

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 8, 2022

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

Re: Reinspection Results

Event ID: Y7F912

#### Dear Administrator:

On January 24, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 24, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any 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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 27, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: Y7F911

#### Dear Administrator:

The above facility was surveyed on December 14, 2021 through December 16, 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 <u>only a suggestion</u> 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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557

Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

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

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

PRINTED: 06/28/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245252	B. WING			C 12/16	6/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, C 2001 EASTWOOD I THIEF RIVER FAI		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD ERENCED TO THE APPROPO DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	abbreviated survey Your facility was for with the requirement for L. The following comp SUBSTANTIATED: H5252063C (MN79F689.  The IJ began on 12 WanderGuard was be functioning but wadditional intervent safe until the Wand Then on 12/8/21 R and was found by a snowbank unharmal immediate intervent elopement when it WanderGuard was in R1 eloping out ollater (on 12/8/21), a visitor outside (on addition, there were placed after the seat 3:30 p.m. admin (DON), and consult IJ was removed on	gh 12/16/21, a standard was conducted at your facility. und to be NOT in compliance nts of 42 CFR 483, Subpart B, long Term Care Facilities. colaints were found to be 12/174), with a deficiency cited at	FC	00	DEFICIENCY)		
	harm with potential that is not immedia The above findings quality of care, and	constituted substandard an extended survey was					
I ABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TI	ITLE	(X	(6) DATE

Electronically Signed 12/29/2021

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG	COMPLETED
		245252	B. WING _		C <b>12/16/2021</b>
	PROVIDER OR SUPPLIER  VER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  2001 EASTWOOD DRIVE  THIEF RIVER FALLS, MN 56701	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
	as your allegation of Departments accepted in ePOC, yat the bottom of the form. Your electronic be used as verificated. Upon receipt of an accepted in epochetic in the form in the substance of Accident Hard CFR(s): 483.25(d) (1) Section 1. Se	f correction (POC) will serve of compliance upon the otance. Because you are rour signature is not required of first page of the CMS-2567 ic submission of the POC will cion of compliance.  acceptable electronic POC, and refacility may be conducted to notial compliance with the en attained.  Azards/Supervision/Devices 1)(2)	F 00	00	ill have prevent
	immediate jeopardy The IJ began on 12 WanderGuard was			to do if the wander guard does not Educated staff of facility0020eloper risk policy, including policy updates Educated staff on use of and initiati wander guard when the wander guard working. There are binders on be	ment ing ard is

PRINTED: 06/28/2022 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MR NO.</u>	<u>0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		ELE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245252	B. WING			12/1	) 16/2021
NAME OF F	PROVIDER OR SUPPLIER		Ī	;	STREET ADDRESS, CITY, STATE, ZIP CODE		
				:	2001 EASTWOOD DRIVE		
THIEF RI	VER CARE CENTER				THIEF RIVER FALLS, MN 56701		
	OLIMANA DV. OTA	TEMENT OF DEFICIENCIES					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	safe until the Wand Then on 12/8/21 Rand was found by a snowbank unharmed immediate intervent elopement when it wanderGuard was in R1 eloping out of later (on 12/8/21), a visitor outside (on addition, there were placed after the secat 3:30 p.m. adminition (DON), and consulting J was removed on noncompliance remseverity level of D, harm with potential that is not immediate.  Review of facility restate Agency (SA) "went outside wear sweatpants. He substantial the substantial than the subst	erGuard could be replaced. I eloped out of the building a visitor/contractor lying in a ed. The facility failed to place tions to prevent a future was again determined R1's not functioning, which resulted the building again an hour and was found by another ampus) unharmed. In a no immediate interventions cond elopement. On 12/15/21, strator, director of nursing ant were notified of the IJ. The 12/16/21, at 1:46 p.m. but nained at the lower scope and which indicated no actual for more than minimal harm the jeopardy.  port number 345259 to the dated 12/8/21, indicated R1 ing 2 tee-shirts and osequently fell on the ice as he	F 6	6889	ends of the building (both pods) on program and utilize the wander guarchecker to ensure they are working If there are no wander guard brace available, staff will initiate 30 minute checks until the resident can have new wander guard placed. Facility has established a protocol ensure back-up wander guards are available/reduced time in shipping facility. Educate staff checking the wander placement and working ability, they use the free text in the order administration that they are working not. Educate staff on maltreatment polic a resident elopes, that it is maltreat and reportable to the state. Nurse Manager will be checking the wander guard bracelet functionality every 3 weeks and to keep them in file for compliance checking. DON or designee will complete aud functioning wander guards every de 12/24/2021, three times a week for	g daily. lets e the to e in the guard y are to g or cy and twent e daily y tests a soft dits of ay until	
	notified that the res bank by a pharmac medications to the investigation to the "replaced wandergo working condition" reoccurrence to res R1's annual Minima	nto the snow bank. Staff was ident was outside in the snow by tech that was delivering facility." Review of the 5-day SA dated 12/9/21, indicated and bracelet as his was not in as the action taken to prevent ident.  al Data Set (MDS) dated R1's diagnoses included			weeks, two times a week for two wand once a week for two weeks to compliance. Report findings to QA update as needed. Will address in staff meeting and ir meeting minutes. Completion date January 19th, 2022. Audit results will be brought to QAF update for review and further recommendations.	ensure and the of	

