DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 2, 2021

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

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

Dear Administrator:

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

On January 19, 2021, the Minnesota Department(s) of Health and Public Safety completed a survey/revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

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

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

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

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

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 01/19/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 1/14/20 - 1/16/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was in full compliance Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/13/21 through 1/19/21, an abbreviated survey was completed at your facility by the Minnesota Department of Health to conduct a COVID-19 Focused Infection Control survey and a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities The following complaints were found to be SUBSTANTIATED: H5252045C (MN69002) deficiency cited at F600 H5252047C (MN56756) deficiency cited at F689 H5252048C (MN67277) deficiency cited at F600 H5252049C (MN67615) deficiency cited at F600 The following complaint was found to be substantiated with no deficiencies cited due to actions implemented by the facility prior to survey. H5252050C (MN67548) The following complaints were found to be UNSUBSTANTIATED: H5252046C (MN52867) H5252051C (MN68685)	F 000		

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

Electronically Signed | 02/09/2021

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F 000	Continued From page 1 H5252052C (MN67642) H5252053C (MN55452) In addition, as a result of the investigation deficiencies were cited at F609, F610, F755 and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 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 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		2/23/21

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F 600	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were free from abuse for 1 of 1 resident (R1) who was physically abused by another resident (R2) and for 1 of 1 resident (R5) who experienced verbal abuse from a facility staff member. Findings include: R1's quarterly Minimum Data Set (MDS) dated 11/30/20, indicated R1 had moderate cognitive impairment and diagnoses which included Parkinson's disease, anxiety disorder, depression and psychotic disorder. The MDS also indicated R1 was non-ambulatory and required extensive assistance with all activities of daily living (ADL) except was independent with eating. The MDS further indicated R1 had delusions but had no physical, verbal or other behavioral symptoms during the look back period. R1's care plan dated 12/4/20, indicated R1 received Risperdal (antipsychotic) for a diagnosis of delusional disorder and Xanax (antianxiety) for diagnosis of anxiety disorder. R1 exhibited target behaviors which included paranoia, delusional statements and anger as well as, sweating, increased verbiage and irritability. The care plan directed staff to offer a snack, activity or provide 1:1 support. R2's quarterly MDS dated 11/5/20, indicated R2 had moderate cognitive impairment and diagnoses which included Alzheimer's disease, dementia, and anxiety disorder. The MDS also indicated R2 exhibited no psychosis, behavioral symptoms, rejection of care or wandering during	F 600	The resident has the right to be free from abuse. TRCC failed to keep R1 free from physical abuse and R5 free from verbal abuse. To ensure that R1 was not abused again, TRCC monitored R2□s whereabouts and her level of agitation with R1. TRCC also engaged R2 more with conversation and activity to keep her from going towards R1□s room. To ensure that R5 was not verbally abused again, staffing schedule was changed so that NA-A did not work on Blueberry. NA-A signed a corrective action form on how to talk to residents and had training on abuse and customer service. She was off of work for 30 days and when she picked up shifts the DON visited with her, along with being monitored by the nurse manager. All residents have the potential to be physically abused by other residents. The DON or designee will assess all residents to see if they have the potential to be abusive to other residents due to agitation. Interventions will be put in place depending on the findings of the assessments and care plans will be updated. All residents have the potential to be verbally abused. DON or designee will interview all residents to see if they have been verbally abused and then follow the abuse policy if abuse happened. The Social Worker will also follow up with those residents that have been verbally abused.	

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F 600	Continued From page 3 the look back period. The MDS further identified R2 required limited assistance with locomotion on and off the unit. R2's General Nurse Observation, identified as the Care Area Assessment dated 11/5/20, indicated R2 was alert and oriented to name and date of birth. She often wandered around the facility. She had a Wander guard in place. No behavioral problems present for R2. R2's care plan dated 12/3/20, indicated R2 experienced agitation/restlessness, wandering, and agitation from loud activities and directed staff to observe frequency of agitation/restlessness, update provider with concerns and provide non-pharmacological interventions including music, iPad story, 1:1 visit with family via phone or Zoom. The facility incident report submitted to the state agency (SA) on 11/12/20, indicated on 11/12/20, at 8:00 p.m. R1 had been hollering out at staff repetitively. R2 was frustrated and went to R1 and slapped her on the face. R1 denied being scared of R2 but did not want anything to do with her in the future. R2 and family were in favor of her moving to the other pod so the two of them did not have to interact in the future. The corresponding investigation report dated 11/18/20, identified the action taken to prevent reoccurrence to the subjected resident was the resident who initiated the contact (R2) was moved to another wing. A second incident report submitted to the SA on 1/11/21, indicated on 1/11/21, at 4:50 p.m. R1 called out "Help me" in a loud strident voice for many hours. When all staff were busy, R2 rolled	F 600	All staff will be re-educated on abuse prevention, Maltreatment Prohibition policy and customer service. The findings on the assessments, interviews and interventions will also be part of the education. The DON or designee will monitor if interventions are being followed and that no resident to resident abuse takes place. Random interviews with residents will also take place. This will be done 3x/week for four weeks, 2x/week for four weeks and then 1x/week for weeks and then monthly. Results will be brought to QAPI for recommendations for ongoing monitoring.	

