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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: SM5M
Facility ID: 00448

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **11/01/2006**
6. DATE OF SURVEY **10/17/2016** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35) **04/30**

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

12. Total Facility Beds **70** (L18)
13. Total Certified Beds **70** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date:
Lyla Burkman, Unit Supervisor — 10/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 12/12/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/01/1982** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **10/18/2016** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245252

December 12, 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 September 30, 2016 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 bed.

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

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

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

Sincerely,

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 21, 2016

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

RE: Project Number S5252026

Dear Ms. Halvorson:

On September 6, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 25, 2016. 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 October 17, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 13, 2016 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 August 25, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 30, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 25, 2016, effective September 30, 2016 and therefore remedies outlined in our letter to you dated September 6, 2016, 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 eNotice.

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245252	A. Building B. Wing	10/17/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 09/30/2016	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 09/30/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 09/30/2016
ID Prefix F0311 Reg. # 483.25(a)(2) LSC	Correction Completed 09/30/2016	ID Prefix F0334 Reg. # 483.25(n) LSC	Correction Completed 09/30/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	10/21/2016	28035	10/17/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
8/25/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245252	A. Building 02 - THEIF RIVER CARE CENTER NEW BLDG B. Wing	10/13/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 09/30/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) LB/mm	DATE 10/21/2016	SIGNATURE OF SURVEYOR 36536	DATE 10/13/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 8/23/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: SM5M
Facility ID: 00448

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2. STATE VENDOR OR MEDICAID NO. (L2) **591605000**

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

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

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

6. DATE OF SURVEY **08/25/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **04/30**

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

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

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

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Vienna Andresen, HFE NEII — Date: 09/16/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Mark Meath, Enforcement Specialist — Date: 10/17/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 6, 2016

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

RE: Project Number S5252026

Dear Ms. Halvorson:

On August 25, 2016, 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

Informal Dispute Resolution - **your right to request an informal reconsideration to dispute the attached deficiencies.**

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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 4, 2016, 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 November 25, 2016 (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 February 25, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING ______ B. WING ______	08/25/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		9/30/16

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

Electronically Signed — 09/15/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING ______ B. WING ______	08/25/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a plan of care to include restorative nursing range of motion services for 2 of 4 residents (R67, R19) reviewed who received restorative nursing services which was not identified on their care plans. Findings include: R67's annual Minimum Data Set (MDS) dated 7/28/16, indicated R67's diagnoses included heart failure and osteoporosis. The MDS also indicated R67 had cognitive impairment, was non-ambulatory, and required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS also indicated R67 had lower extremity impairment on one side and had received "0"days of rehab nursing services for range of motion (ROM). R67's Pressure Ulcer Care Area Assessment (CAA) dated 7/28/16, indicated R67 had a functional limitation in ROM and a decline in activities of daily living. R67's physical therapy progress note dated 4/28/16, indicated R67 was being discontinued from physical therapy and was to start a restorative program which included a bilateral lower extremity (LE) strengthening and ambulation program.	F 279	Thief River Care Center aspires to develop care plans that meets a resident s medical, nursing, and mental and psychosocial needs that are identified in their comprehensive assessment. R67 s Care plan was updated with their updated Restorative program plan. R60 s Care plan was updated with their updated Restorative program plan. R19 s Care plan was updated with their updated Restorative program plan. R65 s Care plan was updated with their updated Restorative program plan. All residents with Restorative programs are potentially affected and their programs will be documented on the resident s care plan, by Sept 30, 2016. Restorative training will be provided to nursing staff by Mon 9/26/16. DON/designee will complete random audits 3XwkX4, then weekly X 3, then monthly thereafter to review the resident s Restorative program; to ensure the program is care planned as directed by the resident s POC. Audit results will be brought to the QAPI Committee for review and further	

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R67's Restorative Nursing Program sheet dated 4/29/16, indicated R67 was to receive ROM to LE's for transfers and ambulation, 3-6 X per week. The goal was to increase or maintain strength in LE's for transfers and ambulation.

Review of R67's care plan dated 4/30/2016, did not address the restorative nursing program for ROM.

On 8/25/16, at 12:10 p.m. registered nurse (RN)-A verified R67's plan of care did not address ROM services.

R19's quarterly MDS dated 6/7/16, indicated R19 was diagnosed with Parkinson's disease, chronic ischemic heart disease and peripheral vascular disease. The MDS also indicated R19 had cognitive impairment, required extensive assist with bed mobility, transfers, walking in room, dressing, toilet use, and personal hygiene and had received "0" days of restorative nursing services for ROM. R19's undated, Pressure Ulcer CAA indicated R19 had a recent decline in activities of daily living and immobility.

R19's Restorative Nursing Program dated 10/22/14, which was completed by the physical therapist (PT) indicated R19's goal was to maintain bilateral LE ROM and strength for functional mobility and bed mobility. The PT started R19 on a LE ROM program.

