diffusers are not located within 36 inches of the HVAC system. As a preventative measure maintenance staff is adding the inspection of all smoke	10/16/15

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K 052	Continued From page 4 These deficient practices were confirmed by the Maintenance Supervisor (LL).	K 052	detectors to the facility inspection form. This will ensure that all smoke detectors are and remain a minimum of 36" from any HVAC air diffuser All results will be brought to the QAPI committee meeting on a quarterly basis. Completion date of 10/16/15.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 2, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5252025

Dear Ms. Halvorson:

The above facility was surveyed on September 14, 2015 through September 17, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 Gloria Derfus at (651) 201-3792 or email: gloria.derfus@state.mn.us.**

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

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

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

Sincerely,

Mark Meath

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	09/17/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 9/14/15, 9/15/15, 9/16/15, and 9/17/15 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 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 observation, interview and document review, the facility failed to provide appropriate monitoring and assessment for 1 of 1 resident (R63) who was reviewed with high blood glucose levels. Findings include: R63's Face Sheet dated 7/23/14, indicated R63's diagnoses included chronic airway obstruction (difficulty breathing), diabetes, congested heart failure (decrease in heart function to pump blood), anxiety, renal failure (kidney failure),	2 830	R63¿s Diabetic care was reviewed with her Physician and her POC was revised, R63 will be followed by the Diabetic educator for insulin management. We will be updating the Diabetic educator every 2 weeks until blood sugars are stable between 200 and 300. Staff is to monitor and record for signs/symptoms of hyperglycemic responses when she is having high blood sugars. The facility Blood Glucose Policy was reviewed and revised to include direction	10/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 macular degeneration (poor vision), peripheral autonomic neuropathy (peripheral nerve damage often caused by diabetes). R63's care plan dated 8/29/14, indicated R63 was diabetic and directed staff to conduct glucose monitoring as ordered and to monitor for signs and symptoms of hypoglycemia (low blood glucose levels) and hyperglycemia (high blood glucose levels). R63's quarterly Minimum Data Set (MDS) dated 8/28/15, indicated R63 had no cognitive impairment and was on insulin daily. R63's Physician Order Sheet dated 9/1/15, indicated R63 was scheduled to receive the following medication for her diabetes: - Lantus (insulin) 12 units subcutaneous (injection into the subcutaneous tissue - SQ) every 8:00 a.m. - Lantus 4 units SQ every 8:00 p.m. - Humalog (insulin) 2 units SQ every 5:00 p.m. - Humalog sliding scale (scale utilized to determine the amount of insulin to be given depending on the blood glucose level at the time) twice a day before meals at 8:00 a.m. and 12:00 noon: o Hold if blood sugar is less than 200 milligrams per deciliter (mg/dL) o Give 2 units if blood sugar between 201-250 mg/dL o Give 4 units if blood sugar between 251-300 mg/dL o Give 6 units if blood sugar between 301-350 mg/dL o Give 7 units if blood sugar is greater than 7 units mg/dL - Humalog 2 units SQ if blood sugar greater	2 830	on what to do if a resident is hypoglycemic or hyperglycemic. Nursing staff were reeducated on the revised Glucose Testing Policy and on R63¿s revised Diabetic POC will be completed by 10/16/2015. All residents with Glucose monitoring were assessed to ensure appropriate monitoring and assessment for high and/or low blood sugars is in place by 10/9/2015. (Directions and documentation present in EMR) Random audits of documentation of blood glucose monitoring and follow up as needed will be conducted by the DON/designee 2Xwk X3, then weekly x4. Audit results will be brought to the QAPI committee for review and further recommendations. Completion date: 10/16/15	

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	00448	A. BUILDING: _____ B. WING _____	09/17/2015

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2 830	Continued From page 4 than 500 mg/dL On 9/16/15, at 7:48 a.m. R63 was observed walking to the dining room for breakfast. On 9/16/15, at 10:51 a.m. licensed practical nurse (LPN)-D conducted a blood glucose check on R63. R63's blood glucose level reading at this time was 404 mg/dL. R63's A1C (blood test which indicated how well blood glucose levels have been controlled over the last 2-3 months) results were: - 6/4/15, 13.0 - value identified as being high (reference range 4.3-5.7) - 4/9/15, 12.6 - value identified as being high (reference range 4.3-5.7) On 9/17/15, at 11:23 a.m. registered nurse (RN)-B stated R63 was to have her blood sugar level checked four times a day (before each meal and at bedtime). RN-B confirmed R63's last three months of blood sugar reading results as listed below and verified R63's medical record lacked documentation of a recheck on any of these high readings: - 9/11/15, at 9:03 p.m. blood glucose result = 548 mg/dL - 9/10/15, at 9:23 p.m. blood glucose result = 560 mg/dL - 8/30/15, at 9:01 p.m. blood glucose result = 555 mg/dL - 8/30/15, at 5:15 p.m. blood glucose result = 595 mg/dL - 8/24/15, at 8:54 p.m. blood glucose result = 600 mg/dL - 8/18/15, at 8:31 p.m. blood glucose result = 561 mg/dL - 8/17/15, at 7:31 p.m. blood glucose result =	2 830		