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F 600	Continued From page 4	F 600		

into R1's room and slapped her across the face twice. Staff intervened and separated them. The corresponding investigation report dated 1/16/21, indicated the action taken to prevent reoccurrence to the subjected resident included immediate intervention to provide 1:1 with staff member and move the medication cart so the TMA [trained medication aid] could keep R2 in view. Action taken to prevent reoccurrence to the other resident included 1:1 with staff for an hour, stationed the medication cart so R2 would be in sight as resident would not stay in room, and after 6 p.m. R2 put on 15 minutes checks. R2 seen by psychiatry and started on gabapentin 100 milligrams (mg) daily for anxiety.

R2's Behavioral Clinic note dated 1/12/21, indicated R2 was seen for medication management of mood disorder, Alzheimer's dementia with behavioral disturbance, and generalized anxiety disorder. Staff identified R2 had been demonstrating increased "sundowners and agitation in the evenings." Staff identified the family would like R2 seen by the provider because she "slapped another resident across the face last night." Staff reported the resident that was hit was "yelling constantly for help at inappropriate times." They reported R2 became agitated by this behavior. When asked about the behavior, R2 was able to recall the events and was able to identify what happened and who she had hit. R2 explained she did what she did and stated, "I got tired of her yelling." Family and staff were concerned because this behavior continued to escalate as R2's cognitive function began to decline. Staff reported R2's behavior always occurred in the evening. R2's memory had begun to decline but she was still oriented to person and place. R2's cognitive function

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F 600	Continued From page 5	F 600		

diminished in the evening and this led to more impulsiveness and less ability to be redirected. Staff reported R2's anxiety was under better control but began to ramp up in the evening. R2 had issues concentrating due to memory loss and a decrease in cognitive function. Provider started gabapentin 100 mg once day at 3 p.m.

During observation on 1/13/20, at 3:04 p.m. the door to R2's room was shut and was located on the Evergreen Road Unit. The Evergreen Road unit was quiet and no residents were in the common areas.

-At 3:05 p.m. R1 rested in bed on the Evergreen Road unit, under the covers. R1 called out "Help me" intermittently. A rope with a keep out sign attached to it was clipped to one side of R1's door.

-At 3:10 p.m. R1 could be heard calling out "Help me" throughout the unit.

-At 3:35 p.m. R2 wheeled self in a wheelchair by propelling herself with her feet on the Evergreen unit by the main hallway next to the nurses' station. The nurse consultant (NC) directed R2 back to her room. NC left the area and R2 remained in her room with the door open.

-At 3:38 p.m. R1 was resting quietly with no calling out at this time.

During observation on 1/14/21, at 9:12 a.m. R2 was up and dressed seated in a wheelchair, in the common area by the nurses station. R2 sat quietly with no adverse mood or behaviors observed.

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During interview on 1/14/21, at 10:55 a.m. NA-B and TMA-A stated they were working on the evening of 1/11/21, when R2 hit R1. NA-B stated she had been giving a bath, NA-C had been charting at the desk, the director of nursing (DON) was talking on the telephone by the COVID area and TMA-A was talking on the telephone at the nurses' station. NA-B indicated she came out of the tub room and heard what had happened.

TMA-A stated she witnessed R2 slap R1 in the face twice and told her "I said, shut up." R1 had been yelling out "help" during the shift and indicated this had been a common thing. R1's calling out had become worse since they had taken her off Xanax. NA-B and TMA-A verified there had been a previous incident of R1 slapping R2 in the face in November and TMA-A stated after that incident R2 had been moved to the Blueberry unit. TMA-A indicated after she witnessed the incident, she brought R2 to her room and provided her with a snack and reported the incident to the DON right away. The DON had instructed maintenance be called to put up a barrier and he was there and installed a rope with a keep out sign within an hour. They have tried to feed R2 her meals in her room, however that did not work so they had to feed her in the common area so they knew where she was at. They also asked about bathroom needs and assisted her to lay down if tired, however, nothing seemed to change her behaviors.