R19's Restorative Nursing Program dated

Provider's plan of correction (F 279): recommendations.

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F 279	Continued From page 3 10/22/14, which was completed by the occupational therapist (OT) indicated R19's goal was to maintain bilateral upper extremity (UE) ROM and strength in order to maintain functional use. The OT started R19 on a UE ROM program. R19's current, Restorative Nursing Program sheet indicated R19 was to receive: - bilateral UE and LE ROM, 3-6 x a week. R19's current care plan did not address R19's ROM restorative program. On 8/25/16, at 11:20 p.m. RN-A verified R19's plan of care did not include the ROM plan. The Care Plans policy revised 9/1/15, indicated the plan of care identified resident needs, problems or concerns and was updated on an ongoing basis as needed, based on changes that occurred between care conferences. The care plan also specified which members of the interdisciplinary team were responsible for working with the resident to meet the identified specific goals.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		9/30/16

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F 282	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan interventions were implemented for 2 of 3 resident (R60, R65) who required restorative services and failed to provide a renal diet as directed by the care plan for 1 of 1 resident (R14) who required a renal diet. Findings include: R60's range of motion/restorative services was not provided as directed by the care plan. R60's care plan dated 8/18/16, indicated R60 was to ambulate on parallel bars with rehab staff as directed by R60's restorative nursing program, with two staff assistance and would continue to work with physical and occupational therapy through the next quarter. R60's Restorative Nursing Program (RNP) dated 5/18/16, sheet indicated R60 was to receive the NuStep to both upper and lower extremities 3-6 X a week. R60's physician order dated 7/19/16, indicated R60 was to have restorative nursing services for lower extremity (LE) ROM and parallel bar ambulation 1 x a day. Special instructions were indicated as follows: -L/E ROM exercises as directed 3-6x/week.	F 282	Thief River Care center s goal is to provide services by qualified persons in accordance with each resident s written plan of care. R60 s Restorative program was reviewed by Therapy and Restorative Nsg Coordinator, revised if appropriate, by Therapy staff and Rstv Coordinator, and the Care plan was updated with their Restorative program plan. R65 s Restorative program was reviewed by Therapy and Restorative Nsg Coordinator, revised if appropriate, and the care plan was updated with their Restorative program plan. All residents with Restorative programs are potentially affected and their programs will be reviewed and revised (prn) and documented on the resident s care plan, by Sept 30, 2016. Restorative training will be provided to all Nursing staff, to include importance of not pulling Restorative staff to the floor and completing all Rstv programs as care planned. DON/designee will complete random audits 3XwkX4, then weekly X 3, then monthly thereafter, to ensure the Restorative program is being provided as directed by the resident s POC. Audit results will be brought to the QAPI	

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F 282	Continued From page 5 -U/E ROM exercises as directed 3-6x/wk. NuStep exercise 1 x a day, special instructions: On 8/25/16, at 11:20 p.m. RN-A verified R60's care plan was correct and was not followed, as directed. R65 did not receive range of motion/restorative services as directed by the plan of care. R65's care plan printed on 8/25/16, indicated restorative nursing plan as directed by therapy with rehab aide and ambulates with rehab as indicated on restorative nursing plan. R65's R65's Physicians Order Sheet dated 8/25/16, indicated upper extremity range of motion (ROM) one time per day during day and passive ROM as directed to right shoulder. NuStep exercises on time per day Tuesday and Thursday during the day and ambulation one time per day every Monday, Wednesday, and Friday. Ambulation as indicated on restorative nursing plan. R65's restorative nursing program dated 9/28/15, indicated ROM to maintain current ROM to right upper extremity, and PROM for right shoulder. R65's Restorative nursing program dated 10/14/15, indicated walking to maintain level of function with ambulation. R65's Restorative nursing program dated 10/6/15, indicated ROM-NuStep for both lower extremities and left upper extremity to increase strength and activity tolerance.	F 282	Committee for review and further recommendations. R14 s renal diet was reviewed by the ESRD s Registered Dietician (RD), the facility s RD and the resident, in order to determine alternatives to food items the resident was refusing, in order to meet the requirements for the resident s renal diet. The resident s menu options were updated according to the renal diet assessment on 9/15/2016. The Dietary manager will conduct audits on the resident s renal diet menus and reception of the updated food alternatives 2XwkX2, weekly X3, then monthly thereafter. The RD will be updated on a monthly basis and consulted as needed if resident refuses the dietary recommendations. Audit results will be brought to the QAPI committee for review and further recommendations.	

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R65's restorative nursing aide treatment sheet for August 2016, indicated upper extremity ROM was completed 6 of 25 opportunities. NuStep exercises were completed 0 times and indicated resident refused. Ambulation was completed one time on 8/24/16, by wife, and documentation lacked signatures for other dates. The documentation indicated R65 walked with wife on August 1, 6, 18, 20, and 24.