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2 830	Continued From page 5 562 mg/dL - 8/17/15, at 8:47 p.m. blood glucose result = 562 mg/dL - 8/15/15, at 7:22 p.m. blood glucose result = 600 mg/dL - 8/2/15, at 9:37 p.m. blood glucose result = 541 mg/dL - 7/28/15, at 10:14 p.m. blood glucose result = 513 mg/dL - 7/28/15, at 8:23 p.m. blood glucose result = 556 mg/dL - 7/18/15, 3:53 p.m. blood glucose result = 530 mg/dL - 7/14/15, at 7:24 p.m. blood glucose result = 554 mg/dL - 7/7/15, at 9:36 p.m. blood glucose result = 511 mg/dL - 7/7/15, at 11:59 a.m. blood glucose result = 557 mg/dL - 7/2/15, at 8:40 p.m. blood glucose result = 517 mg/dL - 7/1/15, at 5:23 p.m. blood glucose result = 554 mg/dL - 6/29/15, at 8:13 p.m. blood glucose result = 531 mg/dL - 6/28/15, at 9:12 p.m. blood glucose result = 541 mg/dL - 6/25/15, at 9:04 p.m. blood glucose result = 531 mg/dL - 6/24/15, at 3:37 p.m. blood glucose result = 562 mg/dL - 6/23/15, at 9:43 p.m. blood glucose result = 600 mg/dL R63's progress note dated 7/28/15, at 10:14 p.m. indicated R63 was hyperglycemic and had no odor or acetone on her breath. However, R63's progress notes for the other dates and times of the high blood glucose readings noted above lacked documentation related to an assessment	2 830		

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2 830	Continued From page 6 for signs and symptoms of hyperglycemia. The Consultant Pharmacist's Medication Review for R63 dated 5/28/2015, indicated R63's A1C was up to 12 from 10 and the suggested course of action indicated R63 was a brittle diabetic and the past recommendation for insulin adjustment had been declined as R63 had a history of falls from hypoglycemia. The pharmacist recommended a need to identify A1C and blood sugar goals for R63. The follow up action indicated by medical doctor (MD)-A was that an A1C had been done. No goals had been recommended by the MD. The Nurse Communication to Physician Order dated 4/8/15, indicated R63 had been hyperglycemic with symptoms and requested any changes. MD-A's response dated 4/9/15, indicated no changes as R63 was brittle and to give 2 units insulin for blood sugars greater than 500 mg/dL. R63's physician progress note dated 8/22/15, indicated R63 was receiving Lantus 12 units in the morning and 4 units at night and sliding scale Humalog. In addition, acknowledgement of R63's blood glucose level being over 600 mg/dL and that R63 was a brittle diabetic with past episodes of hypoglycemia. On 9/17/15, at 9:21 a.m. RN-B stated for blood glucose levels over 500 she would normally notify the physician and would recheck the blood glucose level in 30 minutes. RN-B stated she would especially recheck R63's blood sugar level within 30 minutes if R63's blood sugar levels were over 500. On 9/17/15, at 2:32 p.m. the director of nursing	2 830		

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2 830	Continued From page 7 (DON) stated R63 used to have an order for nursing to give an additional 2 units of Humalog insulin every one hour until 8:00 p.m. or until R63's blood glucose level went below 500. On 9/17/15, at 3:45 p.m. the DON stated she would not expect staff to recheck R63's blood glucose level even if it read "high", nor would it be an expectation of staff to notify the physician if R63's blood glucose level was over 500 because they (physician) would ask what we wanted them to do about it. The DON stated she would expect staff to document if R63 was having any signs and symptoms of hyperglycemia. The DON stated the goal was to maintain R63's blood glucose levels between 200-300 mg/dL. The DON verified R63's 600 mg/dL readings could have been higher than 600 as the glucose machine only read "high" when a blood sugar was above 600 mg/dl. The DON also stated staff were unable to document "high" on the monitoring form so they wrote 600 mg/dL as that was the highest reading the machine read. The DON also confirmed it had been a long time ago since R63 had been hospitalized for a hypoglycemic episode. On 9/17/15, at 4:38 a.m. the consulting pharmacist confirmed nursing staff should have been monitoring R63 for signs and symptoms of hyperglycemia and rechecking R63's blood glucose levels when they were reading over 500 mg/dL. The Assure Platinum blood glucose monitoring system manufacture instructions indicated if blood glucose levels are above 600 mg/dL, the machine will read "Hi". The test should be repeated with a new test strip and if this message showed again, contact the healthcare	2 830		

