Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 27, 2023

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

RE: CCN: 245252
Cycle Start Date:

Dear Administrator:

On November 14, 2023, we notified you a remedy was imposed. On December 21, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 1, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 29, 2023 be discontinued as of December 1, 2023. (42 CFR 488.417 (b))

In our letter of November 14, 2023, 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 November 29, 2023. 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,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
November 14, 2023

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

RE: CCN: 245252
Cycle Start Date: November 1, 2023

Dear Administrator:

On November 1, 2023, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On November 1, 2023, the situation of immediate jeopardy to potential health and safety cited at F578 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 29, 2023.

This Department is also recommending 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 November 29, 2023, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 29, 2023, (42 CFR 488.417 (b)).

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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 29, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Thief River Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 29, 2023.. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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.

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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, Licensing and Certification Program 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 May 1, 2024 (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 DENIAL OF PAYMENT

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

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions

are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / 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.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 11/01/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 10/30/23, to 11/1/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/30/23 through 11/1/23, a standard recertification survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F578 when the facility failed to ensure resident advance directives were accurately documented in the clinical record to reflect the residents' current wishes which affected 3 of 28 residents (R57, R32, R25). The IJ began on 10/26/23, and the immediacy was removed on 11/1/23. In addition to the recertification survey, the following complaints were reviewed with no deficiency issued.	F 000		

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

Electronically Signed | 11/16/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 11/01/2023

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	Continued From page 1 H52526823C (MN00097856). H52526822C (MN00097232). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 578 SS=J	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578		12/1/23

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 11/01/2023

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 578	Continued From page 2 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure resident advance directives were accurately documented in the clinical record to reflect the residents' current wishes which affected 3 of 28 residents (R57, R32, R25) reviewed for advanced directives. This deficient practice resulted in an immediate jeopardy (IJ) for R57, R32, and R25 who would have received cardiopulmonary resuscitation (CPR), contrary to their wishes, in the absence of a pulse or respirations. The IJ began on 10/26/23, when R57's, R32's, and R25's electronic health record (EHR) main screen banner identified they were Full Code (administer CPR) however, their updated Physician Orders For Life Sustaining Treatment (POLST) all identified wishes of do not	F 578	Residents' advanced directives were not accurately documented in the clinical record to reflect the residents' current wishes. R57, R32, and R25 electronic health records were updated to reflect the residents or resident representatives verbal wishes for code status. Their POLSTs have been added to their paper chart with their preferences identified. This could happen to all residents at Thief River Care Center. All residents' electronic health records and paper charts were audited to ensure that they matched and reflected the resident or resident representatives' wishes. All new	

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 11/01/2023

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 578	Continued From page 3 resuscitate (DNR). The administrator, director of nursing (DON), and nurse consultant (NC)-A were notified of the IJ on 10/31/23, at 4:54 p.m. The IJ was removed on 11/1/23, at 3:41 p.m. when the facility had implemented corrective action, however non-compliance remained at the lower scope and severity level of D, isolated with no actual harm but potential to cause more than minimal harm. Findings include: R57 R57's admission Minimum Data Set (MDS) dated 9/12/23, identified R20 had moderate cognitive impairment and diagnoses which included: chronic kidney disease, transient ischemic attach (TIA) (temporary period of symptoms similar to a stroke) and aphasia (disorder that affects how someone communicates). R57's care plan revised 9/18/23, identified R57's advanced directives had the potential for significant change in medical condition, and R57's code status would be reviewed quarterly and as needed (PRN). R57's EHR banner identified R57's code status: full code. R57's EHR Health Care Directive, undated, indicated full code, would change to DNR/ DNI (do not intubate) insertion of a tube to aid in breathing) when POLST completed- waiting on signatures. R57's POLST was not yet signed by the physician but signed by DON on 10/26/23, which identified	F 578	admissions will be asked their wishes, and this will be put into the electronic health record and a POLST will be filled out. The Advanced Care Planning and CPR policies were reviewed, and no changes were needed at this time. The DON or designee will provide education to all licensed nursing staff on the POLST/Advanced Directive procedure. The DON or designee will audit all new admits and perform monthly audits for a total of 12 weeks, to ensure that the EHR and POLST match. Findings will be brought to QAPI for further recommendations for monitoring.	