On 8/24/16, at 9:49 a.m. R65 was observed ambulating with family member (FM)-A, who applied R65's right arm support, and transfer belt. R65 was observed to grab hand rail in hallway in pod area and FM-A was holding the transfer belt and following with R65's wheelchair (w/c). R65 ambulated approximately 25 feet and then seated himself into his w/c, R65 then raised up from w/c with FM-A's support and held onto a four footed cane and FM-A was holding transfer belt and pulling w/c behind resident. R65 ambulated approximately 25 feet and then sat back down into his w/c. FM-A proceeded to remove arm support and transfer belt and pushed R65 in his w/c back to his room.

On 8/23/16, at 5:31 p.m. FM-A stated R65 did not get his therapy again today. FM-A stated she was at the facility everyday and knew therapy was not getting done. FM-A stated the rehab aide had told her she would get pulled to the floor to help with resident cares and did not have time to provide rehab services. FM-A stated she walked R65 daily to make sure he received exercise and was able to get out of his wheelchair.

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On 8/25/16, at 9:57 a.m. registered nurse (RN)-B verified rehab was not provided for R65 and stated the rehab staff were pulled from restorative services in order to help provide direct resident cares.

On 8/25/16, at 10:18 a.m. NA-A stated rehab was not getting done due to being assigned to work with residents on the floor rather than provide restorative services and stated staff tried to do the best they could but restorative services does not always get done.

On 8/25/16, at 11:18 a.m. FM-A stated, she wanted R65 to receive restorative care so he remained strong and maintained transfer ability. FM-A stated she was advocating for her husband to ensure he was getting the help he needed.

On 8/25/16 , at 2:28 p.m. RN-B verified R65 should have received his restorative services as directed by the care plan.

R14 did not receive a renal diet as directed by the care plan.

R14's current care plan with a start date of 7/30/14, indicated R14 was to receive a renal diet which consisted of a 2 gram, low potassium diet with a 1500 milliliter (ml) fluid restriction (750 ml for nursing and 750 ml for dietary). The plan also indicated R14 would be offered fried eggs at brunch and dinner meal to encourage high

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Continued From page 8
protein foods.

On 8/24/16, at 8:21 a.m. R14 was observed seated in a wheelchair in the dining room for breakfast. R14 was served a meal of oatmeal with brown sugar and a glass of water.
-At 8:43 a.m. R14 stated she was done eating, removed her clothing protector, unlocked the wheelchair brakes and pushed back from the table. R14 ate 100% of her oatmeal but did not drink any of her water.

On 8/24/16, at 11:49 a.m. R14 was observed seated at a table in the dining room. NA-B approached R14 and obtained R14's menu with her identified meal preferences.
-at 11:51 a.m. NA-B offered R14 watermelon which she refused. R14 was then delivered a meal of pureed beef chow mein, mashed potatoes and gravy and a 240 ml glass of water.
-at 11:56 a.m. R14 ate her meal independently.
-at 12:06 p.m. R14 continued to eat only her mashed potatoes and gravy.
-at 12:16 p.m. R14 finished eating her meal. She consumed 75% of the mashed potatoes and gravy and took one bite of the pureed beef chow mein.
-at 12:17 p.m. R14's meal menu slip for the noon meal was reviewed. The menu slip indicated Renal Puree diet. No dairy, fluid restriction. Mashed potatoes and gravy were observed to be a menu choice.

On 08/25/16, at 1:59 p.m. RN-B confirmed R14 received a pureed renal diet. At the same time, the culinary director (CD) confirmed the therapeutic diets offered by the facility included a

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F 282	Continued From page 9 renal diet. CD indicated a renal diet addressed increased protein needs and included dietary restrictions, one of which included mashed potatoes. CD indicated each resident received a printed menu of meal options specific to their prescribed diet from which to choose each meal. When asked to review R14's mention options for the day, CD opened a computer program and displayed R14's current menu. CD confirmed R14 was to receive a renal pureed diet. CD also confirmed the menu sheet included an option of mashed potatoes and gravy which she indicated should not have been included in the menu. CD further indicated R14's daily menu did not include eggs which should have been an option. CD indicated the menu options were incorrect and she had not been aware the menu was incorrect. The Care Plan policy dated 9/1/15, indicated the plan of care included the approach to meeting identified goals including the care and services that must be provided to meet those goals, the frequency of services and date which expected goal were to be achieved. The policy also indicated the plan of care specified which members of the interdisciplinary team were responsible for working with residents to meet specific goals.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		9/30/16