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2 830	Continued From page 8 professional immediately! Contact the physician for advice if test results are very high and/or show symptoms of high blood glucose. The Blood Glucose Testing policy dated 4/13, provided instructions on how to obtain a blood glucose sample, however did not give direction on what to do if a resident was hypoglycemic or hyperglycemic. No policy on critical value reporting or notification of clinical change to the provider were provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review and revise polices for monitoring and assessment of blood glucose levels and provide additional training to involved staff. A designated staff could monitor the system to assure monitoring and assessment are being completed and residents are supported to receive adequate interventions. The quality assurance committee could provide on going monitoring of the process to assure monitoring and assessments of blood glucose levels are being responded to appropriately. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food	2 965		10/16/15

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2 965	Continued From page 9 served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess nutritional risk and implement appropriate interventions in order to minimize the risk of weight loss for 1 of 3 residents (R63) reviewed who was underweight. Findings include: R63 was underweight and continued to slowly lose weight and facility failed to complete a comprehensive nutritional assessment and implement appropriate interventions to address weight loss. R63's Face Sheet dated 7/23/14, indicated R63's diagnoses included chronic airway obstruction (difficulty breathing), diabetes, congested heart failure (decrease in heart function to pump blood), anxiety, renal failure (kidney failure) and underweight. R63's quarterly Minimum Data Set (MDS) dated 8/28/15, indicated R63 had no cognitive impairment, had feelings of being tired and having little energy, required set up assistance only with meals and was on a therapeutic diet. R63's care plan dated 2/23/15, indicated R63 had	2 965	R63 was seen by RD on 9-17-15. R63 stated she doesn¿t want supplements and feels this is a good weight for her. DM spoke with R63 and R63 feels that 97# is her ideal body weight and would only be concerned about her weight if is fell below 95#. R63 weight range will be from 95 to 105# per input from R63, IDT and consult DM. All residents with a BMI < 18.5 will have identified ideal body weights and weight range goals, unless the resident¿s clinical condition demonstrates that it is not possible. Residents will be assessed for appropriate interventions to maintain and increase weight as needed. DM will make notes with the identified information and adjust the care plan on identified residents. DM will refer all residents whose BMI drops below 18.5 to the RD for review and recommendations. Random audits of documentation of nutritional assessment will be conducted by the DON/designee 2Xwk X3, then weekly x4. Audit results will be brought to the QAPI committee for review and further recommendations. Completion date: 10/16/2015	

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2 965	Continued From page 10 a potential for weight loss. Interventions included to provide R63 with nutritional extra calories for weight maintenance or weight gain and to provide R63 sugar free hot chocolate and whole milk. R63's dietary risk assessment conducted on 8/27/15, indicated R63 was a moderate dietary risk. Nurse communication note to the physician dated 8/27/15, indicated R63 was currently on an 1800 calorie diet and that R63 never met this caloric intake goal. R63's resident dietary assessment dated 8/27/15, indicated R63 was on a therapeutic diet and was not on a planned weight loss program. R63's physician orders dated 9/1/15, directed staff to provide R63 with a cup of hot chocolate with whole milk once a day at 9:00 a.m. On 9/16/15 at 7:48 a.m. R63 was served her breakfast in the dining area which consisted of a cup of coffee, glass of tomato juice, toast and a bowl of peaches (no hot chocolate with whole milk). On 9/17/15, at 8:37 a.m. R63 confirmed she had coffee to drink for breakfast and no hot chocolate with whole milk. R63's weight history was:	2 965		

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2 965	Continued From page 11 - 9/15/15 - 97.8 pounds - 8/14/15 - 97.8 pounds - 7/17/15 - 98.6 pounds - 6/19/15 - 99.2 pounds - 6/8/15 - 103.8 pounds Dietary note dated 9/15/15, indicated R63 was on a consistent carb diet (diabetic diet) and had a supplement ordered which was whole milk with no sugar added hot chocolate. In addition, R63's weight had been stable with a slight weight loss. R63's body mass index (BMI - (index utilized to assess when a person is overweight or underweight) was 16.2, which indicated R63 was underweight. R63 had tried other supplements in the past, but didn't like them or they affected her blood sugar too much. R63 liked the whole milk with no sugar added hot chocolate, however, refused it during the summer months on some days. R63 ate small portions of food, but usually consumed 50-100% of her meals. Most current registered dietician (RD) note dated 8/23/14, indicated R63 had had some weight loss. It was suggested for R63 to have protein and fat through her food with every meal. In addition, it was recommended R63 be on a nutritional supplement to help stop continued weight loss. Recommendation was to provide R63 with Glucerna (nutritional supplement) twice a day. Contact the RD with any further nutritional questions or concerns. RD will follow as needed. R63's medication administration record for August	2 965		

