### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL TE SURVEY AGENCY		D: OOTB Facility ID: 00448
1. MEDICARE/MEDICAID PROVIDER (L1) 245252 2.STATE VENDOR OR MEDICAID NO (L2) 591605000		3. NAME AND AD (L3) THIEF RIVI (L4) 2001 EASTV (L5) THIEF RIVI	ER CARE CEN VOOD DRIVE ER FALLS, MI	NTER N	(L6) <b>56701</b>	4. TYPE OF ACTIO  1. Initial 3. Termination 5. Validation 7. On-Site Visit	N: 7 (L8)  2. Recertification 4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF OV (L9) 11/01/2006		7. PROVIDER/SU  01 Hospital	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey After	Complaint
6. DATE OF SURVEY 11/05/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDII	NG DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds  14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNF	70 (L18) 70 (L17) N 19 SNF	Compliance1. Ac B. Not in Com		ram ed Waivers:	And/Or Approved Waivers Of  2. Technical Personnel  3. 24 Hour RN  4. 7-Day RN (Rural S)  5. Life Safety Code  * Code: A  15. FACILITY MEETS  1861 (e) (1) or 1861 (j) (1):	6. Scope of Sec_7. Medical Dir	rvices Limit ector n Size
70 (L37) (L38)	(L39)	(L42)	(L43)		1001 (0) (1) 01 1002 (1) (1)	. ,	
16. STATE SURVEY AGENCY REMAI	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION D	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Lyla Burkman, Unit Su	ıpervisor	0	1/05/2016	(L19)	Mark Meath	、, Enforcement Specia	01/05/2016 (L20)
PAR	TII - TO BE	COMPLETED B	BY HCFA RE	GIONAL	OFFICE OR SINGLE S	STATE AGENCY	
DETERMINATION OF ELIGIBILIT      1. Facility is Eligible to Par      2. Facility is not Eligible			PLIANCE WITH ITS ACT:	I CIVIL		nncial Solvency (HCFA-257 rol Interest Disclosure Stmt re:	
22. ORIGINAL DATE  OF PARTICIPATION  07/01/1982  (L24)	23. LTC AGREEI BEGINNING (L41)		LTC AGREEM ENDING DAT (L25)		26. TERMINATION ACTION  VOLUNTARY  01-Merger, Closure  02-Dissatisfaction W/ Reimburs	0 INVOLUM 05-Fail to I	L30) ITARY Meet Health/Safety Meet Agreement
	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions: uspension Date:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	er Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)			

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

11/13/2015

(L32)

31. RO RECEIPT OF CMS-1539



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 Meeth

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



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

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245252	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/5/2015
Name	of Facility		Street Address, City, State, Zip Code	
TH	IEF 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	I	(Y5)	Date	(Y4	) Item		(Y5)	Date	(Y	4) Item		(Y5) I	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0309		10/16/2015		ID Prefix	F0325		10/16/2015		ID Prefix	F0329		10/16/2015
0	483.25					483.25(i)					483.25(I)		_
LSC		_		_	LSC				_	LSC			
			Composition					Carra atian					Compostion
			Correction Completed					Correction Completed					Correction Completed
ID Prefix	F0371		10/09/2015		ID Prefix	F0431		10/09/2015		ID Prefix			
Reg. #	483.35(i)				Reg. #	483.60(b), (d), (e)				Reg. #			
LSC					LSC					LSC			_ _
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg.#			-		Reg. #			
					•								_
									+				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			_
LSC				_	LSC				_	LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			·		ID Prefix					ID Prefix			_
Reg.#					Reg.#					Reg. #			
LSC					LSC					LSC			_
Reviewed By	Review	red E	Зу	D	ate:	Signature of	Surve	yor:				Date:	
State Agency	LB/n	nm		1	1/30/20	015		28035	5			11/05	5/2015
Reviewed By	Review	ed E	Ву	D	ate:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed on:			_			-				a Summary of		
	9/17/2015					Unco	rrecte	d Deficiencies	s (C	VIS-2567) Sent	to the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245252	( <b>Y2) Multiple Constr</b> A. Building B. Wing	F RIVER CARE CENTER NEW BLDG	(Y3) Date of Revisit 11/20/2015
Name	of Facility		Street Address, City, State, Zip Code	
TH	IIEF RIVER CARE CENTER		2001 EASTWOOD DRIVE	
			THIEF DIVED 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) I	Date
		(	Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			11/17/2015		ID Prefix			10/16/2015		ID Prefix			_
Reg. #	NFPA 101				•	NFPA 101				Reg. #			_
LSC	K0038				LSC	K0052				LSC			_
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ID Drofiv			Completed		ID Drofiv			Completed		ID Drofiv			Completed
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Reg. #					Reg. #			•		Reg. #			_
LSC					LSC								_
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			Completed					Completed					Completed
ID Prefix			·		ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			<del>-</del> -
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Reg. #					Reg. #					Reg. #			_
LSC					LSC					LSC			_
Reviewed By	Revie	ewed B	у	Da	te:	Signature of	f Surve	yor:				Date:	
State Agency	, TL/	/mm		1	1/30/20			2720	00			11/20	/2015`
Reviewed By	Revie	ewed B	у	Da	te:	Signature of	f Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed or	n:				Check f	for anv	Uncorrected I	Defic	iencies. Was	a Summary of	1	
	9/15/2015						•				to the Facility?	YES	NO

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: OOTB

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PAR	Γ I - TO BE COMPLETED BY TH	E STATE SURVEY AGENCY	Facility ID: 00448
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245252  2.STATE VENDOR OR MEDICAID NO.     (L2) 591605000	3. NAME AND ADDRESS OF FACILIT (L3) THIEF RIVER CARE CENTE (L4) 2001 EASTWOOD DRIVE (L5) THIEF RIVER FALLS, MN		4. TYPE OF ACTION: 2 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 11/01/2006	1	02 (L7) 09 ESRD 13 PTIP 22 CLIA	7. On-Site Visit 9. Other  8. Full Survey After Complaint
6. DATE OF SURVEY <b>09/17/2015</b> (L34)  8. ACCREDITATION STATUS: (L10)  0 Unaccredited 1 TJC 2 AOA 3 Other	03 SNF/NF/Distinct 07 X-Ray	10 NF 14 CORF 11 ICF/IID 15 ASC 12 RHC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35)  04/30
11LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12.Total Facility Beds 70 (L18)  13.Total Certified Beds 70 (L17)	TT D. N. C. C. T. M. D.		6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF 19 SN  70	IF ICF IID	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38) (L39) 16. STATE SURVEY AGENCY REMARKS (IF APPLICATION OF APPLICATION			
17. SURVEYOR SIGNATURE  Debra Vincent, HFE NE II	Date : 10/22/2015	18. STATE SURVEY AGENCY  Shellae Dietrich, Ce.	APPROVAL Date:  rtification Specialist 11/12/2015 (L20)
PART II - TO	BE COMPLETED BY HCFA REG	` '	
DETERMINATION OF ELIGIBILITY      1. Facility is Eligible to Participate     2. Facility is not Eligible  (L21)	20. COMPLIANCE WITH CIVERIGHTS ACT:		uncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e:
22. ORIGINAL DATE 23. LTC AGRI OF PARTICIPATION BEGINNI 07/01/1982 (L24) (L41)	EEMENT 24. LTC AGREEMEN NG DATE ENDING DATE (L25)	26. TERMINATION ACTION:  VOLUNTARY  01-Merger, Closure  02-Dissatisfaction W/ Reimbursem	05-Fail to Meet Health/Safety
A. Susper	ATIVE SANCTIONS usion of Admissions: (L44) Suspension Date: (L45)	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	n OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE: (L28)	29. INTERMEDIARY/CARRIER NO. 03001	30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DAT	E (L33) DETERMINATION APPR	ROVAL



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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