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F 309	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facilty failed to provide a renal diet as ordered for 1 of 1 resident (R14) who was diabetic and required a renal diet. Findings include: R14's Face Sheet dated 8/25/16, indicated R14 had diagnoses which included end stage renal disease, hypertension and diabetes. R14's quarterly Minimum Data Set (MDS) dated 6/21/16, indicated R14 was cognitively intact and received dialysis. The MDS also indicated R14 was independent with eating and required set up only. R14's Nutrition Care Area Assessment dated 4/4/16, directed to refer to the dietary manager notation and assessment regarding nutrition. The Dietary Progress Note dated 3/24/16, indicated R14's diet was a renal diet. The Progress Note indicated R14 had chronic kidney disease and received hemodialysis three times per week. The Progress Note also indicated R14 was put on a pureed diet, thin liquids, was packed a lunch for dialysis days and had a high protein diet. R14's Physician Order Sheet included an order	F 309	Thief River Care Center endeavors to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the resident s comprehensive assessment and care plan. R14 s renal diet was reviewed by the ESRD s Registered Dietician (RD), the facility s RD and the resident, in order to determine an appropriate renal menu with alternatives to food items the resident was refusing, in order to meet the requirements for the resident s renal diet. The resident s menu options were updated according to the renal diet assessment on 9/15/16. Other residents with renal diets could be potentially affected and will have their renal diets reviewed to ensure are receiving the appropriate renal menu. The RD will be updated on a monthly basis and consulted as needed if resident is noncompliant with the dietary recommendations. The Dietary manager will conduct audits on the residents renal diet menus and reception of the updated food alternatives 2XwkX2, weekly X3, then monthly	

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F 309	Continued From page 11 dated 3/31/16, for puree renal diet three times per day at 8:00 a.m., 12:00 p.m. and 5:00 p.m. Special instructions: thin liquids via cup with no straw. R14's current care plan with a start date of 7/30/14, indicated R14 was to receive a renal diet which consisted of 2 gram, low potassium diet with a 1500 milliliter (ml) fluid restriction (750 ml for nursing and 750 ml for dietary). The plan also indicated R14 would be offered fried eggs at brunch and dinner meal to encourage high protein foods. The Dietitian Progress Note dated 7/6/16, indicated R14 was on the proper diet and was on a protein supplement which was needed to replenish after dialysis. On 8/24/16, at 8:21 a.m. R14 was observed seated in a wheelchair in the dining room for breakfast. R14 was served a meal of oatmeal with brown sugar and a glass of water. -At 8:43 a.m. R14 stated she was done eating, removed her clothing protector, unlocked the wheelchair brakes and pushed back from the table. R14 ate 100% of her oatmeal but did not drink any of her water. On 8/24/16, at 11:49 a.m. R14 was observed seated at a table in the dining room. Nursing assistant (NA)-B approached R14 and obtained R14's menu with her identified meal preferences. -at 11:51 a.m. NA-B offered R14 watermelon which she refused. R14 was then delivered a	F 309	thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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F 309	Continued From page 12 meal of pureed beef chow mein, mashed potatoes and gravy and a 240 ml glass of water. -at 11:56 a.m. R14 ate her meal independently. -at 12:06 p.m. R14 continued to eat only her mashed potatoes and gravy. -at 12:16 p.m. R14 finished eating her meal. She consumed 75% of the mashed potatoes and gravy and took one bite of the pureed beef chow mein. -at 12:17 p.m. R14's meal menu slip for the noon meal was reviewed. The menu slip indicated Renal Puree diet. No dairy, fluid restriction. Mashed potatoes and gravy were observed to be a menu choice. On 8/25/16, at 1:59 p.m. registered nurse (RN)-B confirmed R14 received a pureed renal diet. At the same time, the culinary director (CD) confirmed the therapeutic diets offered by the facility included a renal diet. CD indicated a renal diet addressed increased protein needs and included dietary restrictions, one of which included mashed potatoes. CD indicated each resident received a printed menu of meal options specific to their prescribed diet from which to choose each meal. When asked to review R14's mention options for the day, CD opened a computer program and displayed R14's current menu. CD confirmed R14 was to receive a renal pureed diet. CD also confirmed the menu sheet included an option of mashed potatoes and gravy which she indicated should not have been included in the menu. CD further indicated R14's daily menu did not include eggs which should have been an option. CD indicated the menu options were incorrect and she had not been aware the menu was incorrect.	F 309		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13 The undated Renal Diets policy indicated the dietitian would plan the menus in accordance with the physician ordered diet restrictions.	F 309		
F 311 SS=E	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide and consistently implement rehabilitation/restorative services in order to improve and/or maintain range of motion abilities for 4 of 4 residents (R67, R60, R19, R65) who had not received restorative services as directed. Findings include: R67 did not receive range of motion/restorative services as directed on the nursing restorative program. R67's annual Minimum Data Set (MDS) dated 7/28/16, indicated R67's diagnoses included heart failure and osteoporosis. The MDS also indicated R67 had cognitive impairment, was non-ambulatory, required extensive assist with bed mobility, transfers, dressing, toilet use, and personal hygiene, had one sided lower extremity	F 311	Thief River Care Center aspires to provide the appropriate treatment and services to maintain or improve each resident s ADL abilities. R67 s Restorative program was reviewed and revised as appropriate, by Therapy staff and Rstv Coordinator. The resident s Care plan was updated with their Restorative program plan. R60 s Restorative program was reviewed and revised as appropriate, by Therapy staff and Rstv Coordinator. The resident s Care plan was updated with their Restorative program plan. R19 s Restorative program was reviewed and revised as appropriate, by Therapy staff and Rstv Coordinator. The resident s Care plan was updated with their Restorative program plan. R65 s Restorative program was reviewed	9/30/16