NA-B stated R2 resided on the Blueberry unit for approximately two weeks but had problems with another resident on that unit and was moved back to the Evergreen Road Unit. They had suggested moving R2 back to the other unit but

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F 600	Continued From page 7	F 600		

DON stated they would just put up a keep out sign, and not move her back to the other unit at this time. R2 could get around the rope/sign and though she had not seen R2 unclip the barrier, she had seen R2 in R1's room when the rope had been clipped across the doorway. Further R2 wandered daily and they were told to do 15 minute checks on R2, offer her food, drinks, and try to keep her busy. They tried to keep her within the kitchenette area as she was easier to watch there and indicated R2 used to live next door to R1 and tended to gravitate to that area. NA-B stated there was not a day that R2 did not wander.

During interview on 1/19/21, at 11:37 a.m. the DON confirmed R2 had struck R1 in the face on two occasions, 11/12/20 and 1/11/21. The previous DON had conducted the investigation after the first incident, however, she stated she knew they had implemented frequent checks for R2. They had moved R2 from the Evergreen Road unit to the Blueberry unit after the incident on 11/12/20, as they had thought the Blueberry unit would be less stimulating for R2. There had been another resident on the Blueberry unit who yelled and called out and R2 had been entering rooms and an incident occurred when R2 had wandered into the other resident's room. Therefore, it had been decided to move R2 back to a different room on the Evergreen unit so they could keep a closer eye on her. R2 was moved back to the Evergreen unit on 11/25/20. DON stated she was unsure if an assessment had been completed prior to R2's return to the Evergreen unit but she would check. R1 had behaviors which included calling out, and verified R2 was identified to become agitated with loud activity and wandered throughout the facility

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however, indicated the only intervention put into place to prevent a reoccurrence of an incident between R2 and R1 was to move R2 into a different room on the opposite side of the main hallway. The second incident occurred during a day when the facility was busy with testing activities for COVID-19, residents were being moved into the COVID area on the Evergreen unit and she (DON) was not able to visit R2, as was her routine, due to activities going on in the facility which led to R2 becoming agitated. R1 had been calling out and R2 liked to sit by the nurses' station which was located in close proximity to R1's room. R2 was placed on 15 minute checks after the incident and was seen by psychiatry and prescribed gabapentin for her agitation. During her investigation of the incident on 1/11/21, she had identified R2 gravitated to the area by R1's room. Further, R1 had experienced a decline in condition and incidents of calling out had decreased.

During follow up interview on 1/19/21, at 2:53 p.m. the DON stated she could not find any assessments completed after the incident on 11/12/20, or prior to R2's move back to the Evergreen unit to identify strategies to prevent further altercations between R2 and R1. The DON stated rationale for the move was that the Evergreen unit was quieter and it had went well for 6 weeks.

The Maltreatment Prohibition policy dated 2/19/18, identified the facility had established safeguards to prohibit maltreatment (abuse, neglect and financial exploitation) of any vulnerable adult (VA). The safeguards would adhere to the Federal and State requirements, whichever was most stringent. The policy defined

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physical abuse to include when an individual is injured (hit, slapped, pinched, kicked, scratched, bitten, pushed, burned, controlling behavior through corporal punishment, assaulted or threatened with a weapon or inappropriately restrained). The policy defined VA to VA abuse to include a VA willfully attempting to inflict injury upon another VA. "Willful" means that the individual's action was deliberate (not inadvertent or accidental) regardless of whether the individual intended to inflict injury or harm. Even though a VA may have a cognitive impairment, he/she could still commit a deliberate (willful) act.

R5's quarterly MDS dated 10/27/20, indicated R5 was cognitively intact and had diagnoses which included fibromyalgia and rheumatoid arthritis. R5's care plan dated 12/1/20, identified R5 was able to express her needs and was legally blind.

The facility incident report submitted to the SA on 11/24/20, at 5:17 p.m. indicated the incident had occurred on 11/22/20; however, was not reported until 11/23/20. The report identified an evening shift nursing assistant spoke to R5 in a harsh tone and argued with R5 on 11/22/20.

During interview on 1/14/21, at 9:39 a.m. family member (FM)-B indicated she had visited with R5 via phone on 11/23/20, and stated she was crying as she had not received her supper or medications the night before. FM-B stated R5 had reported an incident with an nursing assistant who had been verbally abusive telling R5 "I don't know why you are acting this way, you were supposed to fill out a slip and you didn't so you aren't going to get supper."

