DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 19, 2021

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

RE: CCN: 245252
Cycle Start Date: October 30, 2020

Dear Administrator:

On November 17, 2020, we notified you a remedy was imposed. On March 16, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 15, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 1, 2021 be discontinued as of March 15, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of November 17, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 1, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
March 1, 2021

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

RE: CCN: 245252
Cycle Start Date: October 30, 2020

Dear Administrator:

On November 17, 2020, we informed you of imposed enforcement remedies.

On February 18, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 1, 2021, will remain in effect.

- Directed plan of correction, Federal regulations at 42 CFR § 488.424 Please see electronically attached documents for the DPOC.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 1, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 1, 2021.

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

As we notified you in our letter of November 17, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 1, 2021.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 30, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's

Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal

dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 02/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 2/16/21 to 2/18/21 at your facility, by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations § 483.73(b)(6). The facility was in full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/16/21 through 2/18/21, an abbreviated survey was completed at your facility by the Minnesota Department of Health to conduct a COVID-19 Focused Infection Control survey and a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was found to be unsubstantiated. H5252055C (MN69774 & MN69778) However, as a result of the investigation a deficiency was identified at F585 and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567	F 000		

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

Electronically Signed | 03/03/2021

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F 000	Continued From page 1 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information	F 585		3/15/21

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F 585	Continued From page 2	F 585		

of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a

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F 585	Continued From page 3 summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a grievance concern regarding a missing personal item was acted upon timely for 1 of 3 residents (R4) who reported a missing military bracelet. Findings include: R4's annual Minimum Data Set (MDS) dated 12/8/20, indicated R4 was cognitively intact and had diagnoses which included anxiety disorder and depression. The MDS also indicated R4 exhibited no psychosis or behavioral symptoms. On 2/17/21, at approximately 3:00 p.m. R4 stated he was missing a military bracelet and agreed to discuss his concern the following day. During interview on 2/18/21, at 10:40 a.m.	F 585	A facility must complete all steps of a grievance including, v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; This requirement was not met by not following up with R4 regarding his missing bracelet after an investigation was performed. The Social Service Director will do a	

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F 585	Continued From page 4 nursing assistant (NA)-A stated R4 had reported R6 flushed his bracelet down the toilet. NA-A indicated R6 did wander into resident rooms and took things but she was not sure if this incident had occurred. NA-A stated she thought she had worked on the day in question but was not sure if R6 had wandered into R4's room and stated she was not sure what happened regarding the incident. The social services designee (SSD) took care of issues with resident missing items. During interview on 2/18/21, at 10:42 a.m. NA-B stated she was not aware R4 was missing any personal items. During follow up interview on 2/18/21, at 10:44 a.m. R4 stated he had been in the bathroom to clean up and had put his military bracelet on the shelf and went out of his room to get a cup of coffee. Afterward, R4 observed R6, in his bathroom, throw a disposable safety razor and R4's military bracelet into the toilet and flushed them. R4 indicated he had reported the concern to registered nurse (RN)-B and also to SSD. R4 stated he hadn't heard a word since he reported the incident which he indicated occurred maybe three to four months ago. R4 stated the bracelet had been engraved with his name and military rank and had "meant a lot to him." During interview on 2/18/21, at 11:13 a.m. RN-B stated she vaguely remembered R4 telling her that R6 had flushed his bracelet down the toilet. RN-B stated she thought she remembered someone other than the facility was going to get him a new one, however indicated SSD handled missing items. R4's Missing Items form dated 11/30/20, and	F 585	formal grievance for R4 regarding his missing bracelet. The SSD will follow up with R4 with a correction plan, and give a copy to him. This could potentially happen to anyone that files a grievance. The Administrator or designee will review and/or revise the Grievance/concern policies and procedures to ensure that all grievances were and will be addressed in a timely manner. The SSD, DON or designee will look at all grievances/concerns since 2/18/21 to make sure that they were addressed and followed up on per policy. The Administrator, DON or designee will educate all staff on the policies and procedures for grievances/concerns. The Administrator, DON or designee will audit for timeliness and compliance with the policies/procedures for grievances/concerns 1x/week for 4 weeks and then monthly thereafter. All findings will be brought to the QAPI committee for recommendations and ongoing compliance.	