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	245252	A. BUILDING ______ B. WING ______	08/25/2016

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F 311	Continued From page 14 impairment and had received "0" days of rehab nursing services for range of motion. R67's Pressure Ulcer Care Area Assessment (CAA) dated 7/28/16, indicated R67 had a functional limitation in range of motion and a decline in activities of daily living. R67's physical therapy noted dated 4/28/16, indicated R67 was being discontinued from physical therapy and was to start a restorative nursing program for a bilateral lower extremity (LE) strengthening and ambulation program. R67's Restorative Nursing Program (RNP) sheet dated 4/29/16, indicated R67 was to receive range of motion (ROM) to LE's for transfers and ambulation, 3-6 X per week. The goal was to increase or maintain R67's strength in LE's for transfers and ambulation abilitiy. R67's care plan dated 4/30/2016, did not address the RNP for ROM. Review of R67's RNP ROM to be completed 3-6 times a week revealed the following: -July 2016: During the week of the 1st - 7th, no ROM was completed During the week of the 16th - 23rd, ROM was completed once. -August 2016: During the first week of the 1st - 7th, ROM was	F 311	and revised as appropriate, by Therapy staff and Rstv Coordinator. The resident s Care plan was updated with their Restorative program plan. All residents with Restorative programs are potentially affected and their programs will be reviewed and revised (prn) and documented on the resident s care plan, by Sept 30, 2016. Restorative training will be provided to nursing staff by Mon September 26, 2016. DON/designee will complete random audits 3XwkX4, then weekly X 3, then monthly thereafter to review the resident s Restorative program; to ensure the program is care planned and provided as directed by the resident s POC. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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F 311	Continued From page 15 completed twice. During the week of the 8th - 15th ROM was not completed. On 8/25/16, at 10:30 a.m. nursing assistance (NA)-A verified R67 was not receiving ROM 3-6 times a week as directed on the RNP sheets. NA-A stated with the staffing crunch right now, restorative was being pulled to work on the floor. NA-A stated she was pulled from working in restorative therapy on Saturday, Sunday, Monday, and Tuesday of this week. NA-A stated she was able to work in therapy on Wednesday and no one was scheduled to work provide restorative services on Thursday. On 8/25/16, at 12:10 p.m. registered nurse (RN)-A verified restorative services had not been provided as directed per R67's restorative plan. R60 did not receive range of motion/restorative services as directed on the RNP. R60's annual MDS dated 7/21/16, indicated R60 was diagnosed with heart failure and osteoporosis. The MDS also indicated R60 had intact cogntion, required extensive assist with bed mobility, transfers, walking in room, dressing, toilet use, and personal hygiene, had functional limitations in ROM in upper extremties and lower extremity impairment on one side. The MDS indicated during the MDS reference period R60 had received "0" days of restorative nursing services for range of motion.	F 311		

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F 311	Continued From page 16	F 311		

R60's Pressure Ulcer CAA dated 7/21/16, indicated R60 had a functional limitation in range of motion and a decline in activities of daily living.

R60's physical therapy note dated 9/15/15, indicated R60 had been discontinued from physical therapy and was to start a restorative program 3-5x's a week.

The 5/18/16, RNP sheet indicated R60 was to receive Nustep and ROM to both UE and LE's 3-6 x's a week.

R60's physician order dated 7/19/16, indicated R60 was to have restorative nursing for lower extremity (LE) ROM and parallel bar-ambulation 1 x a day, special instructions:

-L/E ROM exercises as directed 3-6x/week.
-U/E ROM exercises as directed 3-6x/wk.
Nustep exercise 1 x a day, special instructions:

R60's care plan dated 8/18/16, indicated R60 would continue with RNP through the next quarter.

Review of R60's RNP for ROM indicated it was to be provided 3-6 times. R60's August, 2016 Restorative Treatment sheet revealed the following:

-1st-7th: ROM and NuStep were both completed

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F 311	Continued From page 17	F 311		

twice
-8th-15th zero ROM and zero NuStep completed
-16th-21st ROM and NuStep were both completed twice.

On 8/23/16, at 5:50 a.m. R60 stated she was to be getting rehab every day however, this week had not had rehab because the restorative aide was pulled to work on the floor. R60 stated she asked at lunch time if there was going to be rehab today and NA-A stated there would be no restorative services because she was working on the floor. R60 stated the restorative aid was pulled to the floor quite often and for a two week period such as last week and the week before they did not have any restorative services, that she could recall. R60 stated this had been going on for a long time because the facility was shorthanded a lot.