During interview on 1/15/2021, at 9:51 a.m.

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registered nurse (RN)-A stated she had not been working on the night in question, however, R5 had reported the incident to her the next day. RN-A indicated R5 had reported NA-A had told her it was R5's fault that she had not received supper and RN-A stated R5 had been very, very upset and her feelings were strongly hurt. RN-A stated she believed she had reported the concern to the charge nurse.

During interview on 1/15/21, at 9:57 a.m. RN-C stated on 11/22/20, at 5:45 p.m. R5 was looking for food as her supper meal was missed but when food was offered she got mad and went off to her room. RN-C stated NA-A came up to the desk and said something about how R5 was acting immature and indicated she knew NA-A said something to R5 that "set her off."

During interview on 1/15/21, at 11:17 a.m. R5 stated NA-A had gotten mad at her and yelled at her. R5 indicated she did not remember what NA-A said but stated she went out the door yelling and was half way to the kitchenette and was still yelling. NA-A had brought her a salad and she had asked her to make Ramen noodles and then NA-A had started yelling. There were two nurses sitting at the desk and they heard all of it. R5 stated she just went to bed. Further, R5 stated she talked RN-A the next day who reported the incident. R5 stated she felt NA-A was verbally abusive and she had felt scolded.

During interview on 1/19/2021, at 11:30 a.m. DON stated she had talked to R5 and NA-A after the incident and had NA-A write up a report of the incident. DON stated the incident met the facility criteria of verbal abuse and she had developed a performance improvement plan related to NA-A's

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F 600	Continued From page 11 employment. The Maltreatment Prohibition policy dated 2/19/18, defined verbal abuse as the use of oral, written, or gestured language that willfully includes derogatory terms to VA's or their families, or within in their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse included threats of harm, saying things to frighten a vulnerable adult. The policy directed all staff were expected to be in control of their own behavior, were to behave professionally, and should appropriately understand how to work with the nursing home population.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		2/23/21

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F 609	Continued From page 12 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report, no later than two hours, to the State Agency (SA) an allegation of verbal abuse for 1 of 1 resident (R5) who experienced verbal abuse and failed to report an injury of unknown source without serious bodily injury within 24 hours for 1 of 3 residents (R3) who experienced a bruise of unknown source. Findings include: R5's quarterly Minimum Data Set (MDS) dated 10/27/20, indicated R5 was cognitively intact and had diagnoses which included fibromyalgia and rheumatoid arthritis. R5's care plan dated 12/1/20, identified R5 was able to express her needs and was legally blind. The facility incident report submitted to the SA on 11/24/20, at 5:17 p.m. indicated the incident had occurred on 11/22/20; however, was not reported to staff until 11/23/20. The report identified an evening shift nursing assistant spoke to R5 in a harsh tone and argued with R5 on 11/22/20. During interview on 1/15/21, at 9:51 a.m. registered nurse (RN)-A stated she had not been working on the night in question, however, R5 had reported the incident to her the next day.	F 609	A facility must report abuse immediately, but no later than 2 hours, and report an injury of unknown source no later than 24 hours. R5 felt that NA-A was verbally abusive and felt scolded by her during an evening shift. The incident was reported to the DON on 11/23/20. The DON did not get it reported to SA until 11/24/20, which was past the requirement of 2 hours. Disciplinary action was taken against NA-A and her work assignment was changed. There has been no report of this since this incident. R3 had a bruise on her wrist which she or the staff could not explain where it came from. This was reported to staff sometime in December and a report was not filed to SA until December 12/31/20. R3 has not had an injury of unknown source since this incident. The staff involved was re-educated on the timeframes of when abuse and an injury of unknown source needs to be sent to the SA. All Staff will have re-education and training on the Maltreatment Policy and Maltreatment Reporting Guidelines. All residents have the potential to have this happen to them. The DON or	