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F 585	Continued From page 5	F 585		

signed by the social service designee (SSD), identified the report of a missing item was received by the SSD from R4. R4 reported R6 had come into his bathroom and took his military bracelet and flushed it down the toilet. The incident happened at 10:00 a.m. and was reported to the SSD at 2:00 p.m. The missing item was investigated by the person receiving, however, the sections for areas searched, investigation information, response, and resolution were blank. A sheet of paper was attached to the form with handwritten notes which indicated:
- 12/1/20: searched R6's room for bracelet - not able to find. Alerted staff working on Evergreen to be on the look out for the bracelet and to keep an eye out when working in other resident rooms. Missing items report distributed to all departments.
- 12/2/20: RN-B reported they had been working here since R4 admitted and had not seen a military bracelet. Staff also reported R4 did not get along with R6 and ? [questioned] if he was trying to get R6 in trouble.
The form lacked documentation of follow up and resolution with R4 on his missing bracelet.

During interview on 2/18/21, at 11:35 a.m. SSD reviewed R4's Missing Item form and verified R4 had reported the missing bracelet to her. SSD stated R4 had reported a couple of missing items around this same time. SSD indicated when a resident reported something missing she would first go to the laundry room to see if the item could be found and would then wait a couple of days to see if it surfaced. SSD indicated staff had told her R4 would often report items were missing even after they were found. SSD indicated they had looked for R4's missing item and had not

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F 585	Continued From page 6 found it. SSD verified no further follow up on R4's bracelet was documented. During interview on 2/18/21, at 3:59 p.m. with the director of nursing (DON) and nursing consultant (NC), DON stated the facility protocol was for SSD to investigate lost items. DON stated the facility had reimbursed residents for missing items if it was identified the facility was responsible for the loss. The nurse consultant included the facility would then replace the item. DON indicated she had not been aware of R4's missing item report until this survey, and stated R4's concern should have been followed up. The Resident Concerns policy dated 1/7/19, indicated resident concerns related to personal belongings, resident rooms, equipment, missing items, behaviors, etc. would be i. reported to the Social Service Department ii. determined if it is a reportable incident iii. documented on a concern form and/or other designated place i.e. on a log or in the medical record iv. routed to the appropriate department head would would document their follow up and return to Social Services v. Social Services or appropriate department would report back to the individual with the concern as appropriate. iv. Social Services/designee would keep the concern forms on file.	F 585		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		3/15/21

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F 880	Continued From page 7	F 880		

designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 8 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was completed for 1 of 2 residents (R2) who's personal cares were observed during the COVID-19 Focused Infection Control Survey. Findings include: On 2/17/21, at 7:41 a.m. nursing assistant (NA)-C and trainee NA-D entered R2's room and donned clean gloves. NA-C and NA-D removed R2's incontinence brief with a large amount of urine. NA-C and NA-D assisted R2 onto their left side. NA-C cleansed R2's buttocks, wiping front to back, rolled R2 side to side and applied a clean	F 880	The facility must ensure (vi) the hand hygiene procedures to be followed by staff involved in direct resident contact. This was not met by NA-C not removing soiled gloves, washing hands and then donning clean gloves on during R2□s cares. Also did not take contaminated gloves off while picking up room. The DON or designee will re-educate NA-C on the policy and procedure for hand hygiene. The DON or designee will review/revise TRCC□s policies and procedures on hand hygiene during cares and while at work.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 02/18/2021