Alzheimer's, dementia and had severe cognitive

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		245252	B. WING	i	12	C / <b>16/2021</b>
	PROVIDER OR SUPPLIE		•	STREET ADDRESS, CITY, STATE, ZIP 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 5670	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 689	impairment. R1 refrom one staff for however, was abl independently for MDS, indicated R exhibit any wander R1's Elopement F10/21/21, identifier related to "decreas status, has attem However, assessito interventions in elopement.  R1's care plan dadisplayed paranoi people of stealing to him. R1's care one on one attent and beverages. Ron R1 being an elfor staff when resor exit seeking be after survey entrato include R1 had directed staff to offer activity wher replace Wander Guard for located on R1's left Review of R1's prof the two elopem Further review of 12/10/21, indicate practitioner who "resident. The following resident. The following resident.	equired extensive assistance activities of daily living, e to utilize wheelchair mobility. Further review of 1 had delusions but did not ering behaviors.  Risk Assessment dated and R1 as an elopement risk ased motivation and cognitive pted to leave in the past."  ment lacked information related a place to prevent a future  ted 12/8/21, indicated R1 d behaviors and would accuse a his car and that staff were lying plan directed staff to provide ion, distractions, and offer food at 1's care plan lacked information dependent risk and interventions ident was displaying wandering shavior. However, on 12/14/21, nce, R1's care plan was revised a history of elopement and beerve for wandering behaviors, in restless, redirect as able, suard every 85 days, and check placement and functioning	F	689		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245252	B. WING		12	C / <b>16/2021</b>
	PROVIDER OR SUPPLIER  VER CARE CENTER		,	STREET ADDRESS, CITY, STATE, ZIP C 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 5670	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 689	evidence that a UA with the results.  R1's Incident Detai indicated, "Resider glasses getting fixeroom but was too fi any supper. He whroom. At [6:05 p.m for medication deliv something about a The delivery man a into the wheelchair bring him down to bathroom. He is sit me now. He has not falling sideways intincident report, lack interventions place for R1. Review of a 12/8/21, at 7:15 p.r his car when he se down the hallway. I assistant "another and helped him bar This incident report offered food and R Review of licensed dated 12/1/21, indic [WanderGuard] not of the 24-hour reports	ls report dated 12/8/21, at has been fixated on his ed. He did come to the dining ixated on his glasses to eat eeled himself out of the dining. It his writer went to the door very. The delivery person said man in a wheelchair outside. It is sisted with resident getting and back into the facility. I did his room so he could use the ting at the nursing station with the bruises or scratches from to snowbank." Further review of ked evidence of immediate do prevent future elopements a second incident report dated m. indicated R1 was fixated on lf- propelled in his wheelchair it was noted by a nursing visitor had seen him outside ck in through the front doors." It indicated staff reoriented R1, 1 went to his room.  nurses' 24-hour report sheet cated R1's "WG to working." In addition, review out sheets lacked evidence of	F 6	,		
	sitting at the edge of bracelet was on his	50 p.m. R1 was observed to be of his bed and a WanderGuard is left wrist. R1 stated he had a nap and appeared to be				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245252	B. WING_		12	C / <b>16/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	mildly confused wh questions.  On 12/14/21, at 3:1 (LPN)-A indicated Fand concerned about it." Further, L two elopements on WanderGuard brack wasn't working for a week wasn't working so with addition, LPN-A in wander "nearly everexit the building in the control of the wheelchard injuries noted. RN-facility and assessed indicated she re-ord DON. RN-A then not car and wheeling phallway and called time the CNA reach back into the facility indicated she re-ord the staff got him reached a WanderGuard, but both incidents. RN-	en responding to surveyors  8 p.m. licensed practical nurse R1 was known to "get agitated but things and he won't forget PN-A indicated prior to R1's 12/8/21, R1 required a selet, however, "it hasn't been if not more. Everybody knew it we were watching him closely." indicated R1 was noted to ry day" and has attempted to	F 68	39		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED C	
		245252	B. WING _		12	/16/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	on with him [R1]."  On 12/15/21, at 8:1 "persistently ask whe should be doing" are reassurance but its reorient due to pool LPN-B indicated she for functioning a weit was not functioning and I believe WanderGuard] in the ordered some."  On 12/15/21, at 8:4 (NA)-A indicated Relopement risk and NA-A indicated staff elopement risk and however "some aid communicating" and the nursing care guent or indicated and gray interventions that in and distractions. Relinterventions are in were just added to RN-B indicated, "Stand interventions a sheets, however, as sheets did not identificated she was a was not working but when she was made."	6 a.m. LPN-B indicated R1 will here he should be or what he and "we [staff] use a lot of very difficult to redirect and r short-term memory." Further, he checked R1's WanderGuard eek or week and a half ago and ag, "so I passed it through e we didn't have it [new he building. I believe we  3 a.m. nursing assistant 1 was not identified as an did not wear a WanderGuard f are made aware of interventions through report, s are not good at d NAs are also able to look at	F 68				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	COM	E SURVEY IPLETED