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F 609	Continued From page 13 RN-A indicated R5 had reported NA-A had told her it was R5's fault that she had not received supper and RN-A stated R5 had been very, very upset and her feelings were strongly hurt. RN-A stated she believed she had reported the concern to the charge nurse. During interview on 1/15/2021, at 11:17 a.m. R5 stated NA-A had gotten mad at her and yelled at her. R5 indicated she did not remember what NA-A said but stated she went out the door yelling and was half way to the kitchenette and was still yelling. R5 stated she talked RN-A the next day who reported the incident. R5 stated she felt NA-A was verbally abusive and she had felt scolded. During interview on 1/19/2021, at 11:30 a.m. the director of nursing (DON) stated she had received information regarding the incident between R5 and NA-A on 11/23/20, but had not reported the incident to the SA until 11/24/20. DON verified the report was late and should have been reported within two hours as required. R3's quarterly MDS dated 12/1/20, indicated R3 had severe cognitive impairment and would have physical and verbal behaviors directed towards others 1-3 days a week. R3 had diagnoses which included non-Alzheimer's dementia and hallucinations. An incident report submitted to the SA on 12/31/20, identified on 12/31/20, at 10:00 a.m. trained medication assistant (TMA)-B reported to RN-E and the DON a bruise was found on R3. The bruise was located on R3's right wrist and measured 6.7 centimeters (cm). The inner wrist	F 609	designee will re-educate all staff on the Maltreatment Policy and the Maltreatment Reporting Guidelines. The DON or designee will also train the charge nurses and nurse managers on how to do a report on the OHFC website. That way they can do the initial report within the 2 hour or 24 hour time frame. The DON or designee will monitor incident reports and reporting times 3x/week for four weeks, 2x/week for four weeks, and 1 x/week for four weeks and then weekly thereafter. The monitoring results will be brought to QAPI for recommendations for ongoing monitoring.	

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had impressions of fingerprints and the outer wrist had bruising shaped as a thumb.

An email dated 1/4/21, received by the DON from family member (FM)-A identified FM-A was visiting R3 around 12/20/20, and noticed a bad bruise on R3's right wrist. FM-A described the bruise as very dark and looked like a pool of blood under the skin. FM-A went to Blueberry nurses' station and asked if anyone knew what happened to R3's wrist, but they did not know about the bruise or what happened. FM-A asked them to document the bruise and keep an eye on it as she was concerned of it becoming a clot.

During interview on 1/14/21, at 3:14 p.m. TMA-B said she could not remember the exact date she reported the bruise but it was around the end of December 2020 or beginning of January 2021. TMA-B stated when she saw the bruising on R3's right wrist it looked like someone had grabbed R3's wrist and she was concerned for R3's safety and immediately reported it to the RN nurse manager and then to the DON.

During interview on 1/15/21, at 8:17 a.m. FM-A said she knew of the bruise on R3's wrist before they facility called on 12/31/20, to report the bruise. FM-A said the Sunday before Christmas she had visited her mother and saw a large, dark bruise around her right wrist which looked like pooling blood. FM-A said she went to nurses' station and talked with staff there to see if they knew how it happened and they responded they did not know anything. FM-A then asked staff to please chart on it and keep an eye on it and keep her updated.

During interview on 1/15/21, at 11:58 a.m. the

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F 609	Continued From page 15 DON stated as soon as the bruise was reported by FM-A it should have been reported to the SA because it was a "vulnerable adult issue". DON stated there was not record of staff being told by family. During interview via telephone on 1/19/21, at 2:00 p.m. the interim administrator stated any reports of injury of unknown origin would need to be reported to the SA within 2 hours [although requirements are 24 hours unless allegations caused serious bodily injury] upon discovery. If a family member had brought it to the attention of staff, the 2 hours would start then. The administrator stated R3's bruise should have been report immediately after family brought it to staff's attention. The Skilled Nursing Facility Maltreatment Reporting Guidelines dated 4/1/19, directed each care center must report to the State Agency any suspected maltreatment (all alleged violations involving abuse, neglect, exploitation or maltreatment, including injuries of unknown source and misappropriation of resident property) immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		2/23/21

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F 610	Continued From page 16 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct a thorough investigation for injuries of unknown origin for 1 of 3 residents(R3) reviewed for unknown injury. Findings include: R3's quarterly minimum data set (MDS) dated 12/1/20, indicated R3 had severe cognitive impairment and would have physical and verbal behaviors directed towards others 1-3 days a week. R3 had diagnoses which included non-Alzheimer's dementia and hallucinations. An incident report submitted to the SA on 12/31/20, identified on 12/31/20, at 10:00 a.m. trained medication assistant (TMA)-B reported to registered nurse (RN)-E and the director of nursing (DON) a bruise was found on R3. The bruise was located on R3's right wrist and measured 6.7 centimeters (cm). The inner wrist had impressions of fingerprints and the outer wrist had bruising shaped as a thumb.	F 610	In response to allegations of abuse, neglect, exploitation, or mistreatment, that facility must have evidence that all alleged violations are thoroughly investigated. R5 had a bruise of unknown origin that was reported at the end of December. A thorough investigation was not found. R5 had a recent skin assessment done and no new bruises of any were found. Staff will continue to monitor. All resident have the potential to get injures of unknown source. DON or designee will look through the skin and wound charting and incidents to see that RCA and if any further investigations need to be done. DON or designee will do investigation/RCA audits 3x/week for 4 weeks, 2x/week for 4 weeks, and 1 x/week for 4 weeks. Findings will be brought to QAPI for further recommendations for ongoing monitoring.	