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F 880	Continued From page 9 brief. NA-C and NA-D each put a shoe on R2's feet. NA-C did not remove their contaminated gloves or perform hand hygiene after cleansing R2's buttocks, before placing R2's shoes on their feet. NA-C and NA-D assisted R2 to a seated position and removed R2's nightshirt. NA-C preceded to wipe R2's armpits and under each breast with a wet, then dry cloth and applied deodorant to both of R2's armpits with the same contaminated gloves. R2 began wiping their nose on their bare arm. NA-D provided a tissue to NA-C who assisted R2 with wiping and blowing their nose, with the same contaminated gloved hands. NA-C discarded the used tissue in trash. NA-C failed to removed their contaminated gloves and perform hand hygiene and proceeded to close a folding desk lid, got a bra out of a drawer across the room, and finished dressing R2. NA-C placed a wheeled walker in front of R2 and applied a gait belt to R2's waist. Next, NA-C grabbed the handles of R2's wheelchair with her contaminated gloved hands and placed the wheelchair next to the bed and locked the brakes. NA-C proceeded to straightened items on R2's dresser with the same contaminated gloved hands. NA-C and NA-D assisted R2 to a standing potion with the assistance of R2's walker. NA-C and NA-D pulled up R2's pants, pivoted R2 to their wheelchair, and assisted R2 to sit. NA-C picked up bedding, with the same contaminated gloves, that had fallen on the floor during the process and placed it back on the bed. NA-D removed their gloves and applied hand sanitizer. NA-C wheeled R2 to the shared bathroom. NA-D put on clean gloves. NA-C	F 880	The DON or designee will educate all staff on the policies/procedures for hand hygiene and have all staff do a competency on hand hygiene. The DON or designee will perform hand hygiene audits 3x/week for 4 weeks, 2x/week for 4 weeks, and 1 x/week for 4 weeks and then monthly thereafter and as needed. The findings of the audits will be brought to QAPI for further recommendations and ongoing compliance.	

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F 880	Continued From page 10	F 880		

began to remove R2's incontinence brief and realized R2 was actively having a bowel movement. All bowel contents remained in the adult brief which NA-C then discarded. NA-C and NA-D, assisted R2 onto the toilet. NA-C then took off their contaminated gloves and applied new gloves without performing hand hygiene.

While R2 was on the toilet, NA-C brushed R2's hair, applied toothpaste to a toothbrush and brushed R2's teeth. While waiting for R2 to finish on the toilet NA-E entered bathroom, donned clean gloves and stayed with R2 and NA-D while NA-C put the dirty bedding into a plastic bag. When R2 indicated they were ready, NA-E and NA-C assisted R2 to a standing position with a gait belt while NA-D provided perineal care. NA-D removed gloves and washed hands. R2 was pivoted with assistance of NA-E and NA-C to the wheelchair. NA-E and NA-C removed gloves. NA-C wheeled R2 to the dining room then washed their hands in the kitchenette.

During interview on 2/17/21, at 1:48 p.m. NA-C stated they did not change their gloves after providing pericare and should have. NA-C stated she occasionally used hand sanitizer or washed their hands after removing gloves and before putting on clean gloves but stated it's a personal choice and didn't believe it was a policy.

During interview on 2/18/21, at 4:04 p.m. the director of nursing (DON) stated staff should use hand sanitizer and apply clean gloves upon entering a resident room. Gloves should be removed when they were visibly dirty and hand sanitizer applied before applying clean gloves. DON indicated a failure to do so would be an infection control concern.

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F 880	Continued From page 11 The facility Hand Hygiene policy, revised 5/8/17, indicated staff should wash their hands if moving from a contaminated body site to a clean body side during resident care, before and after contact with environmental surfaces or equipment in the immediate vicinity of the resident and after removing gloves or gowns. In other situations, alcohol-based hand sanitizers that are at least 60% alcohol may be used to decontaminate hands, instead of soap and water: When hands do not appear to be soiled, before and after assisting a resident when not in contact with bodily fluids, before and after contact with environmental surfaces or equipment in the immediate vicinity of the resident, and between glove changes.	F 880		

Electronically delivered
March 1, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: RJ0M11

Dear Administrator:

The above facility was surveyed on February 16, 2021 through February 18, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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	00448	A. BUILDING: _____ B. WING _____	C 02/18/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/16/21 to 2/18/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be UNSUBSTANTIATED: H5252055C (MN69774, MN69778). However, as a result of the investigation, licensing orders were issued at MN Rule 4658.0900 Subp. 1 and MN St. Statute 144.651 Subd. 20. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was completed for 1 of 2 residents (R2) who's personal cares were observed during the COVID-19 Focused Infection Control Survey. Findings include: On 2/17/21, at 7:41 a.m. nursing assistant (NA)-C and trainee NA-D entered R2's room and donned clean gloves. NA-C and NA-D removed R2's incontinence brief with a large amount of urine. NA-C and NA-D assisted R2 onto their left side. NA-C cleansed R2's buttocks, wiping front to back, rolled R2 side to side and applied a clean brief. NA-C and NA-D each put a shoe on R2's feet. NA-C did not remove their contaminated gloves or perform hand hygiene after cleansing R2's buttocks, before placing R2's shoes on their	21375	Corrected	3/15/21

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21375	Continued From page 3	21375		

feet. NA-C and NA-D assisted R2 to a seated position and removed R2's nightshirt. NA-C preceded to wipe R2's armpits and under each breast with a wet, then dry cloth and applied deodorant to both of R2's armpits with the same contaminated gloves.