		245252	B. WING				C <b>16/2021</b>
	PROVIDER OR SUPPLIER  VER CARE CENTER			200	REET ADDRESS, CITY, STATE, ZIP CODE  1 EASTWOOD DRIVE RIFE RIVER FALLS, MN 56701	1 12/	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	found out R1's was didn't put anything is exit seeking to be hunsure what was in incidents on 12/8/2 the process is once WanderGuard is not can't answer what it On 12/15/21, at 10 services director (Eaware of R1's Wan properly prior to his Further, ESD stated any extras because they were out. I thir I should check to m In addition, ESD stated and evenings due to done or not being on longer working. The working and stated, "communicated working and stated," with an elope has a WanderGuar staff are able to loo and what interventing DON confirmed R1 12/14/21, with elope	not working and stated, "I n place because he wasn't conest with you." RN-B was nplemented following R1's 1, as well. When asked what e staff identify the ot working, RN-B stated, "I	F 6	889			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		245252	B. WING		12	C / <b>16/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 567	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C  (EACH CORRECTIVE ACTIV  CROSS-REFERENCED TO THE CORRECTION OF CO	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 689	looking for his glass fell on the ice." The indicated she was a not working that nig "keep eyes on him for the evening and incident until the fol DON was unsure with the second incident on [Maintenance] for a and we found out with were ordered." Whe place until the new stated, "check on his know where R1 is a she verbally update it anywhere looking one-hour safety che she was not aware not working on 12/1 it was not working on 12/1 it was not working for R1 now WanderGuard was addition, administratidentify a WanderGuards available for R1 now Wa	ses and he tried to stand and the was no injury noted. DON aware R1's WanderGuard was 19ht, so DON directed staff to until he went to bed." DON left I was not aware of the second Illowing morning on 12/9/21. What was put into place after to the 12/9/21, DON stated, "I asked a WanderGuard to replace it we didn't have any so then they en asked what was put into WanderGuard arrived, DON him more frequently" and to at "every hour." DON indicated that the WanderGuard was 1/21, and you can assume that from 12/1/21 through 12/8/21.  14 a.m. administrator was not be not working on 12/1/21. In a tor indicated when staff four indicated when staff four indicated when staff four indicated if there were no allable "they should call as back ups in his office." tor indicated if there were no allable in the building at that seed to do safety checks.  4 p.m. RN-C indicated staff ne overnight shift for tioning. RN-C indicated if a	F6	89		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245252	B. WING _		12	C 2/16/2021	
	PROVIDER OR SUPPLIER  VER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COUNTY OF THIEF RIVER FALLS, MN 5670	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	report it to the next find the new ones. and let them know. incident she knew I functioning and "I h probably weeks be exact date but I had RN-C stated, "The working and I don't know if it was reportimes I think I just of the state of the	entified as not working, "I will shift. I don't know where to I just report it to the next shift "RN-C confirmed prior to R1's his WanderGuard was not heard it wasn't working fore that. I can't tell you the d known it wasn't working." night before he got out I was believe it was working. I don't red. It was reported so many gave up on it."  colicy titled, Elopement revised all residents will be assessed ag or elopement and if the d to be at risk for elopement en in place to prevent an enurse will enter these into the in. Further review of policy will test the notification bracelet ily for proper signaling and celet. However, the policy staff if the WanderGuard and is not functioning they are supposed to ct the resident from an on 12/1/21, was removed on m. after the facility mented a removal plan which ng: equiring a WanderGuard were	F 68	9			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED	
		245252	B. WING			C / <b>16/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701		10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR  (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	- Updated elopei - Updated maltre to take when a Wai and - All staff/ nurses prior to working nex but noncompliance and severity level of	ment policy eatment policy to include steps inderGuard is not functioning s were to review both policies at shift; remained at the lower scope f D, which indicated no actual for more than minimal harm	F6	89		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 27, 2021

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

RE: CCN: 245252

Cycle Start Date: November 17, 2021

Dear Administrator:

On December 9, 2021, we informed you that we may impose enforcement remedies.