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2 965	Continued From page 12 and September 2015, lacked documentation that R63 had been provided hot chocolate and whole milk daily. On 9/16/15, at 11:00 a.m. R63 stated she had tried ensure and boost (both nutritional supplements) and she didn't like them. R63 stated the hot chocolate and whole milk was okay. R63 stated she liked ice cream and malts. On 9/17/15, at 11:18 a.m. registered nurse (RN)-B confirmed R63 was weighed weekly and verified R63 had continued to lose weight. On 8/27/15, at 11:38 a.m. dietary manager (DM) confirmed R63 had been on Glucerna (nutritional supplement), however that had been discontinued on 10/29/14. The DM confirmed R63 was slowly still losing weight. The DM stated R63 did have a slight weight gain when R63 was drinking the hot chocolate and whole milk, however, when summer came R63 didn't want it because of the heat. The DM verified R63's BMI was 16.2 on 9/15/15, which indicated R63 was underweight. The DM verified the RD had not been involved with R63's care in at least the past six months. The DM confirmed she would refer any resident who had significant weight loss or gain to the RD for further assessment and would definitely refer a resident who was underweight like R63 or if the DM was having a difficult time finding supplements which met the preferences of the resident. On 9/17/15, at 1:46 p.m. an attempt to contact the RD was made. The RD was unable to return	2 965		

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2 965	Continued From page 13 a call during this survey time. The job description for the consulting dietician indicated the RD would review and chart on residents that were at high risk, weight loss/change, wounds, new admissions, annual MDS's or that required assessments and charting for a variety of reasons. The job description for the DM included under the nutritional and clinical management portion: - determine residents' diet needs and develop appropriate plan in cooperation with the RD - review, revise, and implement the nutrition assessment and plan of care No policy on nutritional risk and assessment was provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review and revise polices for nutritional assessments and the implementation of nutritional supplements. The DON or designee could provide education to involved staff. The DON or designees could develop an auditing system to ensure nutritionally at risk residents are assessed and nutritional interventions have been implemented. The quality assurance committee could provide on going monitoring of the process to assure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		

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21155	MN Rule 4658.0675 Subp. 5 Mechanical Cleaning and Sanitizing; Chemical Subp. 5. Chemical sanitization. Single-tank machines, stationary-rack machines, door-type machines, and spray-type glass washers using chemicals for sanitization may be used, provided that: A. wash water temperatures, addition of chemicals, rinse water temperatures, and chemical sanitizers used are in conformance with NSF International Standard No. 3, incorporated by reference in subpart 2, and Standard No. 29, Detergent and Chemical Feeders for Commercial Spray-Type Dishwashing Machines, issued by NSF International, November 1992. These standards are incorporated by reference. They are available through the Minitex interlibrary loan system. They are not subject to frequent change; B. a test kit or other device that accurately measures the parts per million concentration of the sanitizing solution must be available and be used, and a log of the test results must be maintained for the previous three months; C. containers for storing the sanitizing agent must be installed in such a manner as to ensure that operators maintain an adequate supply of sanitizing compound; and D. a visual or audible warning device must be provided for the operator to easily verify when the sanitizing agent is depleted. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the meat slicer was cleaned and sanitized after use in order to prevent the contamination of food. This had the potential to affect 62 of 64 residents who received	21155	The meat slicer was cleaned and sanitized 9/17/2015. No further debris/residue on meat slicer noted after cleaning by Dietary Manager.	10/9/15

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21155	Continued From page 15 their meals from the kitchen. Findings include: On 9/14/15, at 2:00 p.m. during the initial kitchen tour with the dietary manager (DM), the facility meat slicer was observed to have pieces of dried meat and residue on the blades and on the base of the machine. The DM verified the findings and stated the meat slicer was not clean, however, also stated it had just been used that day. At this time, the DM asked the evening cook to clean it. When asked how staff cleaned and sanitized the meat slicer, the DM stated it had to be cleaned in the three compartment sink because it would not fit inside the dishwasher. The DM stated staff used sanitation chemicals in the three compartment sink and staff used chemical paper testing strips to ensure the chemical sanitizer was within the recommended sanitizing solution. When asked to see the logs to verify the appropriate sanitization method was utilized in the sink, the DM stated the facility had not logged / documented any of the test strip results because the three compartment sink was not used that often as everything else went in the dishwasher. On 9/16/15, at 1:10 p.m. the DM lifted the cover off the meat slicer and it was again observed to be unclean with pieces of dried debris / residue on the blades and the base of the machine. The DM confirmed it was not cleaned. The DM stated she was unsure if the staff person had utilized the three compartment sink to clean the meat slicer or not.	21155	All Dietary Staff were educated on cleaning the meat slicer on 9/21/2015. Meat slicer must be cleaned and sanitized after each use. Documentation of chemical sanitizer will be documented on new form when 3 compartment sink is used. Staff has been educated on 10/9/2015 on how to document chemical sanitizer test strips. Audits will be completed for the first four uses every time the slicer is used. Staff will notify Dietary Manager or designee when used. Then audits will be completed randomly for four months to ensure meat slicer is clean and documentation completed. All audits will come quarterly to the QAPI committee meeting.	