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 11/01/2023

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 578	Continued From page 4 DNR. R57's Resident Care Conference Signature form dated 9/14/23, identified R57's code level remained DNR/DNI. The facility untitled report form dated 10/30/23, identified R57's code status was Full Code. During an interview on 10/31/23 at 1:12 p.m., licensed practical nurse (LPN)-A stated if a resident was not breathing or heart stopped, she would check to see if they were DNR, and if not she would begin cardiopulmonary resuscitation (CPR). LPN-A reviewed R57's EHR's banner and identified R57 was full code so she would perform CPR. LPN-A indicated she would check resident's EHR banner first, then check the facility's twenty four hour report form to identify their code status. LPN-A confirmed the untitled report form identified R57 as full code. During an interview on 10/31/23 at 1:18 p.m., registered nurse (RN)-A stated a resident's code status was determined when they were admitted. RN-A confirmed R57's banner identified full code. RN-A indicated in the absence of a pulse or respirations if a resident was full code she would immediately start CPR and call 911. RN-A stated her usual process was to enter full code into a resident's EHR banner until the facility received the POLST signed by the physician, even if their wishes were DNR. RN-A indicated the nurse manager who received the POLST signed by the physician then would change the banner to DNR. During an interview on 10/31/23 at 2:30 p.m., DON confirmed R57's POLST was not in her medical record yet as they were waiting for the	F 578		

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 11/01/2023

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 578	Continued From page 5 provider to send a signed copy back. DON confirmed she had documented R57's EHR health care directive as full code, made a note "will be DNR/ DNI when POLST was completed", and changed R57's EHR banner to read Full Code on 10/26/23. DON confirmed R57's code status was DNR and had confirmed this with family member (FM)-A. DON indicated her understanding was a resident's wish to be DNR could not be honored until the physician had signed the POLST. As a result, she had recently completed an audit to assure all resident's POLSTs were signed before they would follow the resident's wish to be DNR. During an interview on 10/31/23 at 3:53 p.m., FM-A confirmed R57's wishes were DNR. FM-A stated he had discussed this when R57 was first admitted and also at a meeting on 10/9/23. FM-A stated he had informed RN-A and DON he would not want them to perform CPR on R57. R32 R 32's quarterly MDS dated 9/9/23, indicated R32 had intact cognition and had diagnosis which included: cancer of the endometrium, depression, and kidney failure. Identified R32 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. R32's care plan revised 10/23/23, identified R32's advance directives had the potential for significant change in medical condition, and identified R32 's code status was DNR and code status would be reviewed quarterly and as	F 578		

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 11/01/2023

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 578	Continued From page 6 needed. During an interview on 10/31/23 at 9:12 a.m., R32 stated the facility had spoke to her about her wishes a while back and she indicated she wanted to be DNR. R32's EHR banner on 10/30/23 at 5:02 p.m., indicated full code. R32's EHR Health Care Directive, on 10/30/23 at 5:02 p.m., indicated full code, would be DNR/DNI when POLST completed; waiting on signatures. R32's POLST signed by the provider on 10/27/23, identified DNR. R32's Resident Care Conference Signature form dated 1/4/23, 3/29/23, 6/28/23, and 9/27/23, identified R32's code status was a DNR. Facility untitled report dated 10/31/23, identified R32's code status as DNR. During an interview on 10/31/23 at 1:19 p.m., licensed practical nurse (LPN)-D stated in the event a resident did not have a pulse or respirations she would review the paper daily report sheet for code status and proceed accordingly. During an interview on 1/31/23 at 1:24 p.m., registered nurse (RN)-D stated in the event a resident did not have a pulse or respirations, she would look at the banner which was located in the EHR for code status and proceed accordingly. R25 R25's quarterly MDS dated 10/17/23, indicated	F 578		