PRINTED: 10/22/2015 FORM APPROVED OMB NO. 0938-0391

-	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245252	B. WING		09/17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ΓS	F 000		
	as your allegation on Department's accept enrolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are rour signature is not required of first page of the CMS-2567 nic submission of the POC will cion of compliance.			
F 309 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with CARE/SERVICES FOR EING	F 309		10/16/15
	provide the necessary or maintain the high mental, and psycho	receive and the facility must ary care and services to attain nest practicable physical, social well-being, in e comprehensive assessment			
	by: Based on observat review, the facility fa monitoring and ass (R63) who was revi levels. Findings include: R63's Face Sheet of	NT is not met as evidenced ion, interview and document ailed to provide appropriate essment for 1 of 1 resident ewed with high blood glucose dated 7/23/14, indicated R63's chronic airway obstruction		R63s Diabetic care was reviewed with her Physician and her POC was revise R63 will be followed by the Diabetic educator for insulin management. We be updating the Diabetic educator ever weeks until blood sugars are stable between 200 and 300. Staff is to monit and record for signs/symptoms of hyperglycemic responses when she is having high blood sugars.	ed, will ry 2
ADODATOD	V DIDECTORIS OR BROVIE	ER/SUPPLIER REPRESENTATIVE'S SIGI	VATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245252	B. WING			09/1	7/2015
	PROVIDER OR SUPPLIER  VER CARE CENTER			20	TREET ADDRESS, CITY, STATE, ZIP CODE 001 EASTWOOD DRIVE		.,,
	VEH GAHE GEHTER			TI	HIEF RIVER FALLS, MN 56701		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	failure (decrease in blood), anxiety, ren macular degenerat autonomic neuropa often caused by dia R63's care plan dar diabetic and directed monitoring as order and symptoms of higlucose levels) and glucose levels).  R63's quarterly Mir 8/28/15, indicated R63's Physician Or indicated R63 was following medication.  Lantus (insuling (injection into the severy 8:00 a.m.  Lantus 4 units.  Humalog (insulational Humalog sliding determine the amodepending on the battwice a day before noon:  Mold if blood sumilligrams per decion Give 2 units if bang/dL  Give 4 units if bang/dL	), diabetes, congested heart heart function to pump al failure (kidney failure), ion (poor vision), peripheral ithy (peripheral nerve damage abetes).  Ited 8/29/14, indicated R63 was ed staff to conduct glucose red and to monitor for signs ypoglycemia (low blood I hyperglycemia (high blood I hyperglycemia (high blood I hyperglycemia daily.  Ider Sheet dated 9/1/15, scheduled to receive the n for her diabetes:  I 2 units subcutaneous ubcutaneous tissue - SQ)  SQ every 8:00 p.m. In) 2 units SQ every 5:00 p.m. In g scale (scale utilized to unt of insulin to be given allood glucose level at the time) meals at 8:00 a.m. and 12:00  ugar is less than 200	F3	809	The facility Blood Glucose Policy we reviewed and revised to include dir on what to do if a resident is hypogor hyperglycemic.  Nursing staff were reeducated on the revised Glucose Testing Policy and R63 is revised Diabetic POC will be completed by 10/16/2015.  All residents with Glucose monitoring were assessed to ensure appropriation monitoring and assessment for high and/or low blood sugars is in place 10/9/2015. (Directions and docume present in EMR)  Random audits of documentation of glucose monitoring and follow up an edded will be conducted by the DON/designee 2Xwk X3, then were Audit results will be brought to the committee for review and further recommendations.  Completion date: 10/16/15	ection lycemic  he l on pe ate h by entation of blood s kly x4.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  IG	` '	ATE SURVEY DMPLETED
		245252	B. WING _		0!	9/17/2015
-	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	mg/dL o Give 7 units if bunits mg/dL - Humalog 2 unit than 500 mg/dL On 9/16/15, at 7:48 walking to the dinin On 9/16/15, at 10:5 (LPN)-D conducted R63. R63's blood gtime was 404 mg/d R63's A1C (blood to blood glucose level the last 2-3 months - 6/4/15, 13.0 - v (reference range 4 4/9/15, 12.6 - v (reference range 4 4/9/15, at 11:2 (RN)-B stated R63 level checked four fand at bedtime). R three months of blo listed below and ve lacked documentat these high readings - 9/11/15, at 9:03 548 mg/dL - 9/10/15, at 9:03 560 mg/dL - 8/30/15, at 9:01 555 mg/dL	a.m. R63 was observed groom for breakfast.  1 a.m. licensed practical nurse a blood glucose check on glucose level reading at this L.  est which indicated how well shave been controlled over results were: alue identified as being high 3-5.7) value identified as being high 3-5.7)  3 a.m. registered nurse was to have her blood sugar times a day (before each meal N-B confirmed R63's last od sugar reading results as rified R63's medical record ion of a recheck on any of	F 30			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245252	B. WING		09	/17/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP  2001 EASTWOOD DRIVE  THIEF RIVER FALLS, MN 5670	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 309	600 mg/dL - 8/18/15, at 8:3 561 mg/dL - 8/17/15, at 7:3 562 mg/dL - 8/17/15, at 8:4 562 mg/dL - 8/15/15, at 7:2 600 mg/dL - 8/2/15, at 9:3 541 mg/dL - 7/28/15, at 10 513 mg/dL - 7/28/15, at 8:2 556 mg/dL - 7/18/15, at 7:2 554 mg/dL - 7/7/15, at 9:3 511 mg/dL - 7/7/15, at 11:5 557 mg/dL - 7/2/15, at 8:4 517 mg/dL - 7/2/15, at 8:4 517 mg/dL - 7/1/15, at 5:2 554 mg/dL - 6/29/15, at 8:4 531 mg/dL - 6/28/15, at 9:7 541 mg/dL - 6/25/15, at 9:7 541 mg/dL - 6/25/15, at 9:7 531 mg/dL - 6/25/15, at 9:7 531 mg/dL - 6/24/15, at 3:3 562 mg/dL	page 3 54 p.m. blood glucose result = 31 p.m. blood glucose result = 47 p.m. blood glucose result = 48 p.m. blood glucose result = 49 p.m. blood glucose result = 49 p.m. blood glucose result = 40 p.m. blood glucose result = 40 p.m. blood glucose result = 41 p.m. blood glucose result = 42 p.m. blood glucose result = 43 p.m. blood glucose result = 44 p.m. blood glucose result = 45 p.m. blood glucose result = 46 p.m. blood glucose result = 47 p.m. blood glucose result = 48 p.m. blood glucose result = 49 p.m. blood glucose result = 40 p.m. blood glucose result = 41 p.m. blood glucose result = 42 p.m. blood glucose result = 43 p.m. blood glucose result =	F3	309			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		245252	B. WING			09/17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 567	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 309	indicated R63 was odor or acetone on progress notes for the high blood glucolacked documentatifor signs and symptom The Consultant Phase for R63 dated 5/28/was up to 12 from of action indicated I the past recommended and been declined from hypoglycemia. recommended a nesugar goals for R63 indicated by medica A1C had been done recommended by the The Nurse Commundated 4/8/15, indicated 4/8	e dated 7/28/15, at 10:14 p.m. hyperglycemic and had no her breath. However, R63's the other dates and times of ose readings noted above ion related to an assessment toms of hyperglycemia.  armacist's Medication Review 2015, indicated R63's A1C 10 and the suggested course R63 was a brittle diabetic and dation for insulin adjustment as R63 had a history of falls. The pharmacist red to identify A1C and blood B. The follow up action al doctor (MD)-A was that an e. No goals had been he MD.	F3	09		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		245252	B. WING _		09	/17/2015		
	PROVIDER OR SUPPLIER VER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 309	glucose level in 30 would especially re within 30 minutes if over 500.  On 9/17/15, at 2:32 (DON) stated R63 in nursing to give an a insulin every one had R63's blood glucos.  On 9/17/15, at 3:45 would not expect stiglucose level even an expectation of s R63's blood glucos they (physician) wo to do about it. The staff to document if and symptoms of his stated the goal was glucose levels betwo DON verified R63's have been higher the machine only read above 600 mg/dl. Tunable to document so they wrote 600 mg/dl. Tunable to document in the staff to document in the sta	would recheck the blood minutes. RN-B stated she check R63's blood sugar level R63's blood sugar level R63's blood sugar levels were at p.m. the director of nursing used to have an order for additional 2 units of Humalog our until 8:00 p.m. or until e level went below 500.  In p.m. the DON stated she raff to recheck R63's blood if it read "high", nor would it be taff to notify the physician if e level was over 500 because uld ask what we wanted them DON stated she would expect R63 was having any signs yperglycemia. The DON sto maintain R63's blood wen 200-300 mg/dL. The 600 mg/dL readings could from 600 as the glucose "high" when a blood sugar was the DON also stated staff were to "high" on the monitoring form mg/dL as that was the highest e read. The DON also en a long time ago since R63 and for a hypoglycemic staff should have 63 for signs and symptoms of rechecking R63's blood on they were reading over 500.	F 30	9				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	TIPLE CONSTRUCTION ING	` '	TE SURVEY MPLETED
		245252	B. WING	<u> </u>	09	/17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 325 SS=D	system manufactur blood glucose level machine will read "I repeated with a new showed again, cont professional immed for advice if test ressymptoms of high to the symptoms of clinical clauses sample, he on what to do if a resident clinical change to the symptoms.  No policy on critical of clinical change to the symptoms of high to the sympt	m blood glucose monitoring to instructions indicated if s are above 600 mg/dL, the Hi". The test should be we test strip and if this message tact the healthcare diately! Contact the physician sults are very high and/or show blood glucose.  Testing policy dated 4/13, as on how to obtain a blood owever did not give direction esident was hypoglycemic or a value reporting or notification to the provider were provided. NOUTRITION STATUS DABLE  of the provider were that a contable parameters of nutritional day weight and protein levels, its clinical condition this is not possible; and apeutic diet when there is a		309 325		10/16/15
	This REQUIREMENT by:	NT is not met as evidenced				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		SURVEY PLETED
		245252	B. WING		09/-	17/2015
	PROVIDER OR SUPPLIER  VER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  2001 EASTWOOD DRIVE  THIEF RIVER FALLS, MN 56701	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 325	review, the facility f assess nutritional rinterventions in ord weight loss for 1 of who was underweight loss for 1 of who was underweight loss include:  R63 was underweight lose weight and factomprehensive nutrimplement appropriately loss.  R63's Face Sheet of diagnoses included (difficulty breathing failure (decrease in blood), anxiety, renunderweight.  R63's quarterly Min 8/28/15, indicated Fimpairment, had feel having little energy,	tion, interview and document ailed to comprehensively isk and implement appropriate er to minimize the risk of 3 residents (R63) reviewed	F 329		nents and r. DM at 97# is only be fell below om 95 to d consult weight is clinical not essed for a nad will make ion and series and more of inducted then rought to	
	a potential for weig to provide R63 with weight maintenance	ted 2/23/15, indicated R63 had ht loss. Interventions included nutritional extra calories for e or weight gain and to provide chocolate and whole milk.		Completion date: 10/16/2015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245252	B. WING			<b>09</b> /	17/2015
	PROVIDER OR SUPPLIER  VER CARE CENTER			20	TREET ADDRESS, CITY, STATE, ZIP CODE 001 EASTWOOD DRIVE 'HIEF RIVER FALLS, MN 56701		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	Continued From part R63's dietary risk a 8/27/15, indicated Frisk.  Nurse communication 8/27/15, indicated Frisk and that intake goal.  R63's resident dietarindicated R63 was not on a planned with the standard residence of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 was not on a planned with the staff to provide R63 with whole milk oncommunication of the staff to provide R63 was not on a planned with the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk oncommunication of the staff to provide R63 with whole milk	ge 8 ssessment conducted on R63 was a moderate dietary ion note to the physician dated R63 was currently on an 1800 t R63 never met this caloric ary assessment dated 8/27/15, on a therapeutic diet and was	F 3				
	R63's weight histor - 9/15/15 - 97.8 g - 8/14/15 - 97.8 g - 7/17/15 - 98.6 g - 6/19/15 - 99.2 g	oounds oounds oounds					