On 8/25/16, at 10:30 a.m. NA-A verified R60 was not receiving ROM/Nustep 3-6 times a week as indicated on the RNP sheets. NA-A stated with the staffing crunch right now, rehab staff were being pulled to work on the floor. NA-A stated she was pulled from rehab in the past week on Sat, Sun, Mon, Tues, and Thur, however, had worked in rehab on Wednesday.

On 8/25/16, at 11:20 p.m. RN-A verified restorative services had not been provided as directed per R60's plan.

R19 did not receive range of motion/restorative

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F 311	Continued From page 18 services as directed on the nursing restorative program. R19's quarterly MDS dated 6/7/16, indicated R19 was diagnosed with Parkinson's disease, chronic ischemic heart disease and peripheral vascular disease. The MDS also indicated R19 had cognitive impairment, and required extensive assist with bed mobility, transfers, walking in room, dressing, toilet use, and personal hygiene. The most recent, undated Pressure Ulcer CAA indicated R19 had a recent decline in activities of daily living and immobility and had received "0" days of restorative nursing services for range of motion. The RNP dated 10/22/14, which was completed by the physical therapist (PT) indicated R19's goal was to maintain both lower extremities (LE) ROM and strength for functional mobility and bed mobility in the facility. The PT started R19 on a LE ROM program. The RNP dated 10/22/14, which was completed by the occupational therapist (OT) indicated R19's goal was to maintain both upper extremities (UE) ROM and strength for functional use of UE. The OT started R19 on a UE ROM program. The current RNP sheet indicated R19 was to receive bilateral ROM to UE and LE's 3-6 x a week.	F 311		

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F 311	Continued From page 19	F 311		

R19's current care plan did not address the ROM restorative program.

Review of R19's RNP ROM to be completed 3-6 times a week revealed the following:

July, 2016, indicated
1st-7th, ROM was completed 1 time.
16th-23rd, ROM was completed 2 time.
24th-31st, ROM was completed 2 times.

August, 2016, indicated:
-1st-7th: ROM was completed 1 time.
-8th-15th no ROM was completed 0 times.

On 8/25/16, at 10:30 a.m. NA-A verified R19 was not receiving ROM 3-6 times a week as directed on the RNP sheets. NA-A stated with the staffing crunch right now rehab staff were being pulled to work on the floor.

On 8/25/16, at 11:20 p.m. RN-A verified restorative services had not been provided as directed per R19's plan.

R65 did not receive range of motion/restorative services as directed on the nursing restorative program.

R65's annual MDS dated 7/26/16, indicated R65's diagnoses included cerebrovascular accident and seizure disorder. The MDS also indicated R65 had cognitive impairment, required assist of one

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F 311	Continued From page 20 with bed mobility, transfers, dressing, toilet use, and personal hygiene, had one sided upper and lower extremity impairment and had received "0" days of restorative nursing services for range of motion and ambulation. R65's Physicians Order Sheet dated 8/25/16, indicated UE ROM one time per day and passive ROM as directed to right shoulder. NuStep exercises one time per day Tuesday and Thursday and ambulation one time per day every Monday, Wednesday, and Friday. Ambulation as indicated on RNP. R65's RNP dated 9/28/15, indicated ROM to maintain current ROM to right upper extremity, and PROM for right shoulder. R65's RNP dated 10/14/15, indicated walking to maintain level of function with ambulation. R65's RNP dated 10/6/15, indicated ROM -NuStep for both lower extremities and left upper extremity to increase strength and activity tolerance. R65's care plan printed on 8/25/16, indicated restorative nursing plan as directed by therapy with rehab aide and ambulates with rehab as indicated on RNP. R65's restorative nursing aide treatment sheet for August 2016, indicated, upper extremity ROM	F 311		

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F 311	Continued From page 21	F 311		

Continued From page 21

was completed 6 of 25 opportunities. NuStep exercises were completed 0 times and indicated R65 had refused. Ambulation was completed one time on 8/24/16, by wife, and documentation indicated R65 had walked with wife on August 1, 6, 18, 20, 24. However, documentation lacked signatures for other dates ambulation was to be provided.

On 8/24/16 at 9:49 a.m. R65 was observed ambulating with family member (FM)-A, who applied R65's right arm support, and transfer belt. R65 was observed to grab hand rail in hallway in pod area and FM-A was holding the transfer belt and following with R65's wheelchair (w/c). R65 ambulated approximately 25 feet and then seated himself into his w/c, R65 then raised up from w/c with FM-A's support and held onto a four footed cane and FM-A was holding transfer belt and pulling w/c behind resident. R65 ambulated approximately 25 feet and then sat back down into his w/c. FM-A removed the arm support and transfer belt and pushed R65 in his w/c back to his room.

On 8/23/16, at 5:31 p.m. R65's FM-A stated, R65 did not get his therapy again today. FM-A stated she was at the facility everyday knew therapy was not getting done. FM-A stated the rehab aide had told her that she got pulled to work on the floor to help with the resident cares, and didn't have time to provide rehab services. FM-A stated she gets so tired, but walked R65 everyday to make sure he received exercises in order to maintain his ability to get out of his chair.