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 11/01/2023

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 578	Continued From page 7 R25 had intact cognition and had diagnosis which included: heart failure, depression, and kidney failure. Identified R25 required minimal assistance with ADL's which included dressing and toileting. R25's quarterly MDS further indicated R25 was independent with transfers and ambulation. R25's care plan revised 10/25/23, identified R25's advance directives had the potential for significant change in medical condition, and identified R25's code status was DNR and code status would be reviewed quarterly and as needed. R25's EHR Banner, on 10/30/23 at 5:10 p.m., identified full code. R25's EHR Health Care Directive indicated, would be DNR/DNI when POLST completed; waiting on provider signature. R25's Progress Notes dated 10/27/23, revealed Dr. Helia sent signed POLST back: DNR with selective treatment options. Will add to hard copy chart. During an interview on 10/31/23 at 9:11 a.m., R25 indicated she could not think right now and stated "It is too early in the morning". R25 declined any further discussion. During an interview on 10/31/23 at 1:23 p.m., RN-B stated in the event a resident did not have a pulse or respirations, she would review the main banner in the EHR and proceed accordingly. RN-B confirmed R25's EHR banner identified Full-Code and R25's code status would be changed to DNR/DNI when a signed POLST was	F 578		

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 11/01/2023

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 578	Continued From page 8 received from the provider. During an interview on 10/31/23 at 1:44 p.m., RN-G stated in the event a resident did not have a pulse or respirations, she would review the main banner in the EHR and proceed accordingly. During an interview on 10/31/23 at 1:51 p.m., RN-H stated in the event a resident did not have a pulse or respirations she would review the main banner in the EHR and proceed accordingly. During an interview on 10/31/23 at 1:54 p.m., RN-E stated in the event a resident did not have a pulse or respirations, she would look at the banner in the EHR for code status and proceed accordingly. RN-E verified discrepancies existed in R25's and R32's advance directive records. R25's and R32's banner in the EHR indicated both residents were a full code status and R25's and R32's POLSTs identified both residents were a DNR. In addition, RN-E verified the advance directive tab in R25's and R32's EHR indicated R25 and R32 were both full code until the POLST was signed. RN-E stated they had been waiting for the MD to sign R25's and R32 's POLST and once the POLST was signed the banners would have been changed to DNR. RN-E was unsure why the banner had not been updated once the POLST had been signed on 10/27/23. During an interview on 10/31/23 at 2:16 p.m., DON confirmed R25 and R32 had a POLST in the hard chart which indicated R25's and R32 's wishes were to be a DNR code status. DON confirmed she had changed R25's and R32's EHR banners and health care directives to full code, and noted "will be DNR/DNI when POLST	F 578		

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 11/01/2023

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 578	Continued From page 9 was completed" on 10/26/23. DON indicated her understanding was a resident's code status wish to be DNR could not be honored until the physician had signed the POLST. As a result, she had completed an audit to assure all resident's POLST were signed before they would follow the resident's wish to be DNR. DON stated her expectation was that the banner in the EHR would have matched the POLST and would have accurately reflected the wishes of R25 and R32. Facility policy titled Cardiopulmonary Resuscitation (CPR) revised 7/1/19, identified St. Francis Health Services of Morris, INC (SFHS) would facilitate the appropriate nursing response according to the residents' wishes, when a resident unexpectedly had an absence of a pulse an/or respirations. Upon admission, the admissions nurse would document the resident's code status (CPR status) on a Physician's Order for Life Sustaining Treatment (POLST) according to the resident and/or their legal representative's wishes and place it on the resident's hard chart. The resident's elected code stats would also be documented in the electronic medical record (EMR). All residents would be presumed to have an order for CPR unless an order for Do Not Resuscitate (DNR) was entered in their POLST, or other advance directive document and their EHR. The IJ was removed on 11/1/23, at 3:41 p.m. when the facility developed and implemented a systemic removal plan which was verified by interview and document review: -All residents' records were reviewed to ensure the POLST form and EHR's were updated to ensure resident's wishes for advance directive were accurate on 11/1/23.	F 578		