R2 began wiping their nose on their bare arm. NA-D provided a tissue to NA-C who assisted R2 with wiping and blowing their nose, with the same contaminated gloved hands. NA-C discarded the used tissue in trash. NA-C failed to removed their contaminated gloves and perform hand hygiene and proceeded to close a folding desk lid, got a bra out of a drawer across the room, and finished dressing R2.

NA-C placed a wheeled walker in front of R2 and applied a gait belt to R2's waist. Next, NA-C grabbed the handles of R2's wheelchair with her contaminated gloved hands and placed the wheelchair next to the bed and locked the brakes. NA-C proceeded to straightened items on R2's dresser with the same contaminated gloved hands. NA-C and NA-D assisted R2 to a standing potion with the assistance of R2's walker. NA-C and NA-D pulled up R2's pants, pivoted R2 to their wheelchair, and assisted R2 to sit.

NA-C picked up bedding, with the same contaminated gloves, that had fallen on the floor during the process and placed it back on the bed. NA-D removed their gloves and applied hand sanitizer. NA-C wheeled R2 to the shared bathroom. NA-D put on clean gloves. NA-C began to remove R2's incontinence brief and realized R2 was actively having a bowel movement. All bowel contents remained in the adult brief which NA-C then discarded. NA-C and NA-D, assisted R2 onto the toilet. NA-C then took

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21375	Continued From page 4	21375		

off their contaminated gloves and applied new gloves without performing hand hygiene.

While R2 was on the toilet, NA-C brushed R2's hair, applied toothpaste to a toothbrush and brushed R2's teeth. While waiting for R2 to finish on the toilet NA-E entered bathroom, donned clean gloves and stayed with R2 and NA-D while NA-C put the dirty bedding into a plastic bag. When R2 indicated they were ready, NA-E and NA-C assisted R2 to a standing position with a gait belt while NA-D provided perineal care. NA-D removed gloves and washed hands. R2 was pivoted with assistance of NA-E and NA-C to the wheelchair. NA-E and NA-C removed gloves. NA-C wheeled R2 to the dining room then washed their hands in the kitchenette.

During interview on 2/17/21, at 1:48 p.m. NA-C stated they did not change their gloves after providing pericare and should have. NA-C stated she occasionally used hand sanitizer or washed their hands after removing gloves and before putting on clean gloves but stated it's a personal choice and didn't believe it was a policy.

During interview on 2/18/21, at 4:04 p.m. the director of nursing (DON) stated staff should use hand sanitizer and apply clean gloves upon entering a resident room. Gloves should be removed when they were visibly dirty and hand sanitizer applied before applying clean gloves. DON indicated a failure to do so would be an infection control concern.

The facility Hand Hygiene policy, revised 5/8/17, indicated staff should wash their hands if moving from a contaminated body site to a clean body side during resident care, before and after contact with environmental surfaces or equipment

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21375	Continued From page 5 in the immediate vicinity of the resident and after removing gloves or gowns. In other situations, alcohol-based hand sanitizers that are at least 60% alcohol may be used to decontaminate hands, instead of soap and water: When hands do not appear to be soiled, before and after assisting a resident when not in contact with bodily fluids, before and after contact with environmental surfaces or equipment in the immediate vicinity of the resident, and between glove changes. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise all facility policies and procedures regarding infection control such as handwashing and . Education could be provided to all staff. The DON or designee could initiate a monitoring system to ensure compliance. The quality assurance committee could monitor the effectiveness of the plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as	21880		3/15/21

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21880	Continued From page 6 well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a grievance concern regarding a missing personal item was acted upon timely for 1 of 3 residents (R4) who reported a missing military bracelet.	21880	Corrected	

