DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 22, 2021

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

RE: CCN: 245252
Cycle Start Date: July 29, 2021

Dear Administrator:

On September 8, 2021, we notified you a remedy was imposed. On October 7, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 29, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 29, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 13, 2021, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 29, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 29, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered
August 13, 2021

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

RE: CCN: 245252
Cycle Start Date: July 29, 2021

Dear Administrator:

On July 29, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 29, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 29, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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 electronic 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 07/29/2021

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 000	INITIAL COMMENTS On 7/28/21, and 7/29/21, a standard abbreviated 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 following complaints were found to be SUBSTANTIATED: H5252059C (MN74725), with a deficiency cited at F760. As a result of the the investigation an additional deficiency was cited at F609 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 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,	F 609		8/30/21

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

Electronically Signed | 08/23/2021

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F 609	Continued From page 1 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. §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 report a significant medication error to the State Agency (SA) for 1 of 3 residents (R)1 reviewed for medication errors. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/8/21, indicated R1 had severe cognitive impairment. R1's diagnoses included chronic obstructive pulmonary disease (COPD) and Alzheimer's disease. The MDS indicated R1 was receiving an opioid seven of seven days during the assessment period. R1's MDS also indicated R1 was on hospice and required oxygen care. R1's medication list from 6/17/21, indicated R1	F 609	The facility is to ensure that all allegations of abuse, neglect, exploitation, or mistreatment are reported no longer than 2 hours after an allegation of abuse or serious bodily injury, or no later than 24 hours for allegations that do not involve abuse and or serious bodily injury. R1 did not receive any pain medications from 6/18/21 – 6/24/21 and this was not reported as a significant medication error. All residents have the potential for this to happen to them. The DON or designee will review all medication errors from 7/29/21 to present for appropriate follow up and reporting. DON or designee will re-educate staff on vulnerable adult, maltreatment and report	

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F 609	Continued From page 2 received scheduled morphine (a pain medication that also helps with breathing for patients with COPD and is highly addictive) on a scheduled basis and received morphine tablet 3.75 milligrams (mg) six times a day for shortness of breath and pain. R1's Medication Administration Record (MAR) 6/18/21, until 6/24/21, at 5:20 p.m. indicated R1 had not received any doses of scheduled morphine. During an interview on 7/28/21, at 2:14 p.m. family member (FM)-A stated she came to visit R1 on 6/24/21, at about 5:00 p.m. FM-A stated she noticed R1 was having some difficulty breathing and approached the nurse and asked when R1 received their last dose of pain medication (morphine). FM-A stated the nurse said R1 did not have an order for scheduled morphine. FM-A indicated she told the nurse R1 was on hospice and was to be receiving scheduled morphine six times a day and it should not have been stopped. During an interview on 7/28/21, at 3:07 p.m. the hospice nurse indicated R1 was on morphine and to have it suddenly stopped could cause difficulty for a resident and could be life threatening. During an interview on 7/29/21, at 12:40 p.m. R1's medical doctor (MD)-A stated R1 was receiving scheduled morphine and to have it stopped suddenly could cause increased pain, increased shortness of breath, and withdrawal symptoms. MD-A indicated experiencing those symptoms could be detrimental to R1's health. During an interview on 7/29/21, at 1:09 p.m. with	F 609	policies. DON or designee will do audits on medication errors for appropriate follow up and reporting 3x/week for 4 weeks, 2x/weeks for 4 weeks, 1x/week for 4 weeks. Findings of audits will be brought to QAPI for further recommendations for ongoing monitoring.	

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F 609	Continued From page 3 the administrator and the director of nursing (DON), they stated when R1 missed receiving her medication for six days it should have been reported to administration or to the DON and it was not. They both agreed it was a significant medication error and should have been reported to the State Agency (SA) when it was first identified by staff on 6/24/21, at 5:00 p.m. The administrator and DON stated the medication error was not reported to the SA. The facility's Skilled Nursing Facility Maltreatment Reporting Guidelines dated 4/1/19, identified a medication error as any preventable event that may cause or lead to inappropriate medication use or vulnerable adult harm while the medication was in the control of the care center. The guidelines also identified medication error were to be reported to the SA within 24 hours of discovery of the incident, or within two hours if the incident involved abuse or resulted in serious bodily injury.	F 609		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: During interview and document review the facility failed to ensure continuity of pain medication for 1 of 3 residents (R1) who was reviewed for significant medication errors. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/8/21, indicated R1 had severe cognitive	F 760	1. On the 6th day of the resident not receiving the medication, immediately upon the discovery of the error, the nurse verified the order with the pharmacy, notified hospice and entered a new corrected order and began the medication administration for the new medication. Following the completion of the survey (8/2/21), nursing added documentation of	8/30/21