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 11/01/2023

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 578	Continued From page 10 -The Advanced Care Planning policy and CPR policy was reviewed on 11/1/23. -Licensed Staff were educated on each policy as evidenced by the Education Sign in Sheet and interview. -A process was implemented to assure all other nurses completed mandatory education prior to the start of their next shift on 11/1/23, by notification of required mandatory education via phone/text. -During interviews on 11/1/23, LPN-B, RN-C, RN-A, LPN-C, RN-F, RN-G, RN-H, RN-B, RN-E, LPN-E verified they received education regarding policies and honoring resident's code status wishes.	F 578		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		12/1/23

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 11/01/2023

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 623	Continued From page 11	F 623		

discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual

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 11/01/2023

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 623	Continued From page 12 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the Long Term Care (LTC) ombudsman of a facility initiated transfer for 1 of 1 residents (R60) who was transferred to an	F 623	LTC Ombudsman was not notified of a facility-initiated transfer. The LTC Ombudsman was notified of	

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 11/01/2023

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 623	Continued From page 13 acute care facility on an emergency basis reviewed for hospitalization. Findings include: R60's admission Minimum Data Set (MDS) dated 9/19/23, indicated R60 had severe cognitive impairment and had diagnosis which included status post cholecystectomy (surgery to remove the gallbladder), partial bowel obstruction, and anxiety disorder. Identified R60 required staff assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. Review of R60's progress notes on 9/22/23, revealed the following: -on 9/22/23 at 12:12 a.m., R60 had been having emesis (vomiting) which contained chunks of food that looked like potatoes and a light brown /yellow liquid. Revealed vital signs were stable and R60 had refused to go to the emergency room. -on 9/22/23 at 11:52 a.m., R 60 was refusing to eat and drink. R 60 had a temperature of 99.7 and pulse of 105. R60 had agreed to go to urgent care. -on 9/22/23 at 12:17 p.m., reviewed R60's Sanford chart and noted R60 was transferred to Sanford hospital for a small bowel obstruction. R60's medical record lacked documentation the notice of the hospital transfer was sent to the LTC Ombudsman. During an interview on 11/1/23 at 8:03 a.m.,	F 623	R60's transfer to an acute care facility on an emergency basis. This could potentially happen to all residents. An audit will be done on all residents from 11/1/23 to present to ensure that the Ombudsman was notified of all facility initiated immediate transfers due to the urgent medical needs of the resident. The DON or designee reviewed and revised the policy/procedure for notifying the LTC Ombudsman for all facility initiated emergent transfers. A log was created to be used for the Ombudsman notification. The DON or designee will educate all licensed nursing staff and social services on the procedure of when/how often to notify the LTC Ombudsman. The DON or designee will audit 1x/wk. for 4 weeks, then monthly for 12 weeks. All audit findings will be brought to QAPI for further review and recommendations.	

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 11/01/2023

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 623	Continued From page 14 licensed social worker (LSW) confirmed R60 had been hospitalized and stated she was unaware of the requirement to notify the LTC ombudsman of facility initiated transfers. During an interview on 11/1/23 at 1:26 p.m., director of nursing (DON) confirmed the above findings and indicated she was not aware that a hospitalization was a facility initiated discharge or she would have expected staff ensured the required notification to the LTC Ombudsman would have been completed. Review of a facility policy titled, Bed Hold election & Hospital transfer data revised 7/1/19, lacked documentation of a process for notifying the LTC Ombudsman for emergency hospital transfers.	F 623		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide shaving assistance and personal care for 1 of 1 residents (R19) who was dependent on staff to provide personal hygiene reviewed for activities of daily living (ADL's). Findings include: R19's quarterly Minimum Data Set (MDS) dated 12/14/22, indicated R19 was cognitively intact and had diagnoses which included stroke,	F 677	R19 who is dependent on staff for ADLs was shaved and received nail care. This could happen to all dependent residents. All dependent residents who require assistance with shaving and personal care were observed to see if shaving and nail care was completed within each resident's plan of care. The DON or designee reviewed and revised the dates of the shaving the	12/1/23