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21155	Continued From page 16 On 9/17/1,5 at 11:44 a.m. the administrator stated if cooking equipment was not cleaned or sanitized properly it had the potential to effect all residents that received food from the kitchen. The facility undated Dietary Policy for: Pots and Pans included Three compartment sink washing. The policy indicated utensils and dishes washed by hand will be clean and sanitized. The Procedure included: Check chemical sanitizer with Hydrion PapersQT-40. Immerse for 30 seconds. Compare when wet to 150-400 parts per million. SUGGESTED METHOD OF CORRECTION: The Dietary Manager (DM) could review and revise policies and procedures for sanitary conditions in the Dietary Department and provide appropriate training for involved staff. The DM could monitor the system to assure sanitation standards are maintained. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21155		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's	21426		10/16/15

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21426	Continued From page 17 Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R73) and 2 of 5 employees (LPN-C, NA-B) received the tuberculin skin testing (TST) according to the Centers for Disease Control and Prevention (CDC) guidelines. Findings include: RESIDENT TST: R73 was admitted to the facility on 5/28/14. R73's electronic medical record indicated R73 received the first step TST on 5/28/14, and this test was read as negative and 0 millimeters (mm) induration on 7/3/14 (36 days later). On 9/17/15, at 2:36 p.m. director of nursing (DON) confirmed the above documentation was reflected in R73's medical record.	21426	Corrected	

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21426	Continued From page 18 EMPLOYEE TST: Licensed practical nurse (LPN)-C's hire date was 5/19/15. LPN-C's TST administration form indicated LPN-C received the first step of her TST on 5/19/15. This test was read on 5/21/15, with a negative - 0 mm result. However, LPN-C lacked the completion of the second step TST. Nursing assistant (NA)-B's hire date was 4/1/15. NA-B's TST administration form indicated NA-B received the first step of her TST on 4/1/15. This test was read on 4/1/15, with a negative - 0 mm result (read the same day it had been administered). NA-B received her second step TST on 4/22/15. This test was read on 4/24/15, with a negative - 0 mm result. On 9/17/15, at 10:28 a.m. the DON confirmed according to NA-B's TST administration form, NA-B's first step TST had been administered and read on the same day (4/1/15) and should not have been. On 9/17/15, at 1:56 p.m. The DON confirmed LPN-C did not have her second step TST completed and should have. The Tuberculosis policy dated 4/15, indicated all employees would be required to have a baseline TB screening completed at the time of hire. The baseline TB screening consisted of assessment for current symptoms of active TB disease and	21426		

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21426	Continued From page 19 testing for the presence of infection by administering the two step TST. The two step TST process involved an initial TST with a repeat completed in 1-3 weeks, if the employee was negative. In addition, each resident admitted would have completed a TB screening for symptoms and a standard two step TST. The TST administration form, indicated results of a TST would be read between 48-72 hours of the test being administered. In addition, if the first step TST results were negative, a second step would be completed in one to three weeks after the administration of the first step TST.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992.	21535		10/16/15