On December 16, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

#### REMOVAL OF IMMEDIATE JEOPARDY

On December 16, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

#### **REMEDIES**

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

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 11, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 17, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 17, 2022.

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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

• Civil money penalty. (42 CFR 488.430 through 488.444)

#### SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Thief River Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective December 16, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

#### 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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

#### **DEPARTMENT CONTACT**

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

Susie Haben, Rapid Response Licensing and Certification Program Health Regulation Division Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

#### 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 May 17, 2022 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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 (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: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc">https://mdhprovidercontent.web.health.state.mn.us/ltc</a> 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

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

PRINTED: 06/28/2022 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			,
		00448	B. WING			6/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THIEF R	IVER CARE CENTER		TWOOD DRI /ER FALLS,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre pursuant to a surve found that the deficion herein are not corrected shall with a schedule of the Minnesota Dep Determination of w corrected requires requirements of the number and MN Ru When a rule contain comply with any of lack of compliance, re-inspection with a result in the assess	hether a violation has been				
	You may request a that may result from orders provided that the Department wit notice of assessment in 12/14/21 through survey was conduct surveyors from the Health (MDH). Your compliance with the	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 12/29/21

STATE FORM 6899 If continuation sheet 1 of 12 Y7F911

TITLE

(X6) DATE

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			,			:
		00448	B. WING			6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THIEF R	IVER CARE CENTER		TWOOD DRI			
	0.0000000000000000000000000000000000000		ER FALLS,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED:					
	H5252063C (MN79 issued at 1665.	1174), with a licensing order				
	documenting the St Orders using Feder have been assigned statutes/rules for Nettag number appears."  "ID Prefix Tag." The compliance is listed of Deficiencies" colicomply" portion of column also include violation of the state. "This Rule is not me the surveyor's find Method of Correction. You have agreed to receipt of State lice the Minnesota Department on Head you electronically. It is necessary for State necessary for State enter the word "CO available for text. You electronic State lice heading completion be corrected prior to the Minnesota Department of Department of Head you electronic State lice heading completion be corrected prior to the Minnesota Department of Department of Department of State lice heading completion be corrected prior to the Minnesota Department of Department of Department of State lice heading completion be corrected prior to the Minnesota Department of Department of Department of Department of Department of State lice heading completion be corrected prior to the Minnesota Department of Departme	partment of Health is tate Licensing Correction ral software. Tag numbers of to Minnesota state ursing Homes. The assigned is in the far-left column entitled to state statute/rule out of the in the "Summary Statement umn and replaces the "To the correction order. This test the findings which are in the statute after the statement, the statute after the statement, the state evidence by." Following lings are the Suggested on and Time Period for the participate in the electronic insure orders consistent with the artment of Health in 14-01, available at in. state.mn.us/facilities/regulatificate. The State licensing the on the attached Minnesota althorders being submitted to Although no plan of correction are Statutes/Rules, please RRECTED" in the box ou must then indicate in the ensure process, under the indate, the date your orders will be electronically submitting to artment of Health. The facility and therefore a signature is bottom of the first page of				