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 11/01/2023

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 677	Continued From page 15 diabetes and depression. Identified R19 required extensive assistance with bed mobility, transfers, dressing, toileting, bathing and personal hygiene. R19's care plan modified on 10/27/23, indicated R19 required assistance with grooming and personal hygiene. Staff were to assist R19 with with all personal hygiene including shaving his face and cleaning his nails. During an observation on 10/30/23 at 6:20 p.m., R19 had a beard a approximately 1/4 inch long from ear to ear, over the entire chin and down his neck. R19's finger nails had a black film under them. R19 indicated he requested to be shaved every two to three days and wanted his fingernails to be cleaned. During an observation on 10/31/23 at 1:57 p.m., R19 was seated in his wheelchair attending the resident's Halloween party. R19 continued to have a beard approximately 1/4 inch long from ear to ear, over the entire chin and down in his neck. R19 continued to have a black film under his nails. R19 stated, "Staff still have not given me a bath, shaved me or cleaned under my nails. It really bothers me". During an interview on 10/31/23 at 6:13 p.m., nursing assistant (NA)-A confirmed R19 required extensive assistance with personal hygiene. NA-A indicated R19 was shaved and nails were cleaned on bath days. NA-A stated R19's bath day was on Monday mornings. During an interview on 11/1/23 at 8:48 a.m.,registered nurse (RN)-F confirmed the above findings and indicated R19 had not been shaved or received nail care. RN-F indicated R19	F 677	resident and nails care policies. The DON or designee will educate all nursing staff on the importance of providing ADL care for dependent residents. Also, on communicating/documenting refusals and following the residents care plan. The DON or designee will do audits 3x/week for 4 weeks, 2x/week for 3 weeks, then weekly thereafter on ADL care. For a total of 12 weeks of audits. The findings will be brought to QAPI for further recommendations.	

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 11/01/2023

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 677	Continued From page 16 had not been shaved over the past three days. RN-F stated her expectations were for staff to shave him every two or three days or when R19 requested it. She would expect staff to let her know when R19 was not shaved or had refused cares. During an interview on 11/1/23 at 2:52 p.m., director of nursing (DON) confirmed the above findings. DON indicated she was not aware R19 had not received his bath on Monday and had not received nail care. DON stated her expectations were for staff to follow the resident's care plan. DON would expect staff to complete morning cares including personal hygiene and have communication with nurse managers about any resident needs. Facility policy titled Shaving the Resident revised 10/07, identified staff were to keep residents clean and well groomed. Male residents were to be shaved daily. Facility policy titled Nails Care of, (Finger and Toe) reviewed on 5/3/21, identified staff were to provide cleanliness, to prevent the spread of infection, for comfort, and to prevent skin problems. Soak hands for five minutes in basin of warm water, temperature not to exceed 110 degrees F, when indicated. Scrub nails gently with brush and remove from basin, when indicated.	F 677		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		12/1/23