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		245252	B. WING		09/	17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 325	Continued From pa - 6/8/15 - 103.8 p	_	F 32!	5		
	a consistent carb d supplement ordere no sugar added howeight had been st R63's body mass in assess when a perunderweight) was funderweight. R63 the past, but didn't blood sugar too mu with no sugar adderefused it during the	9/15/15, indicated R63 was on iet (diabetic diet) and had a d which was whole milk with t chocolate. In addition, R63's able with a slight weight loss. Index (BMI - (index utilized to son is overweight or 16.2, which indicated R63 was had tried other supplements in like them or they affected her inch. R63 liked the whole milk d hot chocolate, however, a summer months on some all portions of food, but usually 6 of her meals.				
	8/23/14, indicated I loss. It was sugges and fat through her addition, it was reconstritional supplem weight loss. Recor R63 with Glucerna a day. Contact the	ered dietician (RD) note dated R63 had had some weight sted for R63 to have protein food with every meal. In ammended R63 be on a ent to help stop continued mmendation was to provide (nutritional supplement) twice RD with any further nutritional rns. RD will follow as needed.				
	and September 20	dministration record for August 15, lacked documentation that ided hot chocolate and whole				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION  NG		E SURVEY MPLETED
		245252	B. WING _	·····	09.	/17/2015
	PROVIDER OR SUPPLIER  VER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 325	Continued From pa	ge 10	F 3	25		
	tried ensure and bo supplements) and s stated the hot choc	0 a.m. R63 stated she had nost (both nutritional she didn't like them. R63 olate and whole milk was he liked ice cream and malts.				
	(RN)-B confirmed F	8 a.m. registered nurse R63 was weighed weekly and entinued to lose weight.				
	confirmed R63 had supplement), howe discontinued on 10, R63 was slowly still R63 did have a slig drinking the hot chowever, when sun because of the hea was 16.2 on 9/15/1 underweight. The Deen involved with six months. The Diany resident who hagain to the RD for fidefinitely refer a reslike R63 or if the Di	38 a.m. dietary manager (DM) been on Glucerna (nutritional ver that had been /29/14. The DM confirmed losing weight. The DM stated ht weight gain when R63 was ocolate and whole milk, nmer came R63 didn't want it t. The DM verified R63's BMI 5, which indicated R63 was DM verified the RD had not R63's care in at least the past M confirmed she would refer ad significant weight loss or urther assessment and would sident who was underweight M was having a difficult time is which met the preferences of				
		p.m. an attempt to contact The RD was unable to return rvey time.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		245252	B. WING	i	09	/17/2015
	PROVIDER OR SUPPLIER  VER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODI 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 325	indicated the RD woresidents that were loss/change, wound MDS's or that requifor a variety of reas  The job description nutritional and clinic determine residen appropriate plan in the resident appr	for the consulting dietician buld review and chart on at high risk, weight ds, new admissions, annual red assessments and charting ons.  for the DM included under the cal management portion: ts' diet needs and develop cooperation with the RD dimplement the nutrition	F3	325		
F 329 SS=E	provided. 483.25(I) DRUG RE UNNECESSARY D  Each resident's drug unnecessary drugs, drug when used in eduplicate therapy); without adequate mindications for its us adverse consequent should be reduced and combinations of the  Based on a compresident, the facility who have not used given these drugs us therapy is necessar	g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or onitoring; or without adequate se; or in the presence of aces which indicate the dose or discontinued; or any	F3	329		10/16/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (2	X3) DATE SURVEY COMPLETED
		245252	B. WING		09/17/2015
	PROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE  1001 EASTWOOD DRIVE  THIEF RIVER FALLS, MN 56701	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 329	drugs receive grade behavioral interven	ge 12 Its who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these	F 329		
	by: Based on interview facility failed to ider implement non-pha 3 of 3 residents (Ras needed (PRN) a PRN or scheduled addition, the facility non-pharmacologic attempted prior to tantianxiety/antidepresidents (R14, R2).  Findings include:  Target behaviors an interventions to add Zyprexa (antipsychidentified for R14, non-pharmacologic implemented prior clonazepam (antiar	al interventions were the administration of a PRN ressant medication for 2 of 2 2).  and non-pharmacological dress the use of a PRN otic medication) were not lin addition, al interventions were not to the use of a PRN exiety medication) for R14.		R63 target behaviors and non-pharmacological have been add her prn medication order. R14 prn Zyprexia was discontinued by Dr. K of 9-18-15. R22 and R47 target behavior added to medication order and care was updated to include her target behaviors and non-pharmacological interventions.  All licensed nursing staff and TMSs educated on order entry for psychotr medication. Orders must contain prodiagnosis, target behaviors, and non-pharmacological interventions in order for prn medications and target behaviors for scheduled medications Staff also educated on when providir medication they must try non-pharm intervention prior to providing the medication. Their behavior note need include the behavior and non-pharm intervention, as well as follow-up after administering the medication. Education provided on 10-1-15	on ors plan  opic per  the ang prn  ds to
		gnosis and Allergies sheet cated R14 had diagnoses that		All residents with scheduled psychot	ropic

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		245252	B. WING		09/	17/2015
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2001 EASTWOOD DRIVE  THIEF RIVER FALLS, MN 56701			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 329	included anxiety, demuscle weakness.  R14's quarterly Min 7/7/15, indicated Rimpairment and had antianxiety medicated address this proble resident to ventilate resident's distress, psychosocial stress conditions.  R14's PRN Medicated Address this proble resident to ventilate resident's distress, psychosocial stress conditions.  R14's PRN Medicated Address this proble resident's distress conditions.  R14's PRN Medicated Tyl/15 - 9/16, had ordered that Rimilligrams (mg) (and y PRN. Target be non-pharmacologic identified for the usthe physician had orgiven clonazepam medication) once a identified for the us repetitive complaint paranoia and feelin Non-pharmacologic be used prior to the clonazepam include movie and bring R1	imum Data Set (MDS) dated 14 had no cognitive d trouble sleeping.  Intified R14 received an ion. Approaches identified to m area included encourage a feelings, explore reasons for environmental stressors, sors and treatable medical ation Administration Report (15, indicated the physician 14 could be given Zyprexa 2.5 atipsychotic medication) once a ehaviors and al interventions had not been e of the Zyprexa. In addition, ordered that R14 could be 0.5 mg (antianxiety day PRN. Target behaviors e of the clonazepam were is, nervous statements, g uneasy. Cal interventions identified to administration of the PRN ed 1:1 time, playing cards,	F 3	medications will hat behaviors and care target behaviors, no interventions and p noted. All residents medications will hat behaviors and non-intervention in their plan. Care plan will side effects of their completed by 10-16.  Random audits of Finedication docume conducted by the Diagram of the Care plan will side effects of their completed by 10-16.	e plans that reflect their on-pharmacological otential side effects with prn psychotropic ve identified target pharmacological order as well as care also indicate potential medication. To be 6-15  PRN psychotropic entation will be PON/designee 2Xwk . Audit results will be PI committee for review nendations.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY MPLETED
		245252	B. WING		09.	/17/2015
	PROVIDER OR SUPPLIER  VER CARE CENTER			STREET ADDRESS, CITY, STATE, Z 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56	IP CODE	,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 329	The provider had o medication to be defor one week, then	ge 14 R14's Zyprexa medication. rdered for R14's Zyprexa ecreased to 2.5 mg twice a day Zyprexa 2.5 mg nightly for orexa 2.5 mg once a day PRN.	F 3	329		
	dated 7/1/15-9/16/1 administered clona 7/11/15, 7/18/15, 7/8/16/15, 8/17/15, 8/9/5/15. The documnon-pharmacologic prior to the administed clonazepam. In ad 2.5 mg on 9/7/15. Identification of targemedication and nor	al interventions attempted tration of these doses of dition, R14 received Zyprexa The documentation lacked get behaviors for giving this n-pharmacological had been attempted prior to				
	nursing (ADON) co Zyprexa 2.5 mg PF anxiety. The ADON the identification of non-pharmacologic be attempted prior Zyprexa. The ADO documentation of the interventions attem	p.m. the assistant director of nfirmed R14 had ordered IN and clonazepam PRN for verified the Zyprexa lacked target behaviors and al interventions which should to the administration of the N was unable to find the ne non-pharmacological pted prior to the administration doses of clonazepam.				
	(DON) confirmed th	p.m. the director of nursing ne above administration I's medical record lacked				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG	_ (2	X3) DATE SURVEY COMPLETED
		245252	B. WING			09/17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST 2001 EASTWOOD DRIVE THIEF RIVER FALLS, M		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD B ID TO THE APPROPRI ICIENCY)	
F 329	interventions attem	ige 15 on-pharmacological pted prior the administration of edication being given.	F3	29		
	pharmacist (CP) sta identifying target be non-pharmacologic on an antipsychotic The CP stated each the leadership staff upon their documen non-pharmacologic stated it was a syste facility so she has re	al interventions for residents and antianxiety medication. In month she has reiterated to that they needed to improve intation of target behaviors and al interventions. The CP em's problem throughout the				
	interventions to add	nd non-pharmacological dress the use of a PRN ressant medication) were not				
	diagnoses to includ (difficulty breathing)	dated 7/23/14, indicated R63's le chronic airway obstruction ), diabetes, congested heart heart function to pump insomnia.				
	R63 had no cognitive feelings of being tire out of six days during	S dated 8/28/15, indicated we impairment and had ed and having little energy two ng the observation period, and ntidepressant medication.				
	R63's Physician Or	der Sheet dated 9/1/15,				

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		245252	B. WING	<del> </del>	09/	/17/2015
	PROVIDER OR SUPPLIER VER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	indicated R63 had t (antidepressant me administered PRN. non-pharmacologic identified for the use R63's PRN Medicat from 7/1/15 - 9/16/1 0.25 mg of trazodor 8/26/15, 8/27/15, 8/9/4/15, 9/13/15, and lacked identification this medication and interventions which the administration of the PRN trazodone R22 was administed medication and the pharmacological intadministration of the R22's Face Sheet at R22's Face Sheet R22's Face S	razodone 12.5 mg dication) ordered to be Target behaviors and al interventions had not been e of the trazodone.  cion Administration Report 5, indicated R63 had received ne on 8/23/15, 8/24/15, 31/15, 9/1/15, 9/2/15, 9/3/15, d 9/15/15. The documentation of target behaviors for giving non-pharmacological had been attempted prior to of the trazodone.  p.m. the DON confirmed prior edical record lacked arget behaviors and al interventions for the use of red PRN antianxiety facility failed to attempt non erventions prior to the	F 3.	29		
	bipolar disorder, ge depressive disorder	neralized anxiety disorder, r and end stage renal disease. S, dated 7/2/15, indicated R22				
	had intact cognition	s, dated 7/2/15, indicated R22, felt down and depressed and //antipsychotic medications.				

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN			
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F 329	electronic record, in Lorazepam (Ativan) milligrams (mg) giv needed (PRN) two anxiety disorder. Spindicated nonpharm prior to the adminis Redirection 2) One chart on nonpharm attempted prior to get attempted prior to get and interventions document attempted prior to get administration of the R22's Registered N7/1/15, indicated R2 psychoactive meds Ambien, Trazadone diagnoses of bipola disorder. The note of screaming, clapp would sometimes in get angry if needs of immediately. The note of mediately. The note of screaming clapp would sometimes in get angry if needs of immediately. The note of screaming the behaviors occurred pharmacological's verducing the behaviors occurred pharmacological's verspond to a calm at the scream of the scream o	icians Order Sheet in the indicated an order for (antianxiety), tablet, 0.5 in one tablet by mouth, as times per day for generalized pecial instructions section inacological to be attempted tration of Lorazepam were 1) on One and directed staff to acological interventions giving the PRN medication.  Ition Administration Report 5/15, indicated R22 received orazepam (Ativan) 0.5 mg and on-pharmacological mented prior to the	F3	29			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245252	B. WING			09/	17/2015
NAME OF PROVIDER OR SUPPLIER  THIEF RIVER CARE CENTER				20	TREET ADDRESS, CITY, STATE, ZIP CODE 001 EASTWOOD DRIVE HIEF RIVER FALLS, MN 56701		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	-1:1 time when ava -Answer call light ti -Ask resident if the needed/reason for -Attempt to meet re outReapproach as ne -Ask R22 to go bac down, remove from disruptive for other -Try to answer resi -Behavior would in would be back sho -Use distraction an -offer activity, food  The care plan care psychotropic drug i included to monitor time to make need environmental fact	wing behavioral interventions allable to help her relax. mely. re was anything she calling out/disruptive noises. esidents needs when calling eeded on the part of	F3	329			
	(LPN)-A stated she behaviors during the her behaviors occuladdition, LPN-A state PRN ativan to R22 of any nonpharmac attempted on the Report or in the protection of the Ativan doses gibs 8/25/15, at 1:48 p.r.	B p.m. licensed practical nurse edid not see "a lot" of R22's ne day, rather the majority of arred in the evening. In ated if staff administered the they would document the use cological interventions PRN Medication Administration agress notes. Upon review of liven on 8/25/15, at 6:14 a.m. m., 9/3/15, at 5:44 p.m., .m., and 9/15/15, at 9:53 p.m.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245252		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING			09/17/2015		
NAME OF PROVIDER OR SUPPLIER  THIEF RIVER CARE CENTER				2	TREET ADDRESS, CITY, STATE, ZIP CODE 001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701	,	,2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	record showing that interventions were to the administration	age 19 e was no documentation in the tonon-pharmacological attempted or documented prior n of the PRN Ativan and w why they are not there."	F 3	329			
	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."						
	non-pharmacologic attempted and doct the Ativan or any popular DON stated during been trained on this expected that staff non-pharmacologic R47 was administed the facility failed to anxiety and non-ph	12:22 p.m. the DON verified ral interventions were to be umented prior to administering sychoactive medication. The the nurse's meeting, staff had a requirement and it was documented the use of ral interventions. The red antianxiety medication and identify target symptoms of armacological interventions to to the administration of the					
		dated 9/17/15, indicated R47 included major depressive ion and diabetes.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245252		B. WING			09/17/2015	
NAME OF PROVIDER OR SUPPLIER  THIEF RIVER CARE CENTER				:	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701	, 00/	,
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F 329	F 329 Continued From page 20		F3	329			
	R47 had severe co received antidepres MDS indicated R47	S dated 8/21/15, indicated gnitive impairment and ssant medication daily. The experienced mood symptoms aving little energy half or more ssessment 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.						
	August, and Septer received sertraline	nly Reports for June, July, mber 2015, indicated R47 (Zoloft) 25 mg once daily for through 9/17/15 while in the					
	received antidepres staff to encourage observe for commo	ent care plan indicated R47 ssant medication and directed daily activity attendance, on symptoms of dry mouth/dry es and review medications on					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	NG		(X3) DATE SURVEY COMPLETED	
		245252	B. WING	·····	09	/17/2015
NAME OF PROVIDER OR SUPPLIER  THIEF RIVER CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP C 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 5670	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 329	rounds with physici target symptoms of	an. The care plan lacked	F 3.	29		
	On 9/14/15, at 6:10 p.m. R47 was observed attending an activity in the Evergreen common area. No behaviors were observed.					
	dressed seated in a behaviors were obs -at 11:18 a.m. R47 a table in the dining observed. -at 12:49 p.m. R47 her room. R47 res greeted and made	was seated in a wheelchair at room. No behaviors  was seated in a wheelchair in ponded pleasantly when eye contact. She stated she indicated was satisfied with				
	indication for use o depression and cor symptoms of anxie DON also confirme	p.m. the DON verified the f the Zoloft was anxiety and nfirmed there were no target ty identified for R47. There d there were no al interventions identified for				
	facility should have R47's anxiety and s non-pharmacologic The CP stated she reports on individua	119 p.m. the CP stated the identified target symptoms of should have developed all interventions for the anxiety. provided the facility monthly all resident issues as well as any of issues identified at a				