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The investigation summary submitted to the State Agency (SA) on 1/5/21, identified a bruise that was yellowing (healing). R3 denied pain and was unable to recall what happened to cause the bruise. The facility reviewed the abuse prevention policy and an email received by family member (FM)-A as part of their investigation. FM-A was contacted and stated they had previously reported the bruise, but was not sure who she told. The investigation concluded R3 had a diagnoses of dementia with behavioral disturbances and liked to be independent and at times becomes physically aggressive with staff. Further, R3 received aspirin 81 milligrams daily. The investigation included interviews with TMA-B, RN-E and FM-A.

The internal investigation was requested and included an Incident Details form dated 12/31/20, and included a summary of the bruise as identified in the investigation summary submitted to the SA on 1/5/21. Also included was a list of staff names. The investigation did not include the staff interview details, nor did it include observation of cares for R3 to ensure abuse was not the cause of the bruising.

During interview on 1/15/21, at 11:58 a.m. the DON stated as part of the investigation she interviewed TMA-B, RN-E and FM-A. However, talked to a number of employees about the bruise and if they knew what happened, however, did not document the interviews she conducted. Further, observations of cares were not completed and did not review other resident charts or talk to other residents to rule out abuse as the cause of the bruise. The DON stated a more thorough investigation needed to be

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completed to ensure abuse did not occur.

During interview on 1/15/21, at 4:38 p.m. RN-E stated when she was first informed of the bruise she measured the bruise and did not have time to complete any investigation into the cause of the bruise. A thorough investigation was needed in order to implement appropriate interventions.

During a telephone interview on 1/19/21, at 2:02 p.m. the interim administrator stated they would expect a thorough investigation to be done and documented. Once alerted of the bruise R3 should have been assessed and investigation started to ensure the resident was safe. If the incident was an injury of unknown origin he would expect the facility report to the SA and an investigation started. The administrator would expect the facility to complete a root cause analysis to determine what happened, documented interviews with staff who had worked with VA and whether they noticed anything or not. Further, they would also be expected to talk with other residents and see if similar incidents have occurred. Further, the incident should have been reviewed during inter-disciplinary review team (IDT) meetings and depending on the outcome would expect training to completed with all staff in a timely manner. The administrator stated the injury of unknown origin for R3 was not investigated thoroughly to ensure a proper conclusion.

The facility's Maltreatment Investigation Policy reviewed 1/30/16, indicated an initial investigation must be conducted immediately to determine what happened. The incident report would further be assessed by IDT to evaluated effectiveness of the interventions. The facility's Vulnerable Adult

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F 610	Continued From page 19 (VA) Investigation/Written Report indicated interviews/statement would need to be received from VA and/or family, any people involved and staff.	F 610		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete comprehensive fall assessments following a fall to determine potential effective interventions for 1 of 3 residents (R3) who had a history of repeated falls. Findings include: R3's quarterly minimum data set (MDS) dated 11/18/20, indicated R3 had severe cognitive impairment, and short term memory issues. R3 required limited assistance with bed mobility, transfers and toileting. The MDS identified R3 had one fall without injury since 8/20/20. Diagnoses included non-Alzheimer's dementia and hallucinations. R3's falls Care Area Assessment (CAA) dated 8/26/20, indicated R3 was at risk for falls and had one fall in the past quarter. R3 was to wear gripper socks. R3 was independent with transfers using a front wheeled walker (FWW). R3 was to wear non-slip footwear	F 689	The facility must ensure that the resident has proper fall interventions in place. R3 will have a comprehensive fall assessment done and her care plan will be updated with appropriate interventions. All residents have the potential to fall. The DON or designee will look at all falls that occurred from 1/19/21 to ensure that a falls scene investigation and root cause analysis was done. They will update the care plans with any new interventions or to take interventions off that are not appropriate anymore. The DON or designee will re-educate nursing staff on the fall prevention and management policy. The DON or designee will do fall audits 3x/week for 4 weeks, 2x/week for 4 weeks, and 1x/week for 4 weeks. Findings will be brought to QAPI for further recommendations on ongoing monitoring.	2/23/21

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	245252	A. BUILDING _____ B. WING _____	C 01/19/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 20	F 689		

while out of bed.