Minnesota Department of Health

	na Department of Tie					
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					l c	
		00448	B. WING		1	6/2021
						<u> </u>
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THIEF R	IVER CARE CENTER		TWOOD DR			
	Г	I HIEF RIV	ER FALLS,	MN 56701		T
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF		DATE
IAO		· · · · · · · · · · · · · · ·	170	DEFICIENCY)		
2.000	O	0	2 000			
2 000	Continued From pa	ge 2	2 000			
	PLEASE DISREGA	RD THE HEADING OF THE				
	FOURTH COLUMN WHICH STATES,					
		N OF CORRECTION." THIS				
	APPLIES TO FEDE	RAL DEFICIENCIES ONLY.				
	THIS WILL APPEA	R ON EACH PAGE.				
21665	MN Rule 4658 1400	) Physical Environment	21665			1/19/22
	WINT TOOL 1000.1100	or Hydrodi Erryllorillorik				17 10722
	A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use					
		s to the extent possible.				
	por contain poronighing	o to the extent peccione.				
	This MN Requireme	ent is not met as evidenced				
	by:					
	Based on interview	and document review, the		F689: Thief River Care Center will	ensure	
	facility failed to ensi	ure resident identified as		all residents with wander guards, v	vill have	
	elopement risk had	a functioning WanderGuard		functioning wander guards daily to	prevent	
	unit or other interve	ntions were implemented to		future elopements.		
	prevent elopements	for 1 of 3 residents (R1)		Update elopement policy to include	e what	
	reviewed for elopen	nents. This resulted in an		to do if the wander guard does not	work.	
	immediate jeopardy	∕ (IJ) for R1.		Educated staff of facility0020elope		
				risk policy, including policy updates	S.	
	The IJ began on 12	/1/21 when R1's		Educated staff on use of and initial	ting	
	WanderGuard was	tested and determined to not		wander guard when the wander gu	ıard is	
	be functioning but v	vas not replaced, nor was		not working. There are binders on		
		on put in to place to keep R1		ends of the building (both pods) or		
	safe until the Wand	erGuard could be replaced.		program and utilize the wander gu	ard	
		eloped out of the building		checker to ensure they are working		
		visitor/contractor lying in a		If there are no wander guard brace		
		ed. The facility failed to place		available, staff will initiate 30 minut		
		tions to prevent a future		checks until the resident can have		
	elopement when it v	was again determined R1's		wander guard placed.		
		not functioning, which resulted		Facility has established a protocol	to	
	in R1 eloping out of	the building again an hour		ensure back-up wander guards are	Э	
		ind was found by another		available/reduced time in shipping		
		ampus) unharmed. In		facility.		

Minnesota Department of Health

STATE FORM 6899 Y7F911 If continuation sheet 3 of 12

Minnesota Department of Health						
STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE : COMPI	
		00448	B. WING		12/1	; 6/2021
NAME OF PROVIDE	R OR SUPPLIER	STREET ADI	DRESS. CITY, S	STATE, ZIP CODE		
			TWOOD DRI	•		
THIEF RIVER C	ARE CENTER		ER FALLS,	MN 56701		
	EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21665 Conti	nued From pa	ige 3	21665			
additi place at 3:3 (DON IJ wa nonco sever harm that is Findir Revies State "went sweatried to notifie bank medic invest "repla worki reocco R1's a 10/21 Alzhe impai from howe indep MDS, exhib	on, there were d after the sec d after the sec d p.m. administ), and consult is removed on ompliance remity level of D, with potential is not immediated and in the distribution of the di	e no immediate interventions cond elopement. On 12/15/21, istrator, director of nursing tant were notified of the IJ. The 12/16/21, at 1:46 p.m. but nained at the lower scope and which indicated no actual for more than minimal harm te jeopardy.  eport number 345259 to the dated 12/8/21, indicated R1 ing 2 tee-shirts and beequently fell on the ice as he nto the snow bank. Staff was sident was outside in the snow by tech that was delivering facility." Review of the 5-day SA dated 12/9/21, indicated uard bracelet as his was not in as the action taken to prevent		Educate staff checking the wander placement and working ability, the use the free text in the order administration that they are working Educate staff on maltreatment polithat if not following elopement politresident elopes, that it is maltreatment reportable to the state.  Nurse Manager will be checking the wander guard bracelet functionalitie every 3 weeks and to keep them if ille for compliance checking.  DON or designee will complete authoritioning wander guards every of 12/24/2021, three times a week for two wand once a week for two weeks, two times a week for two wand once a week for two weeks to compliance. Report findings to Quipdate as needed. If a lab/specimen is needed to be collected, it will be documented in progress notes when the lab/speciolected, if it is not collected, it will documented in the progress notes Education to staff members of lab/specimen stipulations. Will addit staff meeting and in the meeting in Completion date of January 19th, Audit results will be brought to Qaupdate for review and further recommendations.	y are to ng or not. icy and icy and a ment and ne daily y tests n a soft dits of day until or two weeks ensure and the imen is ll be also is. dress in ninutes. 2022.	