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		B. WING		09/	17/2015	
NAME OF PROVIDER OR SUPPLIER  THIEF RIVER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701	E		
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE	
facility level. The C and communicated multiple times her r target behaviors an interventions for res medications. The C addressed this issu the facility in Augus	CP indicated she had identified both verbally and in writing ecommendation to identify d non-pharmacological sidents receiving psychotropic CP indicated she had last the as a system problem with t.	F 3.	29			
provided the Nursin Nursing Report Augidentified facility irreaddress and recombe sure target behanon-pharmacologic care plan/medication psychotropic medical	ng Report July 2015, and gust 2015. Both reports egularities for nursing staff to amended the facility needed to aviors and all interventions were on the part of administration record for all eations. The reports identified					
indicated the facility determining the und symptoms so the all environmental, medinterventions could of the resident and medications to included identification orders for PRN psybe time limited (i.e. specific clearly documents).	y supported the goal of derlying causes of behavioral ppropriate treatment of dical, and/or behavioral be utilized to meet the needs identified psychotropic ude anti-anxiety/hypnotic, ntidepressant classes of indicated actions required on of target symptoms and chotropic medications would times 2 weeks) and only for umented circumstances.	F 3	71		10/9/15	
	PROVIDER OR SUPPLIER  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From pa facility level. The C and communicated multiple times her r target behaviors an interventions for res medications. The C addressed this issue the facility in Augus  Upon request, on 9 provided the Nursir Nursing Report Aug identified facility irre address and recom be sure target beha non-pharmacologic care plan/medicatio psychotropic medic these items were m  The undated Psych indicated the facility determining the und symptoms so the a environmental, med interventions could of the resident and medications to inclu antipsychotic and a drugs. The policy i included identificatio orders for PRN psy be time limited (i.e. specific clearly doc 483.35(i) FOOD PF	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  483.35(i) FOOD PROCURE,	PROVIDER OR SUPPLIER  IVER CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 22 facility level. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245252			(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED 09/17/2015		
		B. WING				
NAME OF PROVIDER OR SUPPLIER  THIEF RIVER CARE CENTER			S 2 T			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIO	N
F 371	considered satisfact authorities; and	om sources approved or ctory by Federal, State or local distribute and serve food	F 371			
	by: Based on observa review the facility fa was cleaned and se prevent the contam	NT is not met as evidenced tion, interview and document ailed to ensure the meat slicer anitized after use in order to hination of food. This had the 12 of 64 residents who received e kitchen.		The meat slicer was cleaned and sanitized 9/17/2015. No further debris/residue on meat slicer noted cleaning by Dietary Manager.  All Dietary Staff were educated on cleaning the meat slicer on 9/21/20 Meat slicer must be cleaned and sa after each use.  Documentation of chemical sanitize	15. nitized	
	tour with the dietary meat slicer was obtened and residue of the machine. The stated the meat slice also stated it had jutime, the DM asked When asked how a meat slicer, the DM the three compartment it inside the dishway used sanitation cheeps.	o p.m. during the initial kitchen y manager (DM), the facility served to have pieces of dried on the blades and on the base e DM verified the findings and cer was not clean, however, just been used that day. At this d the evening cook to clean it. It staff cleaned and sanitized the M stated it had to be cleaned in ment sink because it would not asher. The DM stated staff emicals in the three and staff used chemical paper		be documented on new form when compartment sink is used. Staff has educated on 10/9/2015 on how to document chemical sanitizer test structured by the completed for the first uses every time the slicer is used. Swill notify Dietary Manager or design when used. Then audits will be comparted to the QAPI committee meeting.	s been rips. four Staff nee pleted re tion	

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		245252	B. WING		09/17/2015	
	PROVIDER OR SUPPLIER  VER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  2001 EASTWOOD DRIVE  THIEF RIVER FALLS, MN 56701		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 371	within the recomme When asked to see appropriate sanitizations, the DM stated documented any of the three compartments often as everything.  On 9/16/15, at 1:10 off the meat slicer as be unclean with pie on the blades and to DM confirmed it was she was unsure if the three compartment or not.  On 9/17/1,5 at 11:4 if cooking equipment properly it had the purpoperly it had t	sure the chemical sanitizer was ended sanitizing solution.  If the logs to verify the ation method was utilized in the the facility had not logged / the test strip results because tent sink was not used that else went in the dishwasher.  If the person had utilized the sink to cleaned or sanitized to the total to effect all residents rom the kitchen.  If Dietary Policy for: Pots and the compartment sink washing. It utensils and dishes washed an and sanitized. The it initizer with Hydrion erse for 30 seconds. Compare	F 37	Completed 10/9/15		
F 431 SS=E		DRUG RECORDS, UGS & BIOLOGICALS  Inploy or obtain the services of	F 43	1		10/9/15
	.,	. ,			ļ	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245252	B. WING _		09/1	7/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701	•	.,,20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 431	of records of receip controlled drugs in accurate reconciliar records are in orde controlled drugs is reconciled.  Drugs and biological labeled in accordar professional princip appropriate access instructions, and the applicable.  In accordance with facility must store a locked compartment controls, and perminave access to the The facility must premanently affixed controlled drugs list Comprehensive Drugs Control Act of 1976 abuse, except whe package drug districts.	cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be nee with currently accepted oles, and include the ory and cautionary e expiration date when  State and Federal laws, the all drugs and biologicals in the under proper temperature it only authorized personnel to keys.  Ovide separately locked, a compartments for storage of the in Schedule II of the ug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the ninimal and a missing dose can	F 43	1		
	by: Based on observareview, the facility femodication storage	NT is not met as evidenced tion, interview and document ailed to ensure proper and security for 1 of 4 ent carts (Evergreen unit) was		All licensed staffed and TMAs educated on locking of the me carts when not in direct view o medication cart on 10-1-15	dications	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245252	B. WING			09/-	17/2015
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u>,ı                                      </u>	
THIEF R	IVER CARE CENTER				001 EASTWOOD DRIVE HIEF RIVER FALLS, MN 56701		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 431	ensure expired me of 4 carts that store Findings include:  The Evergreen unit unlocked and unat On 9/15/15, at 2:22 the Evergreen unit parked outside and station. Licensed processed behind the medication cart was continuattended until 2: -at 2:27 p.m. LPN-plastic cupsat 2:29 p.m. LPN-locked if left unatted On 09/17/2015, at nursing (DON) stated have been locked with the medication Addindicated med cart when not giving medicated med cart was unattended. The medication and Evergreen unit cordinated on 9/17/15, at 1:48 medication cart was m	dition, the facility failed to dications were removed from 2 and medications  It medication cart was left tended.  It p.m. the medication cart on was observed unlocked and it to the left of the nurses oractical nurse (LPN)-A was nurses station with her back to it working on the computer. Industry observed to be 27 p.m.  It returned to the cart with the confirmed the cart should be inded.  It is p.m. the director of the director cart should be inded the medication cart should	F 4	131	All residents with Xalatan eye drop an order in the computer to order a bottle on day 38 and when new bot arrives to discard the old bottle and new bottle. The date of dispense we used as the date of opening. This will also be used for all new admission that enters the building with Xalatal drops.  All licensed staff and TMAs were educated on 10-1-15 about the new ordering process for Xalatan eye dwell as discarding the old bottle and opening the new bottle when it arrived Residents should only have one be eye drops in the med/tx cart.  Random audits will be completed to ensure med/tx carts are locked whate not in director view of the med/2x per week for 2 weeks and week weeks.  Random audits of the med/tx cart weeks.  Random audits of the med/tx cart weeks.  Random audits of the med/tx cart weeks.  Conducted by the DON/designee with the total conducted by the DON/designee with the conducted by the DON	a new title d use vill be order sions n eye  w rops as d ves. bitle of o en staff (tx carts d) ty for 4  will be and be veekly the	

	(X3) DATE SURVEY COMPLETED		
245252 B. WING 09	09/17/2015		
NAME OF PROVIDER OR SUPPLIER  THIEF RIVER CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  2001 EASTWOOD DRIVE  THIEF RIVER FALLS, MN 56701			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
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 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			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
245252			B. WING		09	/17/2015
	PROVIDER OR SUPPLIER  VER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 5670	CODE	,=
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F 431		ge 28 d the expired medications emoved from use / carts.	F 4	31		

#### 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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PRINTED: 10/20/2015 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  THIEF RIVER CARE CENTER  SIMMAMY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MIN STOTE THAT PRIVER FALLS, MN 56701  WALLEGATION OF CLIENTIFYING INFORMATION)  K 000  INITIAL COMMENTS  FIRE SAFETY  THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO YOUR FACILITY OF YOUR FACILITY OF YOUR FACILITY OF YOUR FACILITY OR	STATEMENT	TEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245252		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - THEIF RIVER CARE CENTER NEW BLDG		(X3) DATE SURVEY COMPLETED	
THIEF RIVER CARE CENTER    CAPID   SUMMARY STATEMENT OF DEFICIENCIES   PRETEX   (EACH DEFICIENCY MUST BE PRECEDED BY PULL   TAG   CROSS-REFERENCE OT THE APPROPRIATE   DEFICIENCY OF THE PROPERTY   CROSS-REFERENCE OF THE APPROPRIATE   DEFICIENCY OF THE PROPERTY   TAG   CROSS-REFERENCE OF THE APPROPRIATE   DEFICIENCY				B. WING		09/15/2015	
(EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG CROSS-REFERNOED TO THE APPROPRIATE DEFICIENCY)  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 CORRECTIVE ASSOCIATION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:					2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701		
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:	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE COMPLETION	
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:	K 000	INITIAL COMMEN	TS	KC	000		
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STATE FIRE MARSHAL DIVISION		Minnesota Departm Fire Marshal Division Thief River Care Co substantial complian participation in Med Subpart 483.70(a), 2000 edition of Nat Association (NFPA) Code (LSC), Chapt PLEASE RETURN CORRECTION FO DEFICIENCIES (K	nent of Public Safety, State on. At the time of this survey enter was found not in ince with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection ) Standard 101, Life Safety ter 18 New Health Care.  THE PLAN OF R THE FIRE SAFETY TAGS) TO:  RE INSPECTIONS		EPO(		

10/12/2015

**Electronically Signed** 

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.