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21535	Continued From page 20 This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to identify target behaviors and implement non-pharmacological interventions for 3 of 3 residents (R14, R63, R47) who received an as needed (PRN) antipsychotic medication or a PRN or scheduled antidepressant medication. In addition, the facility failed to ensure non-pharmacological interventions were attempted prior to the administration of a PRN antianxiety/antidepressant medication for 2 of 2 residents (R14, R22). Findings include: Target behaviors and non-pharmacological interventions to address the use of a PRN Zyprexa (antipsychotic medication) were not identified for R14. In addition, non-pharmacological interventions were not implemented prior to the use of a PRN clonazepam (antianxiety medication) for R14. R14's Disease Diagnosis and Allergies sheet dated 9/17/15, indicated R14 had diagnoses that included anxiety, depression, hypertension and muscle weakness. R14's quarterly Minimum Data Set (MDS) dated	21535	R63 target behaviors and non-pharmacological have been added to her prn medication order. R14 prn Zyprexia was discontinued by Dr. K on 9-18-15. R22 target behaviors added to medication order and care plan was updated to include her target behaviors and non-pharmacological interventions. All licensed nursing staff and TMAs educated on order entry for psychotropic medication. Orders must contain proper diagnosis, target behaviors, and non-pharmacological interventions in the order for prn medications and target behaviors for scheduled medications. Staff also educated on when providing prn medication they must try non-pharm intervention prior to providing the medication. Their behavior note needs to include the behavior and non-pharm intervention, as well as follow-up after administering the medication. Education provided on 10-1-15 All resident with scheduled psychotropic medications will have identified target behaviors and care plans that reflect their target behaviors, non-pharmacological interventions and potential side effects noted. All residents with prn psychotropic medications will have identified target	

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21535	Continued From page 21 7/7/15, indicated R14 had no cognitive impairment and had trouble sleeping. R14's care plan identified R14 received an antianxiety medication. Approaches identified to address this problem area included encourage resident to ventilate feelings, explore reasons for resident's distress, environmental stressors, psychosocial stressors and treatable medical conditions. R14' s PRN Medication Administration Report dated 7/1/15 - 9/16/15, indicated the physician had ordered that R14 could be given Zyprexa 2.5 milligrams (mg) (antipsychotic medication) once a day PRN. Target behaviors and non-pharmacological interventions had not been identified for the use of the Zyprexa. In addition, the physician had ordered that R14 could be given clonazepam 0.5 mg (antianxiety medication) once a day PRN. Target behaviors identified for the use of the clonazepam were repetitive complaints, nervous statements, paranoia and feeling uneasy. Non-pharmacological interventions identified to be used prior to the administration of the PRN clonazepam included 1:1 time, playing cards, movie and bring R14 to her room. R14's progress note dated 8/21/15, at 2:56 p.m., indicated the provider had made rounds and had made a change in R14's Zyprexa medication. The provider had ordered for R14's Zyprexa medication to be decreased to 2.5 mg twice a day for one week, then Zyprexa 2.5 mg nightly for three days then Zyprexa 2.5 mg once a day PRN.	21535	behaviors and non-pharmacological intervention in their order as well as care plan. Care plan will also indicate potential side effects of the medication. To be completed by 10-16-15 Random audits of PRN psychotropic medication documentation will be conducted by the DON/designee 2Xwk X3, then weekly x4. Audit results will be brought to the QAPI committee for review and further recommendations. Completion date: 10/16/15	

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21535	Continued From page 22 R14's PRN Medication Administration Report dated 7/1/15-9/16/15, indicated R14 had been administered clonazepam 0.5 mg on 7/6/15, 7/11/15, 7/18/15, 7/22/15, 8/5/15, 8/8/15, 8/13/15, 8/16/15, 8/17/15, 8/19/15, 8/21/15, 8/25/15, and 9/5/15. The documentation lacked non-pharmacological interventions attempted prior to the administration of these doses of clonazepam. In addition, R14 received Zyprexa 2.5 mg on 9/7/15. The documentation lacked identification of target behaviors for giving this medication and non-pharmacological interventions which had been attempted prior to the administration of the Zyprexa. On 9/16/15, at 1:21 p.m. the assistant director of nursing (ADON) confirmed R14 had ordered Zyprexa 2.5 mg PRN and clonazepam PRN for anxiety. The ADON verified the Zyprexa lacked the identification of target behaviors and non-pharmacological interventions which should be attempted prior to the administration of the Zyprexa. The ADON was unable to find the documentation of the non-pharmacological interventions attempted prior to the administration of the above noted doses of clonazepam. On 9/17/15, at 2:16 p.m. the director of nursing (DON) confirmed the above administration dates/times for R14's medical record lacked documentation of non-pharmacological interventions attempted prior the administration of the clonazepam medication being given. On 9/17/15, at 4:19 p.m. the consulting pharmacist (CP) stated staff should have been	21535		

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21535	Continued From page 23 identifying target behaviors and non-pharmacological interventions for residents on an antipsychotic and antianxiety medication. The CP stated each month she has reiterated to the leadership staff that they needed to improve upon their documentation of target behaviors and non-pharmacological interventions. The CP stated it was a system's problem throughout the facility so she has not written this as a recommendation for each individual resident. Target behaviors and non-pharmacological interventions to address the use of a PRN trazodone (antidepressant medication) were not identified for R63. R63's Face Sheet dated 7/23/14, indicated R63's diagnoses to include chronic airway obstruction (difficulty breathing), diabetes, congested heart failure (decrease in heart function to pump blood), anxiety and insomnia. R63's quarterly MDS dated 8/28/15, indicated R63 had no cognitive impairment and had feelings of being tired and having little energy two out of six days during the observation period, and was receiving an antidepressant medication. R63's Physician Order Sheet dated 9/1/15, indicated R63 had trazodone 12.5 mg (antidepressant medication) ordered to be administered PRN. Target behaviors and non-pharmacological interventions had not been identified for the use of the trazodone. R63's PRN Medication Administration Report from 7/1/15 - 9/16/15, indicated R63 had received	21535		