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F 311	Continued From page 22 On 8/25/16, at 9:57 a.m. RN-B verified rehab services was not completed for R65, because they have had to pull staff from rehab to help provide direct resident cares. On 8/25/16, at 10:18 a.m. NA-A stated rehab was not getting done due to being assigned to work with residents on the floor rather than rehab. NA-A stated staff did the best they could but rehab services were not always provided. On 8/25/16, at 11:18 a.m. FM-A stated, she wanted to R65 to received restorative services in order to stay strong and maintain his ability to transfer. FM-A stated she was advocating for R65 to ensure he gets the service he needs. On 8/25/16 , at 2:28 p.m. RN-B verified R65 should have received his restorative services, as directed. The facilities undated, Restorative Nursing Program policy indicated it was policy to provide a restorative nursing program which focused on achieving and/or maintaining optimal function in accordance with the comprehensive assessment and plan of care.	F 311		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal	F 334		9/30/16

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F 334	Continued From page 23 representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	F 334		

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F 334	Continued From page 24 documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facilty failed to implement their policy for pneumococcal immunizations for 1 of 5 residents (R29) reviewed for immunizations who had no evidence of being offered or having declined the vaccination. Findings include: R29's Minimum Data Set (MDS) dated 5/31/16, identified R29's diagnoses to include dementia, multiple sclerosis, rheumatic disorder of both mitral and aortic valves, chronic obstructive pulmonary disease and dependence on	F 334	Thief River Care Center aspires to offer each resident a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized. Vaccines will be offered to each resident according to the current recommendations from the Centers for Disease Control(CDC). For resident #29 we have offered the Pneumococcal immunization on September 14, 2016. The policy and procedures on pneumococcal immunizations will be educated to our licensed staff by Monday	

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F 334	Continued From page 25 supplemental oxygen. The MDS indicated R29's pneumococcal vaccination was up to date. R29's Resident Vaccinations as of 9/2/16, indicated R29 had been provided the influenza vaccination on 10/27/15, however lacked documentation of when R29 had received the pneumococcal vaccination. On 8/25/16, at 1:52, p.m. R29's record was reviewed with registered nurse (RN)-B. RN-B confirmed the record lacked documentation of R29's pneumococcal vaccination and stated the facility sent residents to their primary physician for these vaccinations. RN-B then accessed R29's clinic record via computer and reviewed the vaccination history. R29's Health Maintenance Summary lacked completion dates for pneumococcal vaccinations and indicated a date due of 3/14/2001. RN-B stated they tried to work together with the physician office to ensure vaccinations were done timely. RN-B confirmed the facility lacked documentation of R29's pneumococcal vaccination or refusal of vaccination. RN-B stated she was not aware of the updated guidelines for pneumococcal vaccination and was not aware R29 was due. The Influenza and Pneumococcal Screening policy dated 8/2015, indicated the determination to vaccinate or not vaccinate based on the resident and power of attorney/family decision or interdisciplinary team assessment would be documented in the medical record. The policy also indicated pneumococcal vaccines would be offered to each resident according to the current	F 334	9/26/2016. DON/designee will complete random audits 3XwkX4, then weekly X 3, then monthly thereafter to review the pneumococcal immunization process; to ensure the program is administrated according to policy and CDC recommendations. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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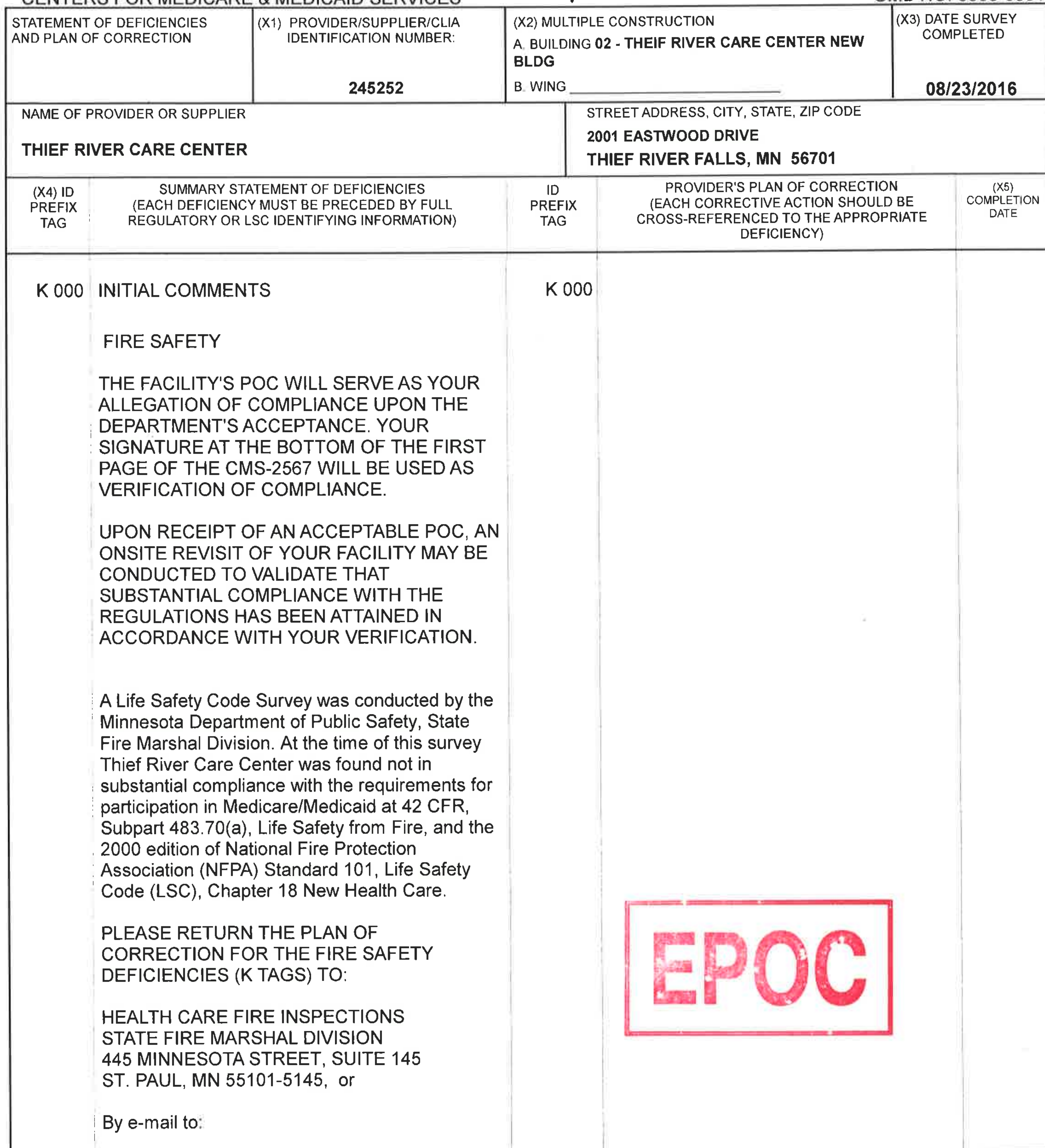
F 334	Continued From page 26 recommendations from the Centers for Disease Control (CDC).	F 334		