Facility ID: 00448

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	TIPLE CONSTRUCTION NG 02 - THEIF RIVER CARE CENTER NEW	(X3) DATE SURVEY COMPLETED	
		245252	B. WING _		09/15/2015
	NAME OF PROVIDER OR SUPPLIER  THIEF RIVER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRICIENCY)	JLD BE COMPLETE
K 000	By e-mail to: Marian.Whitney@s or Angela.Kappenman  THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO  1. A description of v to correct the deficit  2. The actual, or pr  3. The name and/oresponsible for comprevent a reoccurre  Thief River Care Coin 2011 is 1-story, v determined to be or The building is divice 90-minute fire barri  The building is fully accordance with NI Installation of Autor edition. The facility automatic smoke d in all common use NFPA 72 "The Native dition. All sleeping with other hazardod detectors, that are of the control	state.mn.us  n@state.mn.us  RRECTION FOR EACH  ST INCLUDE ALL OF THE  DRMATION:  what has been, or will be, done iency.  oposed, completion date.  r title of the person rection and monitoring to ence of the deficiency  enter building was constructed without a basement and was f a Type II (000) construction. ded into three smoke zones by			

		& WEDICAID SERVICES					0830-038
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245252		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 02 - THEIF RIVER CARE CENTER NEW BLDG			(X3) DATE SURVEY COMPLETED	
			B. WING	·		09/1	15/2015
	NAME OF PROVIDER OR SUPPLIER  THIEF RIVER CARE CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 001 EASTWOOD DRIVE HIEF RIVER FALLS, MN 56701		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 000	Continued From pa	ge 2	K	000			
	The facility has a cacensus of 68 at the	apacity of 70 beds and had a time of the survey.					
K 038 SS=D	NOT MET. NFPA 101 LIFE SA Exit access is arrar	42 CFR, Subpart 483.70(a) is FETY CODE STANDARD aged so that exits are readily les in accordance with section	K	038			11/17/15
	Based on observation determined that the several exit dischar accordance with NF edition, Sections 19 deficient practice of visitors if emergence discharge was necessified in the control of the control	veen 10:30 AM to 1:30 PM on observed that there were 7 of exit discharge paths that had a elevation due to the cement the first expansion joint that is			For 7 of the 9 required exterior exit discharge paths that have an half ind change in elevation due to the ceme sidewalk settling at the first expansic joint that is located 48 inches from the door we are having contractors to refor replace the mud jacks of the sinking paths back to the proper level.  The maintenance staff has been edu on what our plan is for the exit dischapaths on 9/15/15.  There will be quarterly audits that will occur during the maintenance facility inspection event that has been added the current inspection check lists.	ent on ne exit emove ing ucated arge	
	These deficient pra- Maintenance Super	ctices were confirmed by the visor (LL).			All results will be brought to the QAP committee meeting on a quarterly ba		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 02 - THEIF RIVER CARE CENTER NEW  BLDG			(X3) DATE SURVEY COMPLETED		
1	245252			B. WING				15/2015
		NAME OF PROVIDER OR SUPPLIER  THIEF RIVER CARE CENTER			20	REET ADDRESS, CITY, STATE, ZIP CODE 001 EASTWOOD DRIVE HIEF RIVER FALLS, MN 56701		
	(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	K 038 K 052 SS=C	A fire alarm system installed, tested, a with NFPA 70 Natio 72. The system ha	AFETY CODE STANDARD  In required for life safety is and maintained in accordance onal Electrical Code and NFPA is an approved maintenance in complying with applicable	K	038	Completion date 11/17/15.		10/16/15
		Based on observate facility failed to instance system in accordar 2000 NFPA 101, Sowell as 1999 NFPA 2-3.5.1. These detadversely affect the system that could demergency actions affecting residents facility.  Findings include:  On facility tour between 19/15/2015, observate smoke detectors of a HVAC diffuser	is not met as evidenced by: tion and staff interview, the call and maintain the fire alarm nee with the requirements of ections 19.3.4.1 and 9.6, as a 72, Sections 2-3.4.5.1.2, ficient practices could e functioning of the fire alarm delay the timely notification and a for the facility thus negatively staff, and visitors of the  ween 10:30 AM to 1:30 PM on vations revealed that there was that is located within 36 inches s located in the Laundry room			The smoke diffusers that was local within 36 inches of the HVAC systems the laundry room by the bank of draws moved on 9/15/15 over one of 2' X 2' ceiling tile making it more that 36" minimum distance from the air diffuser.  All other smoke diffusers located throughout the building have been audited. Quarterly audits will be do the smoke diffusers throughout the building for one year by the Environ Services Director or the Maintenary employee.  Maintenance staff was educated of 9/15/15 to help ensure that smoke diffusers are not located within 36 of the HVAC system.	em in yers omplete an the one on e nmental ace	
		near the bank of dryers.				As a preventative measure mainte staff is adding the inspection of all		A Print I de Brita Demanda A Communication C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	ILDING 02 - THEIF RIVER CARE CENTER NEW G		COMPLETED		
		245252	B. WING			09/	15/2015
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701		
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K 052	Continued From particles deficient promote Maintenance Super	actices were confirmed by the	K	052	detectors to the facility inspection of This will ensure that all smoke detectors and remain a minimum of 36" any HVAC air diffuser  All results will be brought to the QA committee meeting on a quarterly Completion date of 10/16/15.	ectors from	



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 <u>only a suggestion</u> 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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.

Thief River Care Center October 2, 2015 Page 2

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

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X3) DATE SURVEY COMPLETED			
			R WING	B. WING		
		00448	B. WING		09/17/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
THIEF RIV	ER CARE CENTER		STWOOD DRIVE	50704		
	CLIMMADY CT		IVER FALLS, MN (		TION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE	
2 000	2 000 Initial Comments		2 000			
	****ATTEN	TION*****				
	NH LICENSING CO	ORRECTION ORDER				
		innesota Statute, section on order has been issued				
	· ·	If, upon reinspection, it is				
		ncy or deficiencies cited				
		ed, a fine for each violation assessed in accordance				
		es promulgated by rule of				
	the Minnesota Department of Health.					
		ther a violation has been				
	corrected requires con					
		ule provided at the tag number indicated below.				
		several items, failure to				
	, , ,	e items will be considered				
	-	ack of compliance upon item of multi-part rule will				
		ent of a fine even if the item				
		ng the initial inspection was				
	corrected.					
	You may request a he	earing on any assessments				
	that may result from n	non-compliance with these				
		written request is made to				
	notice of assessment	15 days of receipt of a for non-compliance.				
		•				
	INITIAL COMMENTS					
		articipate in the electronic ure orders consistent with				
	the Minnesota Depart					
	Informational Bulletin					
	· ·	e.mn.us/divs/fpc/profinfo/inf				
	obul.htm The State I delineated on the atta	•				
	delineated on the atta	icheu Minnesola				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

10/12/15 Electronically Signed

TITLE

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00448	B. WING		09	0/17/2015	
	ROVIDER OR SUPPLIER	2001 EAS	DDRESS, CITY, STATE STWOOD DRIVE VER FALLS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 000	you electronically. Al is necessary for State enter the word "correctext. You must then in State licensure proce completion date, the corrected prior to elect Minnesota Department on 9/14/15, 9/15/15, surveyors of this Depabove provider and the orders are issued. Ple electronic plan of correviewed these order they will be completed. Minnesota Department the State Licensing of federal software. Tag assigned to Minnesota Nursing Homes.  The assigned tag nur column entitled "ID Festatute/rule out of correction order. This findings which are in after the statement, "evidence by." Following are the Suggested Medical Time period for Correction Cor	orders being submitted to though no plan of correction e Statutes/Rules, please cted" in the box available for indicate in the electronic iss, under the heading date your orders will be ctronically submitting to the int of Health.  9/16/15, and 9/17/15 artment's staff, visited the interest of condicate in your rection that you have is, and identify the date when id.  Int of Health is documenting correction Orders using numbers have been in a state statutes/rules for interest of Deficiencies" column in Comply" portion of the column also includes the violation of the state statute This Rule is not met as ing the surveyors findings ethod of Correction and into the States, which is the surveyors findings ethod of Correction and into the States, which is not the States, and the surveyors findings ethod of Correction and into the States, which is not the States, and the S	2 000				
		OF CORRECTION." THIS AL DEFICIENCIES ONLY.					