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F 760	Continued From page 4 impairment. R1's diagnoses included chronic obstructive pulmonary disease (COPD) and Alzheimer's disease. The MDS indicated R1 was receiving an opioid seven of seven days during the assessment period. R1's MDS also indicated R1 was on hospice and required oxygen care. R1's care plan dated 3/30/21, indicated hospice care started on 3/30/21, with goal of joint collaboration with hospice team. Approaches included hospice would provide medications related to terminal diagnosis, hospice would provide oxygen, and nursing home staff would notify hospice of any need for change in hospice services. R1's medication lists indicated R1 was receiving scheduled morphine (a pain medication that also helps with breathing for patients with COPD and is highly addictive) on a scheduled basis starting on 4/1/21: --from 4/1/21, until 5/11/21, R1 received morphine solution 2 mg by mouth six times a day for pain and shortness of breath. --from 5/11/21, until 6/4/21, R1 received morphine solution 4 mg by mouth six times a day for pain and increased shortness of breath. --from 6/4/21, until 6/18/21, R1 received morphine tablet 3.75 mg by mouth six times a day for pain and shortness of breath, was changed to tablet form due to swelling in lips and thrush. Also according to R1's medication lists: --from 6/18/21, until 6/24/21, at 5:20 p.m. R1 had not received any doses of scheduled morphine. --on 6/24/21, at 5:20 p.m. R1 was restarted on her morphine solution of 4 mg by mouth six times a day for pain and shortness of breath. --from 6/25/21, until 6/28/21, R1 received	F 760	treatment orders to assess R1's pain and breathing daily. The nurse who was working during the medication and order change was a temporary worker. Her contract ended the last day of the administration of the morphine, so unfortunately we could not provide her education, but she does not work in the facility any longer. 2. All residents on hospice will have a chart audit completed to ensure their medications and orders are reconciled and appropriate with current orders. All residents who receive narcotic medication will be added to the eTAR order to ensure daily pain assessment occurs. This will occur no later than 8/30/21. 3. On 8/10/21 Hospice administration and TRCC administration met to review the incident and created a procedure to ensure communication breakdown between the two providers does not occur again. The procedure included training and orientation of new nurses for both organizations, education for the hospice nurse who did not follow up or communicate with the TRCC staff on the 14 day order or follow up required, and ensuring hospice provides a hand written order to ensure evidence of communication is available and that verbal communication is not the only way we communicate changes of medications. 4. DON or designee will complete one weekly audit on one randomly selected hospice resident per week for 12 weeks. The audit will include reviewing a randomly selected hospice resident's orders and verifying the medications given	

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F 760	Continued From page 5 morphine tablet 3.75 mg by mouth six times a day for pain and shortness of breath. During an interview on 7/28/21, at 2:14 p.m. with family member (FM)-A, she stated she came in to visit R1 on 6/24/21, at about 5:00 p.m. and noticed she was having some difficulty breathing. FM-A approached the nurse and asked when R1 received her last dose of pain medication (morphine). FM-A stated the nurse said R1 did not have an order for scheduled morphine. FM-A indicated she told the nurse R1 was on hospice and was to be receiving scheduled morphine six times a day and it should not have been stopped. FM-A stated the nurse then contacted hospice and got R1's medications restarted. During an interview on 7/28/21, at 3:07 p.m. the hospice nurse (HRN)-A, indicated R1 was changed from morphine solution to morphine tablet on 6/4/21, due to lip swelling and open sores on lips. HRN-A stated when the morphine order changed to the tablet the order was placed in the chart for 14 days and then was to be reassessed and then would be reordered if tolerated. HRN-A stated she assessed R1 on 6/16/21, and indicated the change had worked well for R1. HRN-A indicated R1's morphine should not have been stopped and should have been continued, but the order for continuation of morphine was not entered and was not identified by her nor the facility. HRN-A stated it could cause increased difficulty in breathing for R1. During an interview on 7/29/21, at 12:40 p.m. R1's medical doctor (MD)-A stated R1 was receiving scheduled morphine and to have it stopped suddenly could cause increased pain, increased shortness of breath, and withdrawal	F 760	to that resident are in accordance with their medication orders. The audit will also include physically verifying that the medication is on site. On 8/4 and 8/5/2021 mandatory staff meetings occurred for nursing staff that included Abuse prevention, investigating, reporting, medication errors, serious medication errors, and notification of the DON, social worker, and/or Administrator. All licensed staff were given login instructions and practiced logging into the incident reporting website. 5. Audit results will be brought to the QAPI committee for monitoring and evaluation. 6. Completion date: 8/30/21.	

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F 760	Continued From page 6	F 760		

symptoms. MD-A stated experiencing those symptoms could be detrimental to R1's health.

During an interview on 7/29/21, at 1:09 p.m. with the administrator and the director of nursing (DON), they both stated they were unaware of R1's medication error. The administrator stated the sudden stopping of any medication without the provider or hospice know was a concerning issue. The DON stated if morphine was stopped abruptly it could cause significant issues for R1 and was considered a significant medication error. The administrator agreed this was a significant medication error and should have been reported.