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21535	Continued From page 24 0.25 mg of trazodone on 8/23/15, 8/24/15, 8/26/15, 8/27/15, 8/31/15, 9/1/15, 9/2/15, 9/3/15, 9/4/15, 9/13/15, and 9/15/15. The documentation lacked identification of target behaviors for giving this medication and non-pharmacological interventions which had been attempted prior to the administration of the trazodone. On 9/17/15, at 2:53 p.m. the DON confirmed prior to 9/17/15, R63's medical record lacked documentation of target behaviors and non-pharmacological interventions for the use of the PRN trazodone. R22 was administered PRN antianxiety medication and the facility failed to attempt non pharmacological interventions prior to the administration of the medication. R22's Face Sheet as of 9/17/15, indicated R22 was diagnosed with schizoaffective disorder, bipolar disorder, generalized anxiety disorder, depressive disorder and end stage renal disease. R22's quarterly MDS, dated 7/2/15, indicated R22 had intact cognition, felt down and depressed and received antianxiety/antipsychotic medications. R22's current Physicians Order Sheet in the electronic record, indicated an order for Lorazepam (Ativan) (antianxiety), tablet, 0.5 milligrams (mg) give one tablet by mouth, as needed (PRN) two times per day for generalized anxiety disorder. Special instructions section indicated nonpharmacological to be attempted	21535		

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21535	Continued From page 25 prior to the administration of Lorazepam were 1) Redirection 2) One on One and directed staff to chart on nonpharmacological interventions attempted prior to giving the PRN medication. R22's PRN Medication Administration Report from 6/1/15, to 9/15/15, indicated R22 received 20 doses of PRN Lorazepam (Ativan) 0.5 mg and only 5 doses had non-pharmacological interventions documented prior to the administration of the medication. R22's Registered Nurse progress noted dated 7/1/15, indicated R22 received the following psychoactive meds: Zyprexa, Celexa, Ativan, Ambien, Trazadone and Depakote and had diagnoses of bipolar disorder and schizoaffective disorder. The note also indicated R22 had history of screaming, clapping and yelling at staff and would sometimes make irrational requests and get angry if needs or requests were not fulfilled immediately. The note also indicated these behaviors occurred 1-3 times per week and non pharmacological's were sometimes effective in reducing the behaviors and would sometimes respond to a calm approach and empathy. R22's care plan dated 7/1/15, directed staff to implement the following behavioral interventions -1:1 time when available to help her relax. -Answer call light timely. -Ask resident if there was anything she needed/reason for calling out/disruptive noises. -Attempt to meet residents needs when calling out. -Reapproach as needed -Ask R22 to go back to her room to calm her	21535		

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21535	Continued From page 26 down, remove from situation should behavior be disruptive for others. -Try to answer resident needs immediately. -Behavior would increase if staff tell her they would be back shortly. -Use distraction and/or redirection -offer activity, food or beverage. The care plan care plan further identified psychotropic drug use with interventions that included to monitor for side effects, allow ample time to make needs known, assess environmental factors, encourage activity attendance, venting of feelings and a calm environment. On 9/16/15, at 1:03 p.m. licensed practical nurse (LPN)-A stated she did not see "a lot" of R22's behaviors during the day, rather the majority of her behaviors occurred in the evening. In addition, LPN-A stated if staff administered the PRN ativan to R22, they would document the use of any nonpharmacological interventions attempted on the PRN Medication Administration Report or in the progress notes. Upon review of the Ativan doses given on 8/25/15, at 6:14 a.m. 8/25/15, at 1:48 p.m., 9/3/15, at 5:44 p.m., 9/13/15, at 11:25 p.m., and 9/15/15, at 9:53 p.m. LPN-A verified there was no documentation in the record showing that non-pharmacological interventions were attempted or documented prior to the administration of the PRN Ativan and stated, "I don't know why they are not there." On 09/17/2015, at 12:14 p.m. registered nurse (RN)-A verified non-pharmacological interventions were to be attempted and documented prior to	21535		