Minnesota Department of Health

STATE FORM 6899 OOTB11 If continuation sheet 2 of 32

Minnesota Department of Health

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00448	B. WING		09/17/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THIEF DIV	ER CARE CENTER	2001 EAST	WOOD DRIVE			
I HIEF KIV	ER CARE CENTER	THIEF RIVI	ER FALLS, MN	56701		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	Ξ
2 000	Continued From page	2	2 000			
	THIS WILL APPEAR	ON EACH PAGE				
	THIS WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		2 830		10/16/15	
	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.					
	by: Based on observation review, the facility fail monitoring and asses (R63) who was review levels. Findings include: R63's Face Sheet dat diagnoses included of (difficulty breathing), failure (decrease in here)	t is not met as evidenced  n, interview and document ed to provide appropriate esment for 1 of 1 resident ed with high blood glucose  ted 7/23/14, indicated R63's hronic airway obstruction diabetes, congested heart eart function to pump failure (kidney failure),		R63¿s Diabetic care was reviewed wither Physician and her POC was revise R63 will be followed by the Diabetic educator for insulin management. We be updating the Diabetic educator eveweeks until blood sugars are stable between 200 and 300. Staff is to moniand 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 direct	ed, will ry 2 tor	

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Minnesota Department of Health						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		00448	B. WING		09/17/2015	
			1		1 00/1	1,2010
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THIFF RIV	ER CARE CENTER	2001 EAST	WOOD DRIVE			
		THIEF RIVE	ER FALLS, MN	56701		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
IAG	TREGOLD TOTAL OTTE		IAG	DEFICIENCY)	W (1 E	
2 830	Continued From page	2 3	2 830			
	macular degeneration (poor vision), peripheral autonomic neuropathy (peripheral nerve damage			on what to do if a resident is hypoglyc	emic	
				or hyperglycemic.		
	often caused by diabe			,, ,,		
	,	,		Nursing staff were reeducated on the		
	R63's care plan dated	d 8/29/14, indicated R63 was		revised Glucose Testing Policy and or	1	
	diabetic and directed	staff to conduct glucose		R63¿s revised Diabetic POC will be		
	monitoring as ordered	d and to monitor for signs		completed by 10/16/2015.		
	and symptoms of hyp	oglycemia (low blood				
	glucose levels) and hyperglycemia (high blood			All residents with Glucose monitoring	were	
	glucose levels).			assessed to ensure appropriate		
				monitoring and assessment for high		
	R63's quarterly Minim	num Data Set (MDS) dated		and/or low blood sugars is in place by		
	8/28/15, indicated R6	•		10/9/2015. (Directions and documenta	ation	
	impairment and was o	on insulin daily.		present in EMR)		
	D62's Dhysisian Ords	or Shoot dated 0/1/15		Random audits of documentation of b	lood	
	R63's Physician Orde	heduled to receive the		glucose monitoring and follow up as	1000	
	following medication f			needed will be conducted by the		
	ionowing medication i	of fici diabetes.		DON/designee 2Xwk X3, then weekly	x4	
	- Lantus (insulin) 1	2 units subcutaneous		Audit results will be brought to the QA		
		cutaneous tissue - SQ)		committee for review and further		
	every 8:00 a.m.	,		recommendations.		
	- Lantus 4 units S0	Q every 8:00 p.m.				
	- Humalog (insulin	) 2 units SQ every 5:00 p.m.		Completion date: 10/16/15		
	- Humalog sliding	scale (scale utilized to				
	determine the amoun	t of insulin to be given				
		od glucose level at the time)				
	twice a day before me	eals at 8:00 a.m. and 12:00				
	noon:					
	_	ar is less than 200				
	milligrams per decilite					
		ood sugar between 201-250				
	mg/dL					
		ood sugar between 251-300				
	mg/dL	and augar batwans 201 250				
		ood sugar between 301-350				
	mg/dL o Give 7 units if blo	ood sugar is greater than 7				
	O GIVE / UTILIS II DIC	oo sayar is greater triair i	1			

Minnesota Department of Health

units mg/dL

Humalog 2 units SQ if blood sugar greater

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Minnesota Department of Health

STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		00448	B. WING		09/1	7/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
THIFF RIV	ER CARE CENTER	2001 EAS	WOOD DRIVE			
		THIEF RIV	ER FALLS, MN	56701		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	Continued From page	2 4	2 830			
	than 500 mg/dL					
	On 9/16/15, at 7:48 a walking to the dining i	.m. R63 was observed 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)					
	level checked four time and at bedtime). RN-three months of blood listed below and verification.	a.m. registered nurse as to have her blood sugar nes a day (before each meal B confirmed R63's last I sugar reading results as ned R63's medical record n of a recheck on any of				
	548 mg/dL - 9/10/15, at 9:23 p 560 mg/dL - 8/30/15, at 9:01 p 555 mg/dL - 8/30/15, at 5:15 p 595 mg/dL - 8/24/15, at 8:54 p 600 mg/dL	o.m. blood glucose result =				

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PRINTED: 10/19/2015

Minnesot	ta Department of Healtl	h			FORM	IAPPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLE	
		00448	B. WING		09/1	7/2015
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,		
THIEF RIV	/ER CARE CENTER		/ER FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 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	562 mg/dL - 8/17/15, at 8:47   562 mg/dL - 8/15/15, at 7:22   600 mg/dL - 8/2/15, at 9:37 p. 541 mg/dL	p.m. blood glucose result = p.m. blood glucose result = .m. blood glucose result = 4 p.m. blood glucose result =	2 830			

mg/dL - 7/14/15, at 7:24 p.m. blood glucose result =

556 mg/dL

7/28/15, at 8:23 p.m. blood glucose result =

7/18/15, 3:53 p.m. blood glucose result = 530

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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
, "4D I LAIN	. JOHN LOTTON	IDENTIFICATION NOWIDEN.	A. BUILDING:		CONTE		
		00448	B. WING		09/	17/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
THIEF RIV	ER CARE CENTER		TWOOD DRIVE				
			/ER FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
2 830	Continued From page	e 6	2 830				
	for signs and symptor	ms of hyperglycemia.					
	for R63 dated 5/28/20 was up to 12 from 10 of action indicated R6 the past recommendate had been declined as from hypoglycemia. The recommended a need sugar goals for R63 indicated by medical A1C had been done. The recommended by the recommended by the sugar goals for R63 indicated by medical sugar goals for R63.	d to identify A1C and blood The follow up action doctor (MD)-A was that an No goals had been 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.						
	indicated R63 was rethe morning and 4 un Humalog. In addition blood glucose level be	ress note dated 8/22/15, ceiving Lantus 12 units in its at night and sliding scale , acknowledgement of R63's eing over 600 mg/dL and diabetic with past episodes					
	glucose levels over 50 the physician and word glucose level in 30 mi would especially rech within 30 minutes if R over 500.	inutes. RN-B stated she leck R63's blood sugar level 63's blood sugar levels were					
	On 9/17/15, at 2:32 p	.m. the director of nursing					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		00448	B. WING		09/1	17/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
THIEF RIV	ER CARE CENTER		TWOOD DRIVE ER FALLS, MN			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	 DN	(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETE DATE
2 830	Continued From page	÷ 7	2 830			
	nursing to give an addinsulin every one hou R63's blood glucose I On 9/17/15, at 3:45 p would not expect staf glucose level even if i an expectation of staf R63's blood glucose I they (physician) would to do about it. The Distaff to document if R and symptoms of hyp stated the goal was to glucose levels betwee DON verified R63's 6 have been higher that machine only read "habove 600 mg/dl. The unable to document "so they wrote 600 mg reading the machine only reading t	c.m. the DON stated she f to recheck R63's blood t read "high", nor would it be f to notify the physician if evel was over 500 because d ask what we wanted them ON stated she would expect 63 was having any signs erglycemia. The DON or maintain R63's blood en 200-300 mg/dL. The DON mg/dL readings could in 600 as the glucose igh" when a blood sugar was a DON also stated staff were high" on the monitoring form read. The DON also in a long time ago since R63				
	been monitoring R63 hyperglycemia and re	.m. the consulting nursing staff should have for signs and symptoms of checking R63's blood hey were reading over 500				
	system manufacture i blood glucose levels a machine will read "Hi"	est strip and if this message				

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STATE FORM 6899 OOTB11 If continuation sheet 8 of 32

Minnesota Department of Health

			(X3) DATE SURVEY COMPLETED			
		00448	B. WING		09/17/2015	
	ROVIDER OR SUPPLIER	2001 EAS	DRESS, CITY, STA TWOOD DRIVE VER FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
2 830	for advice if test resul symptoms of high blo  The Blood Glucose To provided instructions glucose sample, how on what to do if a resi hyperglycemic.  No policy on critical v of clinical change to the support of Nursing polices for monitoring glucose levels and prinvolved staff. A design the system to assure are being completed at the receive adequate in assurance committee monitoring of the product of the pr	tely! Contact the physician ts are very high and/or show od glucose.  esting policy dated 4/13, on how to obtain a blood ever did not give direction dent was hypoglycemic or alue reporting or notification the provider were provided.  OD OF CORRECTION:  Ing could review and revise and assessment of blood ovide additional training to gnated staff could monitor monitoring and assessment and residents are supported interventions. The quality is could provide on going cess to assure monitoring olood glucose levels are	2 830			
2 965	-Nutritional Status  Subpart. 2. Nutritional must ensure that a rewhich supplies the call determined by the collassessment. Substitutional Status	Subp. 2 Dietary Service  al status. The nursing home sident is offered a diet loric and nutrient needs as mprehensive resident utes of similar nutritive value sidents who refuse food	2 965		10/16/15	

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Minnesot	Minnesota Department of Health							
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED			
		00448	B. WING		09/17/2015			
					1			
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, ST	,				
THIEF RIV	ER CARE CENTER		TWOOD DRIVI					
		THIEF RI	VER FALLS, MI	N 56701				
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT OF ACTION AND ACTION ACTION AND ACTION ACTION ACTION AND ACTION ACTION AND ACTION A						
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP				
				DEFICIENCY)				
2 965	Continued From none	- 0	2 965					
2 905	Continued From page 9		2 905					
	served.							
	TI: 1015							
	•	t is not met as evidenced						
	by:	intoniou and document		P62 was seen by PD on 0 17 15 P6				
	Based on observation, interview and document review, the facility failed to comprehensively assess nutritional risk and implement appropriate			R63 was seen by RD on 9-17-15. R63 stated she doesn at want supplements				
				feels this is a good weight for her. DN				
		to minimize the risk of		spoke with R63 and R63 feels that 97				
		residents (R63) reviewed		her ideal body weight and would only				
	who was underweight			concerned about her weight if is fell b				
	J			95#. R63 weight range will be from 95				
				105# per input from R63, IDT and cor	nsult			
	Findings include:			DM.				
				All residents with a BMI < 18.5 will ha				
		t and continued to slowly		identified ideal body weights and weight				
	lose weight and facilit			range goals, unless the resident ¿s cli	nical			
	comprehensive nutriti			condition demonstrates that it is not	for			
	weight loss.	e interventions to address		possible. Residents will be assessed appropriate interventions to maintain				
	weight 1055.			increase weight as needed. DM will r				
				notes with the identified information a				
	R63's Face Sheet dat	ted 7/23/14, indicated R63's		adjust the care plan on identified				
		hronic airway obstruction		residents.				
		diabetes, congested heart						
	failure (decrease in he	•		DM will refer all residents whose BMI				
		failure (kidney failure) and		drops below 18.5 to the RD for review	/ and			
	underweight.			recommendations.				
				Random audits of documentation of				
	D001	D 4 0 4 (4450)		nutritional assessment will be conduc	ted			
		num Data Set (MDS) dated		by the DON/designee 2Xwk X3, then				
	8/28/15, indicated R6	•		weekly x4. Audit results will be brough				
	impairment, had feeling	-		the QAPI committee for review and fu	irtner			
		equired set up assistance		recommendations.				
	only with meals and v	vas on a therapeutic diet.		Completion date: 10/16/2015				
				Completion date: 10/16/2015				

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R63's care plan dated 2/23/15, indicated R63 had