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 11/01/2023

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 812	Continued From page 17 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure refrigerated food items were properly labeled, dated, and closed after the packaging was opened to prevent cross contamination which had the potential to affect all 59 residents currently residing in the facility. In addition, the facility failed to ensure refrigerated food items were disposed of after the expiration date. Findings include: During the initial tour of the main kitchen on 10/30/23 at 12:53 p.m., with the dietary manager (DM)-A, the following areas of concern were identified and confirmed by DM-A: Reach in Freezer: -baked ham dated 4/9/23, clear wrap opened over half of ham, covered with ice crystals. -five precooked chicken Kiev-undated and	F 812	TRCC will ensure that food is properly stored/labeled/dated and disposed of after the expiration date. Staff went through all refrigerators, freezer, and food storage areas to ensure that all food items were properly labeled, dated, and closed. Also, to dispose of any food items that were expired as stated in the 2567, and any items that were found not to be properly labeled, dated, and closed or expired were disposed of. The Use and Storage of Food Brought in for Residents policy required no changes and the Food Storage and Temperature policy was reviewed, and the temperature standards were revised. The nursing and dietary staff will be educated on the proper procedure for	

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 11/01/2023

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 812	Continued From page 18 package open. -six precooked chicken breasts-undated and package open. -bag of french fries-undated and package open. -bag of tater tots-undated and package open. -three mini donuts-undated and package open. -four powdered donuts-undated and package open. -three English muffins-undated and package open, covered with ice crystals. -four small metal containers half full of pureed or mechanical soft meat-undated or labeled. Reach in refrigerators: -15 pound box of bacon, one bag open, receiving date 9/15, not dated when opened. -10 pound box of fully cooked sausage, one bag open, receiving date 10/6, not dated when opened. -parmesan cheese container-open date 7/20, no expiration date. -four hard boiled eggs in plastic bag, -open date 10/9 no expiration date -one package cream cheese-undated, package open, no expiration date. On 10/30/23 at 2:33 p.m., nursing assistant (NA)-A and surveyor reviewed contents of the Evergreen kitchenette and the following concerns were identified: freezer: -one package Lean Cuisine-undated, expiration date 4/20/23. -one package Crustless Chicken Pot Pie-undated, expiration 8/23. -four fudge bars, undated, no expiration dates. -nine strawberry shortcake bars, undated, expiration date 7/23.	F 812	food storage, labeling, dating and disposure of food. The Dietary Manager and or designee will do audits on proper food storage, labeling, dating and disposure of food 3x/week for 4 weeks, 2x/week for 3 weeks and then weekly thereafter for a total of 12 weeks. Audit findings will be brought to QAPI for further recommendations and monitoring.	

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 11/01/2023

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 812	Continued From page 19 -five Kemp's popsicle-undated, no expiration date. refrigerator: -three Pizza Hut packages, undated- NA-A stated they were the staff's and put in fridge that day. -one package margarine-undated, no expiration date. -seven strawberry Jello individual containers-undated, expiration date 5/23. -two orange Jello individual containers-undated, expiration date 5/23. -three string cheese-undated, expiration date 9/22/23. -three marble jack cheese sticks, undated, expiration date 10/23/23. -three ham slices in plastic bag, dated 10/4. -opened container of soy sauce, undated, expiration date 3/26/23. -opened container of A1 sauce, undated, expiration date 4/21/23. -opened backing soda, undated expiration date 9/17/23. -three individual containers of pear slices, undated, expiration date 8/14/23. -two containers of lactose milk, undated, expiration date 6/27/23. -one container organic soy milk, undated, expiration date 8/12/23. During the inspection of Evergreen kitchenette on 10/30/23 at 2:33 p.m., NA-A indicated staff used the items in the kitchenette for residents on the unit. DM-A joined surveyor and NA-A during the inspection and confirmed the above findings. On 10/30/23 at 2:55 p.m., DM-A and surveyor inspected the Blueberry kitchenette and the following concerns were verified and identified:	F 812		