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21535	Continued From page 27 administering any prn medication. RN-A stated the documentation should be on the PRN medication form, in the progress notes or in the behavior notes. RN-A verified only 5 doses of R22's PRN Ativan administration had non-pharmacological interventions attempted and documented and the remaining 15 did not have any documentation. RN-A stated " the expectation is for the documentation to be done." ON 9/17/2015, at 12:22 p.m. the DON verified non-pharmacological interventions were to be attempted and documented prior to administering the Ativan or any psychoactive medication. The DON stated during the nurse's meeting, staff had been trained on this requirement and it was expected that staff documented the use of non-pharmacological interventions. R47 was administered antianxiety medication and the facility failed to identify target symptoms of anxiety and non-pharmacological interventions to be attempted prior to the administration of the medicaiton. R47's Face Sheet dated 9/17/15, indicated R47 had diagnoses that included major depressive disorder, hypertension and diabetes. R47's quarterly MDS dated 8/21/15, indicated R47 had severe cognitive impairment and received antidepressant medication daily. The MDS indicated R47 experienced mood symptoms of feeling tired or having little energy half or more of the days of the assessment period.	21535		

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21535	Continued From page 28 R47's Psychotropic Drug Use Care Area Assessment (CAA) dated 6/15/15, indicated R47 received Zoloft 25 milligrams (mg) (an antidepressant medication) once daily. The CAA indicated R47 had reported she had taken it for awhile and had no obvious side effects. The CAA also indicated R47 was a short term resident, the facility would not make any changes to the medication, and would continue to observe for any side effects from the medication. R47's Physicians Order Sheet dated 9/17/15, included an order for sertraline hcl (Zoloft) 25 mg give 1 tablet by mouth 1 time per day for anxiety. R47's EMAR Monthly Reports for June, July, August, and September 2015, indicated R47 received sertraline (Zoloft) 25 mg once daily for anxiety from 6/2/15 through 9/17/15 while in the facility. R47's undated current care plan indicated R47 received antidepressant medication and directed staff to encourage daily activity attendance, observe for common symptoms of dry mouth/dry mucous membranes and review medications on rounds with physician. The care plan lacked target symptoms of anxiety and non-pharmacological interventions for anxiety. On 9/14/15, at 6:10 p.m. R47 was observed attending an activity in the Evergreen common area. No behaviors were observed.	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	09/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21535	Continued From page 29 On 9/16/15, at 7:10 a.m. R47 was up and dressed seated in a wheelchair in her room. No behaviors were observed. -at 11:18 a.m. R47 was seated in a wheelchair at a table in the dining room. No behaviors observed. -at 12:49 p.m. R47 was seated in a wheelchair in her room. R47 responded pleasantly when greeted and made eye contact. She stated she was doing well and indicated was satisfied with her medication regime. On 9/17/15, at 3:01 p.m. the DON verified the indication for use of the Zoloft was anxiety and depression and confirmed there were no target symptoms of anxiety identified for R47. There DON also confirmed there were no non-pharmacological interventions identified for R47's anxiety. On 9/17/2015, at 4:19 p.m. the CP stated the facility should have identified target symptoms of R47's anxiety and should have developed non-pharmacological interventions for the anxiety. The CP stated she provided the facility monthly reports on individual resident issues as well as an executive summary of issues identified at a facility level. The CP indicated she had identified and communicated both verbally and in writing multiple times her recommendation to identify target behaviors and non-pharmacological interventions for residents receiving psychotropic medications. The CP indicated she had last addressed this issue as a system problem with the facility in August. Upon request, on 9/17/15, at 4:30 p.m. the DON	21535		

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21535	Continued From page 30 provided the Nursing Report July 2015, and Nursing Report August 2015. Both reports identified facility irregularities for nursing staff to address and recommended the facility needed to be sure target behaviors and non-pharmacological interventions were on the care plan/medication administration record for all psychotropic medications. The reports identified these items were missing occasionally. The undated Psychotropic Medication policy indicated the facility supported the goal of determining the underlying causes of behavioral symptoms so the appropriate treatment of environmental, medical, and/or behavioral interventions could be utilized to meet the needs of the resident and identified psychotropic medications to include anti-anxiety/hypnotic, antipsychotic and antidepressant classes of drugs. The policy indicated actions required included identification of target symptoms and orders for PRN psychotropic medications would be time limited (i.e. times 2 weeks) and only for specific clearly documented circumstances. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) could assign the interdisciplinary team to review the target behaviors/non-pharmacological interventions and required documentation of current residents receiving psychotropic/psychoactive medications, and refer any concerns to the attending physician and/or consulting pharmacist. The DON could schedule an in-service for nursing staff regarding the regarding medication administration, interventions and documentation. The quality assurance committee could establish a system to audit staff to ensure compliance.	21535		

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21535	Continued From page 31 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		