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
71127271	or definition	IDEITH IOMONOMBER.	A. BUILDING: _	A. BUILDING:		
		00448	B. WING		09/1	7/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THIEF RIV	ER CARE CENTER		TWOOD DRIVE 'ER FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	Continued From page 10		2 965			
	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.					
		v assessment dated 8/27/15, a therapeutic diet and was ght loss program.				
		rs dated 9/1/15, directed vith a cup of hot chocolate a day at 9:00 a.m.				
	breakfast in the dining cup of coffee, glass o	m. R63 was served her g area which consisted of a f tomato juice, toast and a not chocolate with whole				
	•	.m. R63 confirmed she had akfast and no hot chocolate				
	R63's weight history v	vas:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  (X3) D. CO			
		00448	B. WING		09	9/17/2015
	ROVIDER OR SUPPLIER	2001 EA	ADDRESS, CITY, STATE  STWOOD DRIVE  VIVER FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 965	Continued From page - 9/15/15 - 97.8 pc - 8/14/15 - 97.8 pc - 7/17/15 - 98.6 pc - 6/19/15 - 99.2 pc - 6/8/15 - 103.8 pc	ounds ounds ounds ounds	2 965			
	a consistent carb diet supplement ordered on sugar added hot of weight had been stab. R63's body mass ind assess when a persounderweight) was 16 underweight. R63 had the past, but didn't lik blood sugar too much with no sugar added refused it during the stable or sugar added refused it	2, which indicated R63 was ad tried other supplements in the ethem or they affected her not not not not not chocolate, however, summer months on some portions of food, but usually				
	8/23/14, indicated R6 loss. It was suggeste and fat through her for addition, it was reconnutritional supplemer weight loss. Recomme R63 with Glucerna (naday. Contact the R6	ed dietician (RD) note dated is had had some weight ed for R63 to have protein ood with every meal. In amended R63 be on a set to help stop continued nendation was to provide utritional supplement) twice D with any further nutritional s. RD will follow as needed.				
	R63's medication adr	ninistration record for August				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDIEAN	or contribution	IDENTIFICATION NOMBER.	A. BUILDING: _		OOW!! EE	ILD
		00448	B. WING		09/17	7/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
THIEF RIV	ER CARE CENTER		TWOOD DRIVE ER FALLS, MN			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTIO	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
2 965	Continued From page	e 12	2 965			
		, lacked documentation that ed hot chocolate and whole				
	tried ensure and boos supplements) and she stated the hot chocola	a.m. R63 stated she had st (both nutritional e didn't like them. R63 ate and whole milk was e liked ice cream and malts.				
	On 9/17/15, at 11:18 (RN)-B confirmed R6 verified R63 had cont	3 was weighed weekly and				
	confirmed R63 had be supplement), however discontinued on 10/29 R63 was slowly still to R63 did have a slight drinking the hot chock however, when summ because of the heat. was 16.2 on 9/15/15, underweight. The DM been involved with R6 six months. The DM any resident who had gain to the RD for furt definitely refer a resid like R63 or if the DM	9/14. The DM confirmed osing weight. The DM stated weight gain when R63 was				
		.m. an attempt to contact ne RD was unable to return				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			5 444140			
		00448	B. WING		09/1	7/2015
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
THIEF RIV	ER CARE CENTER		WOOD DRIVE ER FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 965	Continued From page	e 13	2 965			
	a call during this survey time.					
	a can dannig and carvey and.					
	indicated the RD wou residents that were at loss/change, wounds	, new admissions, annual d assessments and charting				
	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 provided.	al risk and assessment was				
	The Director of Nursir review and revise poli assessments and the nutritional supplemen could provide educati DON or designees co system to ensure nutriassessed and nutritio implemented. The quantitation of the policy of the provided pro	implementation of its. The DON or designee on to involved staff. The build develop an auditing ritionally at risk residents are nal interventions have been ality assurance committee g monitoring of the process				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00448	B. WING		09/17/2015
	COVIDER OR SUPPLIER	2001 EAS	DDRESS, CITY, STA		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
	machines, stationary- machines, and spray- chemicals for sanitizat that:  A. wash water tel chemicals, rinse wate chemical sanitizers us NSF International Sta by reference in subpa Detergent and Chemi Spray-Type Dishwash NSF International, No standards are incorpo are available through system. They are no B. a test kit or oth measures the parts p the sanitizing solution used, and a log of the maintained for the pre C. containers for must be installed in s that operators mainta sanitizing compound; D. a visual or audible provided for the opera sanitizing agent is de  This MN Requiremen by: Based on observation review the facility faile	anitization. Single-tank rack machines, door-type type glass washers using tion may be used, provided mperatures, addition of the temperatures, and sed are in conformance with andard No. 3, incorporated art 2, and Standard No. 29, cal Feeders for Commercial ning Machines, issued by evember 1992. These prated by reference. They the Minitex interlibrary loan at subject to frequent change; there device that accurately the million concentration of a must be available and be a test results must be evious three months; storing the sanitizing agent uch a manner as to ensure in an adequate supply of and a warning device must be ator to easily verify when the	21155	The meat slicer was cleaned and sani 9/17/2015. No further debris/residue comeat slicer noted after cleaning by Die	n

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MILLIESOF	a Department of Fleatti					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ĒΤΕD
		00448	B. WING		09/1	7/2015
					1 0011	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	, and the second		
THIEF RIV	ER CARE CENTER		WOOD DRIVE			
		I HIEF RIVE	R FALLS, MN	56701		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
21155	Continued From page	15	21155			
	their meals from the kitchen.			All Dietary Staff were educated on		
				cleaning the meat slicer on 9/21/2015		
	Eindings include:			Meat slicer must be cleaned and sanii after each use.	izea	
	Findings include:			alter each use.		
				Documentation of chemical sanitizer v	vill	
	On 9/14/15, at 2:00 p.	.m. during the initial kitchen		be documented on new form when 3		
	-	nanager (DM), the facility		compartment sink is used. Staff has b	een	
	meat slicer was obser	rved to have pieces of dried		educated on 10/9/2015 on how to		
		the blades and on the base		document chemical sanitizer test strip	S.	
		DM verified the findings and				
		was not clean, however,		Audits will be completed for the first fo		
	-	been used that day. At this ne evening cook to clean it.		uses every time the slicer is used. Sta		
		f cleaned and sanitized the		will notify Dietary Manager or designe when used. Then audits will be compl		
		tated it had to be cleaned in		randomly for four months to ensure m		
		nt sink because it would not		slicer is clean and documentation	out	
	-	ner. The DM stated staff		completed.		
	used sanitation chem	icals in the three		·		
	compartment sink and	d staff used chemical paper		All audits will come quarterly to the Q	4PI	
		e the chemical sanitizer was		committee meeting.		
		ded sanitizing solution.				
	When asked to see th					
		on method was utilized in the				
		ne facility had not logged / ne test strip results because				
	•	nt sink was not used that				
		se went in the dishwasher.				
	onton do oronyaming or					
					l	
		.m. the DM lifted the cover				
		d it was again observed to			ĺ	
		es of dried debris / residue			ĺ	
		base of the machine. The			ĺ	
		not cleaned. The DM stated			ľ	
		staff person had utilized the nk to clean the meat slicer				
	or not.	TIK to clean the meat silver			ĺ	
	o. not.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00448	B. WING		09/	17/2015
	ROVIDER OR SUPPLIER	2001 EAS	DDRESS, CITY, STATE STWOOD DRIVE VER FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21155	if cooking equipment	a.m. the administrator stated was not cleaned or sanitized tential to effect all residents	21155			
	Pans included Three The policy indicated u by hand will be clean Procedure included: Check chemical sanit	izer with Hydrion se for 30 seconds. Compare				
	The Dietary Manager revise policies and pr conditions in the Dieta appropriate training for	ary Department and provide or involved staff. The DM tem to assure sanitation				
	TIME PERIOD FOR ((21) Days	CORRECTION: Twenty-one				
21426	MN St. Statute 144A. Prevention And Contr	04 Subd. 3 Tuberculosis ol	21426			10/16/15
	maintain a compreher infection control progressive current tuberculosis in issued by the United Control and Preventice	ram according to the most nfection control guidelines States Centers for Disease				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00448	B. WING		09/17/2015
	ROVIDER OR SUPPLIER	2001 EA	DDRESS, CITY, STA STWOOD DRIVE IVER FALLS, MI	Ē	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
21426	This program must in infection control plan unpaid employees, coresidents, and volunted Health shall provide tregarding implements	ty Weekly Report (MMWR). clude a tuberculosis that covers all paid and ontractors, students, eers. The Department of echnical assistance ation of the guidelines.	21426		
	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.			Corrected	
	Findings include:				
	RESIDENT TST:				
	R73's electronic med received the first step test was read as negainduration on 7/3/14 (				
		.m. director of nursing above documentation was dical record.			

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STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7.1. 231251113.		
		00448	B. WING		09/17/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
THIEF RIV	ER CARE CENTER		STWOOD DRIVE VER FALLS, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
21426	Continued From page 18		21426		
	EMPLOYEE TST:				
	5/19/15. LPN-C's TS indicated LPN-C rece on 5/19/15. This test	ived the first step of her TST was read on 5/21/15, with a lt. However, LPN-C lacked			
	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.				
	according to NA-B's TNA-B's first step TST	a.m. the DON confirmed "ST administration form, had been administered and (4/1/15) and should not			
	On 9/17/15, at 1:56 p LPN-C did not have h completed and should	· · · · · · · · · · · · · · · · · · ·			
	employees would be TB screening comple baseline TB screening	cy dated 4/15, indicated all required to have a baseline ted at the time of hire. The g consisted of assessment of active TB disease and			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SI COMPLE		
		00448	B. WING		09/1	7/2015
	ROVIDER OR SUPPLIER	2001 EAST	RESS, CITY, STA WOOD DRIVE ER FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21426	TST process involved completed in 1-3 ween negative. In addition, would have complete symptoms and a standard The TST administration a TST would be read test being administered step TST results were step TST results were	ce of infection by step TST. The two step I an initial TST with a repeat ks, if the employee was each resident admitted d a TB screening for dard two step TST.  on form, indicated results of between 48-72 hours of the ed. In addition, if the first e negative, a second step n one to three weeks after	21426			
21535	Subpart 1. General. must be free from uniunnecessary drug is a A. in excessive of therapy; B. for excessive of therapy; C. without adequivation of the druger of the document of the doc	A resident's drug regimen necessary drugs. An any drug when used: ose, including duplicate drug	21535			10/16/15