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

F5252026



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING **02 - THEIF RIVER CARE CENTER NEW BLDG** B. WING ______	**08/23/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Thief River Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/15/2016

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Thief River Care Center building was constructed in 2011 is 1-story, without a basement and was determined to be of a Type II (000) construction. The building is divided into three smoke zones by two smoke barriers and two 2 hour fire barriers The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems 1999 edition. The facility has a fire alarm system with automatic smoke detection in the all corridors and in all common use spaces in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have smoke detection with other hazardous areas have automatic fire detectors, that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm is monitored for automatic fire department notification. The facility has a capacity of 70 beds and had a	K 000		

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K 000	Continued From page 2 census of 61 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to provide 3 of several exit discharge walking surfaces in accordance with NFPA 101 Life Safety Code (00) edition, Section 7.1.6.2. During an evacuation this deficient practice could affect 35 of the 61 residents, and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:00 am to 1:30 pm on 08-23-2016 observations and staff interview revealed exit discharge surfaces that exceeded the maximum elevation difference before a bevel or ramp is needed. These areas were located at the west wing near resident room 147, the Blueberry Cafe exit and at the maintenance/storage room exit. The differences are as follows. 1. The west wing exit sidewalk approximately 4 feet out from the door was 1 1/8 inch higher than the adjacent landing. 2. The Blueberry Cafe sidewalk approximately 4 feet out from the door was about 1 inch higher and had pulled away from the adjacent landing by 1 1/2 inches. 3. The maintenance/storage sidewalk approximately 4 feet out from the door was about	K 038	Thief River Care Center will repair the three walking surfaces completed in accordance to NFPA 101 Life Safety Code 2000 Edition, Section 7.1.6.2. We will be sloping the elevation with a vinyl cement patch. We will be sure the slope is in accordance to NFPA 101 which is 1:20. Education will be passed on to the Maintenance Staff. They will be required to communicate any changes to the Environmental Services Director. There will be audits conducted during the quarterly Building Common Area inspections. This event has been added to the Preventative Maintenance calendar and the inspection checklist. The person responsible for the correction and monitoring to prevent a reoccurrence of the same deficiency is the Director of Environmental Services. The QAPI Committee and the AWAIR Committee will review the quarterly audits from the Environmental Services Director.	9/30/16

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K 038	Continued From page 3 1 inch higher than the adjacent landing. This deficient condition was verified by the Interim Facility Administrator and the Director of Environmental Services.	K 038		