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 11/01/2023

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 812	Continued From page 20 refrigerator: -two individual containers of peaches, undated, expiration date 6/3/23. -one container of Heinz 57 sauce, undated, no expiration date. -one container of A1 sauce, undated, expiration date 4/21/23. -one opened plastic bag of cheese slices, dated 10/23, slices appeared dry and discolored on one side. -three string cheese-undated, expiration 9/22/23. -three marble jack cheese sticks, undated, expiration 10/14/23. -one bowl of rice, undated. -one container brew tea, undated expiration 8/17/23. -one bottle Gatorade, undated, no expiration date. -one container organic soy milk, undated, expiration date 8/20/23. -three containers lactose milk, undated, expiration date 6/27/23. -one opened facility container grape juice, undated. -one container almond milk, opened, undated, no expiration date. freezer: -twelve fudge bars, undated, no expiration date. -eight strawberry shortcake bars, undated, no expiration date. -one quart of vanilla ice cream, opened, undated. -bag of pastries, one long john and one caramel role, undated, no label. -dairy queen shake, undated, no label. -one root beer float, undated, no label. -three ice packs.	F 812		

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 11/01/2023

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 812	Continued From page 21 During an interview on 10/30/23 at 3:23 p.m., DM-A confirmed the above findings and indicated meat slices were to be thrown when opened after five days. DM-A stated it was important to dispose of foods past expiration dates. DM-A indicated it was her expectation the dietary staff would inspect the kitchenettes twice a week. DM-A stated it was important for staff to date items and assure they were covered to prevent cross contamination and to prevent food borne illness. DM-A indicated she was not aware staff had not been dating foods when opened, or inspecting the kitchen and kitchenettes to assure foods were dated when opened and dispose of items when outdated or expired. DM-A stated she was not sure why ice packs were in the Blueberry kitchenette freezer and stated it was her expectation they were not stored in the kitchenette freezer where food is also stored. The facility policy titled Perishable Food Management, dated 8/29/22, identified the purpose was to ensure care centers managed perishable food to protect individuals from food-borne illness. The policy identified leftover food would be stored in covered containers or wrapped carefully and securely and clearly labeled before being refrigerated or frozen. Refrigerated leftover food must be used within three days, and discarded on the fourth day. The policy indicated all foods would be routinely monitored to assure that foods, including leftovers, would be consumed by the use-by-date, frozen or discarded. The facility policy titled Use And Storage Of Food Brought In For Residents, dated 1/9/17, identified the refrigerators in the neighborhood kitchens would be checked periodically by dietary or	F 812		

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 11/01/2023

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 812	Continued From page 22 housekeeping staff, and any food not labeled and dated would be removed and disposed of, as well as anything that had been there for greater than three days. The policy indicated nothing but food would be permitted in the freezers. The policy instructed staff to label and date any leftovers or food in storage containers.	F 812		

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 _____	**10/31/2023**

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 An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/31/2023. At the time of this survey, Thief River Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

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 **02 - THEIF RIVER CARE CENTER NEW BLDG** B. WING _____	**10/31/2023**

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

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 _____	**10/31/2023**

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	Continued From page 2 fire sprinkler system. The facility also has smoke detection throughout the corridors and spaces open to the corridors. The facility has a capacity of 70 beds and had a census of 66 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245252	MULTIPLE CONSTRUCTION A. BUILDING: **02 - THEIF RIVER CARE CENTER NEW BLDG** B. WING _____	DATE SURVEY COMPLETE: **10/31/2023**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 761	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/31/2023 at 11:14am, it was revealed by review of available documentation the required annual door inspection documentation was not available at the time of the survey. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.
K 914	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245252	MULTIPLE CONSTRUCTION A. BUILDING: **02 - THEIF RIVER CARE CENTER NEW BLDG** B. WING _____	DATE SURVEY COMPLETE: **10/31/2023**
NAME OF PROVIDER OR SUPPLIER **THIEF RIVER CARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP CODE **2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN**	

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 914	Continued From Page 1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient findings could have an isolated impact on the residents within the facility. Findings include: On 10/31/2023 at 11:18am, it was revealed by review of available documentation the required annual receptacle inspection documentation was not available at the time of the survey. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.