00448         B. WING	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				00448	B. WING			_
THIEF RIVER CARE CENTER  2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701				2001 EAS	TWOOD DRI	VE		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	PREFIX (EACH DEFICIEN	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
to interventions in place to prevent a future elopement.  R1's care plan dated 12/8/21, indicated R1 displayed paranoid behaviors and would accuse people of stealing his car and that staff were lying to him. R1's care plan directed staff to provide one on one attention, distractions, and offer food and beverages. R1's care plan lacked information on R1 being an elopement risk and interventions for staff when resident was displaying wandering or exit seeking behavior. However, on 12/14/21, after survey entrance, R1's care plan was revised to include R1 had a history of elopement and directed staff to observe for wandering behaviors, offer activity when restless, redirect as able, replace WanderGuard every 85 days, and check WanderGuard for placement and functioning located on R1's left wrist.  Review of R1's progress notes lacked evidence of the two elopements occurring on 12/8/21. Further review of R1's progress notes dated 12/10/21, indicated R1 was seen by the nurse practitioner who 'observed and spoke with resident. The following order was received: Collect UA [urinary analysis] for increased confusion." However, R1's progress notes lacked evidence that a UA was attempted or obtained with the results.  R1's Incident Details report dated 12/8/21, indicated, "Resident has been fixated on his glasses getting fixed. He did come to the dining room but was too fixated on his glasses to eat any supper. He wheeled himself out of the dining room. At [6:05 p.m.] this writer went to the door for medication delivery. The delivery person said	to interventions in elopement.  R1's care plan da displayed paranoi people of stealing to him. R1's care one on one attent and beverages. R on R1 being an el for staff when res or exit seeking be after survey entra to include R1 had directed staff to o offer activity wher replace WanderGuard for located on R1's le Review of R1's prof the two elopem Further review of 12/10/21, indicate practitioner who "resident. The follo Collect UA [urinar confusion." Howe evidence that a U with the results.  R1's Incident Detaindicated, "Reside glasses getting fix room but was too any supper. He wroom. At [6:05 p.r.]	t e e e e e e e e e e e e e e e e e e e	to interventions in pelopement.  R1's care plan date displayed paranoid people of stealing he to him. R1's care plants one on one attention and beverages. R1' on R1 being an elogifor staff when reside or exit seeking behavior exit seeking fixed practitioner who "object UA [urinary confusion." However evidence that a UA with the results.  R1's Incident Detail indicated, "Resident glasses getting fixed proom but was too fix any supper. He who room. At [6:05 p.m.]	d 12/8/21, indicated R1 behaviors and would accuse is car and that staff were lying an directed staff to provide n, distractions, and offer food 's care plan lacked information pement risk and interventions ent was displaying wandering avior. However, on 12/14/21, ce, R1's care plan was revised history of elopement and serve for wandering behaviors, estless, redirect as able, and every 85 days, and check blacement and functioning wrist.  gress notes lacked evidence nts occurring on 12/8/21. 1's progress notes dated R1 was seen by the nurse beserved and spoke with ving order was received: analysis] for increased er, R1's progress notes lacked was attempted or obtained  s report dated 12/8/21, t has been fixated on his d. He did come to the dining xated on his glasses to eat eeled himself out of the dining ] this writer went to the door	21665			

Minnesota Department of Health

STATE FORM 6899 Y7F911 If continuation sheet 5 of 12

Millinesc	ita Department of He	aith	1			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						:
		00448	B. WING		1	6/2021
						0.2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THIEF R	IVER CARE CENTER		TWOOD DR			
		THIEF RIV	ER FALLS,	MN 56701		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
1710		,	17.0	DEFICIENCY)		
04665	O	F	04665			
21665	5 Continued From page 5		21665			
	into the wheelchair	and back into the facility. I did				
	bring him down to h	nis room so he could use the				
		ting at the nursing station with				
		bruises or scratches from				
		snowbank." Further review of				
		sed evidence of immediate				
	•	d to prevent future elopements				
	for R1. Review of a second incident report dated					
	12/8/21, at 7:15 p.m. indicated R1 was fixated on his car when he self- propelled in his wheelchair					
	down the hallway. It was noted by a nursing assistant "another visitor had seen him outside					
		ck in through the front doors."				
		indicated staff reoriented R1,				
	offered food and R					
	Review of licensed	nurses' 24-hour report sheet				
	dated 12/1/21, indic	cated R1's "WG				
		working." In addition, review				
		rt sheets lacked evidence of				
	R1's WanderGuard	being addressed.				
		0 p.m. R1 was observed to be				
		of his bed and a WanderGuard				
		left wrist. R1 stated he had				
		a nap and appeared to be en responding to surveyors				
	questions.	en responding to surveyors				
	questions.					
	On 12/14/21, at 3:1	8 p.m. licensed practical nurse				
		R1 was known to "get agitated				
		ut things and he won't forget				
		PN-A indicated prior to R1's				
		12/8/21, R1 required a				
		elet, however, "it hasn't been				
		if not more. Everybody knew it				
		ve were watching him closely."				
		ndicated R1 was noted to				
		ry day" and has attempted to				
	exit the building in t					