R3's care plan last reviewed on 12/1/20, identified R3 had visual impairment, cognitive deficits and was at risk for falls. Interventions added 2/13/17, included staff were to encourage R3 to use call light for assistance; encourage R3 to wear gripper socks when not wearing shoes; inspect R3's shoes and footwear for proper fit and reduced slip soles . On 7/30/20, an additional intervention was added directing staff to check on R3 every two hours for safety. The care plan did not identify any new interventions from recent falls.

R3's progress note(s) and Fall Scene Investigation Report(s) identified the following:

- 1/1/21, at 5:31 p.m. R3 was found lying on right side in fetal position next to the bed at 4:30 p.m. The wheelchair breaks were unlocked and by television (TV) stand. Bed covers were pulled down as if R3 was getting into bed. R3 was wearing slippers with not a lot of grip on the bottom. Floor was dry. Resident was incontinent urine and feces. R3 was able to move all extremities well and had no complaints of pain when standing. R3 received new gripper socks. Family member (FM)-A and primary medical doctor (MD) notified. The corresponding Fall Scene Investigation Report dated 1/1/21, identified the slippers R3 was using did not have a lot of grip left and was to use different gripper socks. The investigation was lacking a comprehensive assessment to potential causative factors of the fall to ensure appropriate interventions were identified, if needed.

-1/11/21, at 2:19 p.m. R3 was found on the floor with her wheelchair behind her. R3's left wheel

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F 689	Continued From page 21	F 689		

was locked, and the right wheel was unlocked. R3 was able to stand with an assist of 2 staff and no injuries were noted. R3 did have some pain in right arm while getting off the floor but did not complain of pain while in wheelchair. R3 could not explain what happened. R3's family and on-call MD notified. The corresponding Fall Scene Investigation Report dated 1/1/21, identified a new intervention to include checking on R3 every 2 hours and reminding R3 to use a call light. However, this was not a new intervention as it was added to the care plan on 2/13/17.

During interview on 1/15/21, at 4:06 p.m. registered nurse (RN)-A stated after the initial fall report was completed the charge nurse or unit manager would do a post fall assessment 24-48 hours after the fall to follow up on why it happened, and ensure interventions were placed.

During interview on 1/15/21, at 4:27 p.m. RN-B stated post fall investigations should start right after resident was safe. Normally they would assess for the root cause of the fall and review interventions put in place at the time of the fall. Then would review care plan to see what interventions have worked and which interventions have not worked and adjust accordingly.

During interview on 1/15/21, at 4:38 p.m. RN- E who was the unit manager stated she was aware of R3's falls and they needed to do a comprehensive fall assessment to identify the reason for the fall and put appropriate interventions in place. RN-E had not had time to do the comprehensive assessment and the fall assessment had not been completed for the falls which occurred on 1/1/21, and 1/11/21. Further,

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F 689	Continued From page 22 the assessments should have been completed to ensure appropriate interventions were placed for R3's safety. The facility's Fall Prevention and Management policy dated 4/12/17, indicated nursing management staff would evaluate the fall by reviewing the fall incident report and the fall scene investigation to determine a root cause analysis of the fall and further interventions may be put into placed according to the determined cause of the fall. This it to prevent further falls. The interdisciplinary team would systematically review the fall and interventions put into place to determine their effectiveness. If an intervention was not effective, new interventions would be developed and implemented.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		2/23/21

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F 755	Continued From page 23 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure accurate reconciliation of controlled narcotic medication to ensure rapid detection of potential narcotic diversion for 1 of 2 residents (R9) who received liquid morphine from an unmarked bottle. Findings include: On 1/15/21, at 4:04 p.m. trained medication aid (TMA)-A was interviewed regarding the facility narcotic reconciliation process. TMA-A indicated at the end of the shift the outgoing TMA or nurse counted all narcotics with the oncoming nurse and both staff members signed off the results in a book. During random reconciliation of the controlled substances in the Evergreen Road medication cart, R9's morphine 100 milligram (ml)/5 milliliter (ml) liquid solution was observed to be in a 30 ml bottle with a pharmacy label attached. The plastic bottle was frosty white in appearance and a clear, colorless solution was observed in the	F 755	Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. R5□s liquid morphine was reconciled. The new amount was put on the bottle as well as in the narcotic book. No diversion was found.R5 received a new bottle with lines on the side that has amounts on them. There is potential that this could happen to any resident that has a liquid controlled narcotic medication. The DON or designee will look over all resident□s medications and reconcile all liquid controlled narcotics.DON talked with Thrifty White Pharmacy and they will send all liquid controlled narcotics in bottles that have lines with the amounts on them. This will help with giving a guide on how much is left in the bottle for counting. The DON or designee will review the	