The Center for Medicare/Medicaid Services (CMS) identifies a significant medication error as one which can cause the resident discomfort or jeopardizes his or her health and safety.

A policy regarding use of opioid medication usage and discontinuation was requested on 7/28/21. No policy was received.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 13, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: C13611

Dear Administrator:

The above facility was surveyed on July 28, 2021 through July 29, 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:

Susan Frericks, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 07/29/2021

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) COMPLETE DATE
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 7/28/21 and 7/29/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5252059C (MN74725) with a licensing order issued at MN Rule 4658.1320 A.B.C. 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 surveyor's 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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.	2 000		

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2 000	Continued From page 2 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		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the	21545		8/30/21

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21545	Continued From page 3 resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: During interview and document review the facility failed to ensure continuity of pain medication for 1 of 3 residents (R1) who was reviewed for significant medication errors. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/8/21, indicated R1 had severe cognitive impairment. R1's diagnoses included chronic obstructive pulmonary disease (COPD) and Alzheimer's disease. The MDS indicated R1 was receiving an opioid seven of seven days during the assessment period. R1's MDS also indicated R1 was on hospice and required oxygen care. R1's care plan dated 3/30/21, indicated hospice care started on 3/30/21, with goal of joint collaboration with hospice team. Approaches included hospice would provide medications related to terminal diagnosis, hospice would provide oxygen, and nursing home staff would notify hospice of any need for change in hospice	21545	Corrected	

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21545	Continued From page 4 services. R1's medication lists indicated R1 was receiving scheduled morphine (a pain medication that also helps with breathing for patients with COPD and is highly addictive) on a scheduled basis starting on 4/1/21: --from 4/1/21, until 5/11/21, R1 received morphine solution 2 mg by mouth six times a day for pain and shortness of breath. --from 5/11/21, until 6/4/21, R1 received morphine solution 4 mg by mouth six times a day for pain and increased shortness of breath. --from 6/4/21, until 6/18/21, R1 received morphine tablet 3.75 mg by mouth six times a day for pain and shortness of breath, was changed to tablet form due to swelling in lips and thrush. Also according to R1's medication lists: --from 6/18/21, until 6/24/21, at 5:20 p.m. R1 had not received any doses of scheduled morphine. --on 6/24/21, at 5:20 p.m. R1 was restarted on her morphine solution of 4 mg by mouth six times a day for pain and shortness of breath. --from 6/25/21, until 6/28/21, R1 received morphine tablet 3.75 mg by mouth six times a day for pain and shortness of breath. During an interview on 7/28/21, at 2:14 p.m. with family member (FM)-A, she stated she came in to visit R1 on 6/24/21, at about 5:00 p.m. and noticed she was having some difficulty breathing. FM-A approached the nurse and asked when R1 received her last dose of pain medication (morphine). FM-A stated the nurse said R1 did not have an order for scheduled morphine. FM-A indicated she told the nurse R1 was on hospice and was to be receiving scheduled morphine six times a day and it should not have been stopped. FM-A stated the nurse then contacted hospice	21545		

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21545	Continued From page 5 and got R1's medications restarted. During an interview on 7/28/21, at 3:07 p.m. the hospice nurse (HRN)-A, indicated R1 was changed from morphine solution to morphine tablet on 6/4/21, due to lip swelling and open sores on lips. HRN-A stated when the morphine order changed to the tablet the order was placed in the chart for 14 days and then was to be reassessed and then would be reordered if tolerated. HRN-A stated she assessed R1 on 6/16/21, and indicated the change had worked well for R1. HRN-A indicated R1's morphine should not have been stopped and should have been continued, but the order for continuation of morphine was not entered and was not identified by her nor the facility. HRN-A stated it could cause increased difficulty in breathing for R1. During an interview on 7/29/21, at 12:40 p.m. R1's medical doctor (MD)-A stated R1 was receiving scheduled morphine and to have it stopped suddenly could cause increased pain, increased shortness of breath, and withdrawal symptoms. MD-A stated experiencing those symptoms could be detrimental to R1's health. During an interview on 7/29/21, at 1:09 p.m. with the administrator and the director of nursing (DON), they both stated they were unaware of R1's medication error. The administrator stated the sudden stopping of any medication without the provider or hospice know was a concerning issue. The DON stated if morphine was stopped abruptly it could cause significant issues for R1 and was considered a significant medication error. The administrator agreed this was a significant medication error and should have been reported.	21545		

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21545	Continued From page 6 A policy regarding use of opioid medication usage and discontinuation was requested on 7/28/21. No policy was received. SUGGESTED METHOD OF CORRECTION: The DON and/or designee, could review the facility's policy and procedures to ensure medication doses are not missed and continuity of scheduled medications. The DON and /or designee could train staff and conduct audits to ensure compliance. TIME PERIOD FOR CORRECTION: Ten (10) days.	21545		