Minnesota Department of Health

STATE FORM 6899 Y7F911 If continuation sheet 6 of 12

PRINTED: 06/28/2022 FORM APPROVED

iviinneso	<u>ita Department of He</u>	eaith	-			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					_	、
		00440	B. WING		40/4	
		00448	B. WING		12/1	6/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		2001 FAS	TWOOD DR	IVE		
THIEF R	IVER CARE CENTER		ER FALLS,			
			LIK I ALLO,			
(X4) ID		TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
		·		DEFICIENCY)		
04005	0 " 15		04005			
21665	Continued From pa	ge 6	21665			
	On 12/14/21 at 3:5	1 p.m. registered nurse				
		1 had no short-term memory				
		kated on something and "there				
		can do." On 12/8/21, R1 was				
		on his glasses and would not				
		II. R1 left the dining room and				
		a matter of minutes. R1 fell				
	out of the wheelchair and into a snowbank with no injuries noted. RN-A brought R1 back into the facility and assessed R1 for injuries. RN-A					
		entated R1 and notified the				
		oted R1 fixated on finding his				
		ast the nursing station in the				
		for a CNA to get R1. By the				
		ned R1, R1 was being brought				
		by a visitor. RN-A then				
		entated R1 once again and				
		ady for bed. RN-A indicated R1				
		d on, however, after the first				
		t RN-A did not check the				
		it did not sound the alarm for				
	· ·	-A stated, "I didn't put any				
		place. I just passed it on in the				
		everyone knew what was going				
	on with him [R1]."	genig				
	On 12/15/21, at 8:1	6 a.m. LPN-B indicated R1 will				
	,	nere he should be or what he				
		nd "we [staff] use a lot of				
		very difficult to redirect and				
		r short-term memory." Further,				
		e checked R1's WanderGuard				
		ek or week and a half ago and				
		ng, "so I passed it through				
		e we didn't have it [new				
		ne building. I believe we				
	ordered some."	io Sanding. I Solic vo we				
	Gradica Sollie.					
	On 12/15/21, at 8:4	3 a.m. nursing assistant				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 7 of 12 Y7F911

NAME OF PROVIDER OR SUPPLIER  THIEF RIVER CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
NAME OF PROVIDER OR SUPPLIER  THIEF RIVER CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE				A. BOILDING.		С	
THIEF RIVER CARE CENTER  2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED IN COMPLET			00448	B. WING			
THIEF RIVER CARE CENTER  THIEF RIVER FALLS, MN 56701  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	NAME OF PR	PROVIDER OR SUPPLIER	R STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	THIEF RIVI	VER CARE CENTER	R				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	040.15	CUIMMA DV CTA				ON	()(5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DEFICIENCY	PRÉFIX	(EACH DEFICIENCY	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
21665 Continued From page 7 21665	21665	Continued From pa	page 7	21665			
(NA)-A indicated R1 was not identified as an elopement risk and did not wear a WanderGuard. NA-A indicated staff are made aware of elopement risk and interventions through report, however "some aids are not good at communicating" and NAs are also able to look at the nursing care guide sheets.  On 12/15/21, at 9:47 a.m. RN-B indicated R1 is not orientated and getting worse. RN-B indicated R1 was identified as an elopement risk with interventions that included 1-1, offer food, drink, and distractions. RN-B indicated all of the interventions are in R1's care plan, however, they were just added to the care plan on 12/14/21. RN-B indicated, "Staff know by word of mouth" and interventions are placed on the care guide sheets ind not identify R1 as an elopement risk nor provide staff with interventions. RN-B indicated sheets did not identify R1 as an elopement risk nor provide staff with interventions. RN-B indicated she was aware that R1's WanderGuard was not working but was unable to give a date when she was made aware. RN-B indicated she updated maintenance to order some when she found out R1's was not working and stated, "I didn't put anything in place because he wasn't exit seeking to be honest with you." RN-B was unsure what was implemented following R1's incidents on 12/8/21, a well. When asked what the process is once staff identify the WanderGuard is not working, RN-B stated, "I can't answer what the process is."  On 12/15/21, at 10:15 a.m. environmental services director (ESD) indicated he was not aware of R1's WanderGuard hot functioning properly prior to his two elopements on 12/8/21. Further, ESD stated, "Prior to that we didn't have any extras because that is when they told me	( e Ne hott On Fii a ir v Fass s nii v v u fi de u ii tt V o Osa p F	(NA)-A indicated Relopement risk and NA-A indicated stafelopement risk and however "some aid communicating" and the nursing care gut On 12/15/21, at 9:4 not orientated and gR1 was identified a interventions that in and distractions. Righter interventions are in were just added to RN-B indicated, "Stand interventions a sheets, however, as sheets did not ident nor provide staff with indicated she was a was not working but when she was made updated maintenant found out R1's was didn't put anything it exit seeking to be hunsure what was in incidents on 12/8/2 the process is once WanderGuard is not can't answer what the Con 12/15/21, at 10: services director (Eaware of R1's WanderGuard is not can't answer what the Con 12/15/21, at 10: services director (Eaware of R1's WanderGuard is not can't answer what the Con 12/15/21, at 10: services director (Eaware of R1's WanderGuard is not can't answer what the Con 12/15/21, at 10: services director (Eaware of R1's WanderGuard is not can't answer what the Con 12/15/21, at 10: services director (Eaware of R1's WanderGuard is not can't answer what the Constant is the Constant in the Constant in the Constant is the Constant in the Constant in the Constant is the Constant in the Constant in the Constant in the Constant is the Constant in the	R1 was not identified as an and did not wear a WanderGuard. It aff are made aware of and interventions through report, aids are not good at and NAs are also able to look at guide sheets.  2:47 a.m. RN-B indicated R1is d getting worse. RN-B indicated as an elopement risk with a included 1-1, offer food, drink, RN-B indicated all of the in R1's care plan, however, they to the care plan on 12/14/21. Staff know by word of mouth are placed on the care guide as of 12/15/21, the care guide as of 12/15/21, the care guide and the interventions. RN-B saware that R1's WanderGuard but was unable to give a date ade aware. RN-B indicated she ance to order some when she as not working and stated, "I g in place because he wasn't be honest with you." RN-B was implemented following R1's //21, as well. When asked what are staff identify the not working, RN-B stated, "I at the process is."  10:15 a.m. environmental (ESD) indicated he was not anderGuard not functioning his two elopements on 12/8/21. Ited, "Prior to that we didn't have	21665			