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F 755	Continued From page 24 bottle. The bottle was devoid of demarcation or graduated measurement markings of any kind. The bottle was less than approximately 1/4 full. The Individual Narcotic Record in the bound book, page 133, identified the amount remaining was expected to be 14.4 ml. TMA-A stated the bottle did not have measurement markings to determine the amount in the bottle, they had been "going by the book." Registered nurse (RN)-B who was standing at the nurses' station by the medication cart, also viewed R9's bottle of morphine and stated there was no way to measure the liquid medication in the current bottle and indicated the facility usually received liquid morphine as a tinted solution in a bottle with measurement markings along the side of the bottle for measurement purposes. RN-B and TMA-A stated staff had been "eyeballing" the measurement and were unaware of any facility policy regarding measurement of liquid medications dispensed in an unmarked bottle. RN-B stated if staff noted a discrepancy in the narcotic count they were to notify the director of nursing (DON). R9's Individual Narcotic Records reviewed on 1/15/21, at 4:50 p.m. identified the morphine 100 mg/5 ml bottle was received by the facility on 12/22/20 and 34 entries of administration of 0.2 ml doses were deducted from the 30 ml total. An additional 88 entries of administration of 0.1 ml doses were deducted for a total remaining of 14.4 ml. During review of the Narcotic Record RN-B measured the remaining morphine solution from the unmarked bottle by dispensing it into a graduated plastic medication cup and stated the amount in the bottle to be slightly over 5 ml (an approximate 9 ml discrepancy).	F 755	policy on reconciling controlled medications and update with any changes. Education will be given to the nursing staff on reconciling controlled medications and signing the narcotic book. The DON or designee will do audits 3x/week for 4 weeks, 2x/week for 4 weeks, and 1x/week for 4 weeks on controlled medication reconciliation and that the count is being looked at with shift change. Finding will be brought to QAPI for further recommendations for ongoing monitoring.	

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F 755	Continued From page 25	F 755		

During interview on 1/15/21, at 5:30 p.m. the DON verified staff would not be able to determine the amount of liquid medication in a bottle without demarcations on the bottle and would not be able to tell if a discrepancy existed by eyeballing the amount. The DON indicated she would have expected the morphine to have been dispensed from the pharmacy in a bottle with measured markings and if not that staff should have notified the pharmacy for a replacement.

On 1/20/21, at 4:42 p.m. the consultant pharmacist (CP) returned a telephone call and verified staff were required to count narcotics at the end of each shift. CP indicated liquid morphine dispensed in an unmarked bottle was a high risk for medication error or diversion and stated staff should have sent it back to the pharmacy to be put into a bottle with incremental markings. CP stated a 10% discrepancy would be acceptable for liquid morphine bottles, in this case it would amount to 3 ml and the amount missing was above and beyond that.

The Controlled Substances policy dated 7/18/16, directed a controlled substance audit was conducted at each shift change. The nurse or TMA going off the shift counts all controlled substances in the controlled substance lock box with the oncoming Nurse or TMA. The controlled substance count should be conducted with a minimum of one licensed personnel. The policy also directed together with the inures of TMA coming on shift, the nurse or TMA going off physically counts the controlled substances on hand. The count should match the recorded balance on the individual count sheet in the bound book. The policy did not include a

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F 755	Continued From page 26 procedure for the count of liquid controlled substances.	F 755		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 2, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: RM7V11

Dear Administrator:

The above facility was surveyed on January 13, 2021 through January 19, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 01/19/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/13/21 through 1/19/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID	

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5252047C (MN56756) with a licensing order issued at MN Rule 4658.0520 Subp. 1 The following complaints were found to be SUBSTANTIATED, however NO licensing orders were issued: H5252045C (MN69002) H5252048C (MN67277) H5252049C (MN67615) H5252050C (MN67548) The following complaints were found to be unsubstantiated: H5252046C (MN52867) H5252051C (MN68685) H5252052C (MN67642) H5252053C (MN55452) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with	2 000	Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS	

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2 000	Continued From page 2 the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000	WILL APPEAR ON EACH PAGE.	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		2/23/21

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 This MN Requirement is not met as evidenced by: F689 SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) , or designee, could review and/or revise policies and procedures related to falls, post fall assessments and the implementation of interventions. The DON , or designee could educate all staff on the completion of assessments including the identification of causal factors of the fall. The DON or designee, could develop an auditing system to ensure compliance and report results of the monitoring to the facility quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830	Corrected	