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wiinnesot	a Department of Healtr	1				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
		00448	B. WING		00/4	7/2015
		00440			09/1	1/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
THEE DIV	ED OADE OENTED	2001 EAS	TWOOD DRIVI	Ē		
I HIEF KIV	ER CARE CENTER	THIEF RI	VER FALLS, MI	N 56701		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ı	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
				DEFICIENCY)		
21535	Continued From page 20		21535			
	This standard is incor	porated by reference. It is				
		Minitex interlibrary loan				
	•	Law Library. It is not				
	subject to frequent ch					
		ango.				
	This MN Requiremen	t is not met as evidenced				
	by:					
		nd document review, the		R63 target behaviors and		
	facility failed to identif	y target behaviors and		non-pharmacological have been adde	d to	
	implement non-pharm	nacological interventions for		her prn medication order. R14 prn		
		R63, R47) who received an		Zyprexia was discontinued by Dr. K or	า	
	as needed (PRN) ant	ipsychotic medication or a		9-18-15. R22 target behaviors added	to	
	PRN or scheduled an	tidepressant medication. In		medication order and care plan was		
	addition, the facility fa	illed to ensure		updated to include her target behavior	s	
	non-pharmacological	interventions were		and non-pharmacological intervention	s.	
	attempted prior to the	administration of a PRN				
	antianxiety/antidepres	ssant medication for 2 of 2		All licensed nursing staff and TMAs		
	residents (R14, R22).			educated on order entry for psychotro	pic	
				medication. Orders must contain prop	er	
				diagnosis, target behaviors, and		
	Findings include:			non-pharmacological interventions in t	:he	
				order for prn medications and target		
				behaviors for scheduled medications.	Staff	
	. 3	non-pharmacological		also educated on when providing prn		
	interventions to addre			medication they must try non-pharm		
		c medication) were not		intervention prior to providing the		
	identified for R14. In			medication. Their behavior note needs	s to	
		interventions were not		include the behavior and non-pharm		
	implemented prior to			intervention, as well as follow-up after		
	cionazepam (antianxi	ety medication) for R14.		administering the medication. Education	on	
				provided on 10-1-15		
	D14's Disease Disease	asis and Allargias shoot		All resident with scheduled paychetres	nio	
		osis and Allergies sheet		All resident with scheduled psychotrop		
		ted R14 had diagnoses that		medications will have identified target		
	•	ression, hypertension and		behaviors and care plans that reflect t		
	muscle weakness.			target behaviors, non-pharmacologica		
				interventions and potential side effects		
	D14's guartaris Minim	num Data Sat (MDS) datad		noted. All residents with prn psychotro		
	K 14 5 qualterly willim	num Data Set (MDS) dated		medications will have identified target		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		00448	B. WING		09/17/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		2001 EAST	WOOD DRIVE		
THIEF RIV	ER CARE CENTER		ER FALLS, MN		
(Y4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21535	Continued From page	e 21	21535		
	7/7/15, indicated R14 had no cognitive impairment and had trouble sleeping.  R14's care plan identified R14 received an			behaviors and non-pharmacological intervention in their order as well as caplan. Care plan will also indicate poter side effects of the medication. To be	
				completed by 10-16-15	
	address this problem resident to ventilate for resident's distress, er	n. Approaches identified to area included encourage eelings, explore reasons for avironmental stressors, and treatable medical		Random audits of PRN psychotropic medication documentation will be conducted by the DON/designee 2Xw X3, then weekly x4. Audit results will brought to the QAPI committee for rev	oe e
				and further recommendations.	
	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.			Completion date: 10/16/15	
	indicated the provider made a change in R1 The provider had orde medication to be decr for one week, then Zy	dated 8/21/15, at 2:56 p.m., had made rounds and had 4's Zyprexa medication. ered for R14's Zyprexa reased to 2.5 mg twice a day yprexa 2.5 mg once a day PRN.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP		
		00448	B. WING		09/	17/2015
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,		
THIEF RIV	ER CARE CENTER		TWOOD DRIVE /ER FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
21535	Continued From page	22	21535			
	dated 7/1/15-9/16/15, administered clonaze 7/11/15, 7/18/15, 7/22 8/16/15, 8/17/15, 8/19/5/15. The documen non-pharmacological prior to the administraclonazepam. In addit 2.5 mg on 9/7/15. Thidentification of target medication and non-p	interventions attempted ation of these doses of ion, R14 received Zyprexa e documentation lacked behaviors for giving this pharmacological ad been attempted prior to				
	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 pharmacist (CP) state	.m. the consulting ed staff should have been				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		00448	B. WING		09/	17/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THIEF RIV	ER CARE CENTER		TWOOD DRIVE /ER FALLS, MN			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	HE APPROPRIATE	COMPLETE DATE
21535	Continued From page	23	21535			
	identifying target beha non-pharmacological on an antipsychotic at The CP stated each in the leadership staff th upon their documentat non-pharmacological stated it was a system facility so she has not recommendation for e	aviors and interventions for residents and antianxiety medication. In onth she has reiterated to at they needed to improve attorn of target behaviors and interventions. The CP of the problem throughout the written this as a 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 had no cognitive feelings of being tired out of six days during was receiving an antic	and having little energy two the observation period, and depressant 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					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		l \ /	E SURVEY PLETED	
		00448	B. WING		09	9/17/2015
	ROVIDER OR SUPPLIER	2001 EAS	DDRESS, CITY, STATE STWOOD DRIVE IVER FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21535	0.25 mg of trazodone 8/26/15, 8/27/15, 8/3 9/4/15, 9/13/15, and 9 lacked identification of this medication and n interventions which has the administration of the	on 8/23/15, 8/24/15, 1/15, 9/1/15, 9/1/15, 9/2/15, 9/3/15. The documentation of target behaviors for giving on-pharmacological ad been attempted prior to the trazodone.	21535			
	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.					
	was diagnosed with s bipolar disorder, gene	of 9/17/15, indicated R22 schizoaffective disorder, eralized anxiety disorder, and end stage renal disease.				
	had intact cognition, f	dated 7/2/15, indicated R22 felt down and depressed and antipsychotic medications.				
	electronic record, indi Lorazepam (Ativan) ( milligrams (mg) give oneeded (PRN) two tindi anxiety disorder. Spe	ans Order Sheet in the icated an order for antianxiety), tablet, 0.5 one tablet by mouth, as nes per day for generalized cial instructions section cological to be attempted				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		00448	B. WING		09	9/17/2015
	ROVIDER OR SUPPLIER	2001 EA	DDRESS, CITY, STATE STWOOD DRIVE IVER FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21535	Redirection 2) One of chart on nonpharmac	ation of Lorazepam were 1) n One and directed staff to	21535			
	from 6/1/15, to 9/15/1	nted prior to the				
	7/1/15, indicated R22 psychoactive meds: 2 Ambien, Trazadone a diagnoses of bipolar disorder. The note also f screaming, clappin would sometimes maget angry if needs or immediately. The not behaviors occurred 1 pharmacological's we	received the following Zyprexa, Celexa, Ativan, and Depakote and had disorder and schizoaffective so indicated R22 had history g and yelling at staff and ke irrational requests and requests were not fulfilled e also indicated these -3 times per week and non ere sometimes effective in res and would sometimes proach and empathy.				
	implement the following and a control of the contro	ely. was anything she lling out/disruptive noises. dents needs when calling				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
00448		B. WING		09	09/17/2015		
THIEF RIVER CARE CENTER 2001 EASTV			DRESS, CITY, STATE TWOOD DRIVE ER FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
21535	disruptive for othersTry to answer resider -Behavior would increwould be back shortly -Use distraction and/or- offer activity, food or  The care plan care plan psychotropic drug use included to monitor for time to make needs kenvironmental factors attendance, venting or environment.  On 9/16/15, at 1:03 p (LPN)-A stated she did behaviors during the or behaviors occurred addition, LPN-A state PRN ativan to R22, the of any nonpharmacole attempted on the PRN Report or in the progress the Ativan doses give 8/25/15, at 1:48 p.m., 9/13/15, at 11:25 p.m. LPN-A verified there we record showing that in	tuation should behavior be  nt needs immediately. ase if staff tell her they by redirection beverage.  an further identified with interventions that r side effects, allow ample nown, assess , encourage activity f feelings and a calm  m. licensed practical nurse d not see "a lot" of R22's day, rather the majority of id in the evening. In d if staff administered the ney would document the use origical interventions N Medication Administration less notes. Upon review of n on 8/25/15, at 6:14 a.m. 9/3/15, at 5:44 p.m., n, and 9/15/15, at 9:53 p.m. livas no documentation in the on-pharmacological lempted or documented prior	21535	DEFICIENCY)			
	on 09/17/2015, at 12 (RN)-A verified non-p	2:14 p.m. registered nurse harmacological interventions and documented prior to					

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		00448	B. WING		09/1	7/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		2001 EAST	WOOD DRIVE			
THIEF RIV	ER CARE CENTER	THIEF RIV	ER FALLS, MN	56701		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
21535	Continued From page	e 27	21535			
21000	administering any profite documentation shipmedication form, in the behavior notes. RN-A R22's PRN Ativan admon-pharmacological documented and the any documentation. Fis for the documentation	n medication. RN-A stated would be on the PRN the progress notes or in the averified only 5 doses of ministration had interventions attempted and remaining 15 did not have RN-A stated " the expectation ion to be done."	21000			
	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.					
		ted 9/17/15, indicated R47 cluded major depressive n 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.					

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NOWIDER.	A. BUILDING:		JOHN LETED	
		00448	B. WING		09/17/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THIEF RIV	ER CARE CENTER		WOOD DRIVE ER FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
21535	Continued From page	28	21535			
	received Zoloft 25 mil antidepressant medic indicated R47 had regawhile and had no ob also indicated R47 was facility would not mak medication, and would any side effects from R47's Physicians Ord included an order for give 1 tablet by mouth R47's EMAR Monthly August, and Septembreceived sertraline (Zo	ated 6/15/15, indicated R47 ligrams (mg) (an ation) once daily. The CAA corted she had taken it for vious side effects. The CAA as a short term resident, the e any changes to the d continue to observe for				
	received antidepressa staff to encourage dai observe for common s mucous membranes a rounds with physician target symptoms of an non-pharmacological	interventions for anxiety.  m. R47 was observed the Evergreen common				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		SURVEY ETED
		00448	B. WING		09/1	17/2015
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
THIEF RIV	ER CARE CENTER		TWOOD DRIVE 'ER FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21535	behaviors were obser-at 11:18 a.m. R47 wa a table in the dining ro observedat 12:49 p.m. R47 wa her room. R47 respo greeted and made ey was doing well and in her medication regime.  On 9/17/15, at 3:01 p indication for use of the depression and confir symptoms of anxiety DON also confirmed the non-pharmacological R47's anxiety.  On 9/17/2015, at 4:19 facility should have id R47's anxiety and shound have id R47's anxiety and should have id R47's anxiety and shound have id R47's anxiety and should have id R47's anxiety an	a.m. R47 was up and wheelchair in her room. No roed. as seated in a wheelchair at form. No behaviors as seated in a wheelchair in inded pleasantly when e contact. She stated she dicated was satisfied with e  a.m. the DON verified the ne Zoloft was anxiety and fined there were no target identified for R47. There there were no interventions identified for interventions identified for D.p.m. the CP stated the entified target symptoms of bull have developed interventions for the anxiety. The entified target issues as well as an fissues identified at a indicated she had identified but verbally and in writing ommendation to identify	21535	DETICIENCY)		
	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					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:		I ' '	(X3) DATE SURVEY COMPLETED	
			B. WING				
		00448	B. WING		09	0/17/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
THIEF RIV	/ER CARE CENTER		STWOOD DRIVE				
		THIEF RI	VER FALLS, MN 5	6701			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21535	EF RIVER CARE CENTER  2001 EASTW THIEF RIVER  (4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		21535	DETICIEN			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE S  A. BUILDING: COMPL		(X3) DATE S	URVEY ETED
		A. BUILDING.				
00448		B. WING		09/17/2015		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THIEF RIVER CARE CENTER  2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701						
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
21535	Continued From page	31	21535			
21333		CORRECTION: Twenty-one				

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