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21880	Continued From page 7 Findings include: R4's annual Minimum Data Set (MDS) dated 12/8/20, indicated R4 was cognitively intact and had diagnoses which included anxiety disorder and depression. The MDS also indicated R4 exhibited no psychosis or behavioral symptoms. On 2/17/21, at approximately 3:00 p.m. R4 stated he was missing a military bracelet and agreed to discuss his concern the following day. During interview on 2/18/21, at 10:40 a.m. nursing assistant (NA)-A stated R4 had reported R6 flushed his bracelet down the toilet. NA-A indicated R6 did wander into resident rooms and took things but she was not sure if this incident had occurred. NA-A stated she thought she had worked on the day in question but was not sure if R6 had wandered into R4's room and stated she was not sure what happened regarding the incident. The social services designee (SSD) took care of issues with resident missing items. During interview on 2/18/21, at 10:42 a.m. NA-B stated she was not aware R4 was missing any personal items. During follow up interview on 2/18/21, at 10:44 a.m. R4 stated he had been in the bathroom to clean up and had put his military bracelet on the shelf and went out of his room to get a cup of coffee. Afterward, R4 observed R6, in his bathroom, throw a disposable safety razor and R4's military bracelet into the toilet and flushed them. R4 indicated he had reported the concern to registered nurse (RN)-B and also to SSD. R4 stated he hadn't heard a word since he reported the incident which he indicated occurred maybe three to four months ago. R4 stated the bracelet	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 02/18/2021

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had been engraved with his name and military rank and had "meant a lot to him."

During interview on 2/18/21, at 11:13 a.m. RN-B stated she vaguely remembered R4 telling her that R6 had flushed his bracelet down the toilet. RN-B stated she thought she remembered someone other than the facility was going to get him a new one, however indicated SSD handled missing items.

R4's Missing Items form dated 11/30/20, and signed by the social service designee (SSD), identified the report of a missing item was received by the SSD from R4. R4 reported R6 had come into his bathroom and took his military bracelet and flushed it down the toilet. The incident happened at 10:00 a.m. and was reported to the SSD at 2:00 p.m. The missing item was investigated by the person receiving, however, the sections for areas searched, investigation information, response, and resolution were blank. A sheet of paper was attached to the form with handwritten notes which indicated:
- 12/1/20: searched R6's room for bracelet - not able to find. Alerted staff working on Evergreen to be on the look out for the bracelet and to keep an eye out when working in other resident rooms. Missing items report distributed to all departments.
- 12/2/20: RN-B reported they had been working here since R4 admitted and had not seen a military bracelet. Staff also reported R4 did not get along with R6 and ? [questioned] if he was trying to get R6 in trouble.
The form lacked documentation of follow up and resolution with R4 on his missing bracelet.

During interview on 2/18/21, at 11:35 a.m. SSD

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reviewed R4's Missing Item form and verified R4 had reported the missing bracelet to her. SSD stated R4 had reported a couple of missing items around this same time. SSD indicated when a resident reported something missing she would first go to the laundry room to see if the item could be found and would then wait a couple of days to see if it surfaced. SSD indicated staff had told her R4 would often report items were missing even after they were found. SSD indicated they had looked for R4's missing item and had not found it. SSD verified no further follow up on R4's bracelet was documented.

During interview on 2/18/21, at 3:59 p.m. with the director of nursing (DON) and nursing consultant (NC), DON stated the facility protocol was for SSD to investigate lost items. DON stated the facility had reimbursed residents for missing items if it was identified the facility was responsible for the loss. The nurse consultant included the facility would then replace the item. DON indicated she had not been aware of R4's missing item report until this survey, and stated R4's concern should have been followed up.

The Resident Concerns policy dated 1/7/19, indicated resident concerns related to personal belongings, resident rooms, equipment, missing items, behaviors, etc. would be
i. reported to the Social Service Department
ii. determined if it is a reportable incident
iii. documented on a concern form and/or other designated place i.e. on a log or in the medical record
iv. routed to the appropriate department head would would document their follow up and return to Social Services
v. Social Services or appropriate department would report back to the individual with the

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21880	Continued From page 10 concern as appropriate. iv. Social Services/designee would keep the concern forms on file. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review, and/or revise policies and procedures to ensure resident/family grievances were appropriately addressed in a timely manner. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21880		