Minnesota Department of Health

STATE FORM 6899 Y7F911 If continuation sheet 8 of 12

PRINTED: 06/28/2022 FORM APPROVED

Minnesota Department of Health

MILLIESC	ota Department of He	ailli				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
						:
		00448	B. WING		1	6/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THIEF R	IVER CARE CENTER		TWOOD DRI			
		THIEF RIV	/ER FALLS,	MN 56701		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
IAO		,	IAG	DEFICIENCY)		
04665	0	0	04665			
21665	5 Continued From page 8		21665			
	I should check to m	ake sure they don't run out."				
	In addition, ESD sta	ated, "She [RN-B] said one				
	was outdated and I	think that was [R1]'s."				
		48 a.m. director of nursing				
		anderGuards were being				
		vernight shift but after R1's				
		ged to be checked on days				
	and evenings due to "they were either not being done or not being communicated that they were no longer working." When asked what the					
	1 -	WanderGuards are identified				
		no extras are found, DON ate to the am staff so that they				
		e is nothing in place at this				
		h you." DON indicated staff				
		ment risk is by knowing who				
		d on and the licensed nursing				
		k in the care plans to identify				
		ons are in place. However,				
		's care plan was updated on				
	12/14/21, with elope	ement risk and interventions.				
	DON indicated on 1	2/8/21, R1 "eloped outside				
	looking for his glass	ses and he tried to stand and				
		re was no injury noted. DON				
		aware R1's WanderGuard was				
		ht, so DON directed staff to				
		until he went to bed." DON left				
		was not aware of the second				
		lowing morning on 12/9/21.				
		hat was put into place after				
		Once DON was aware of the 12/9/21, DON stated, "I asked				
		WanderGuard to replace it				
		re didn't have any so then they				
		en asked what was put into				
		WanderGuard arrived, DON				
		im more frequently" and to				
		at "every hour." DON indicated				
		d staff but, "I didn't document				

Minnesota Department of Health

STATE FORM 6899 Y7F911 If continuation sheet 9 of 12

PRINTED: 06/28/2022 FORM APPROVED

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00448	B. WING		12/1	6/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
THIEF R	IVER CARE CENTER		TWOOD DRI				
	OLIMANA DV. OTA		ER FALLS,			0.5	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21665	Continued From pa	ge 9	21665				
	it anywhere looking one-hour safety che she was not aware not working on 12/1 it was not working f  On 12/15/21, at 11: aware that there we available for R1 nor WanderGuard was addition, administratidentify a WanderG were expected to "WanderGuards avamaintenance. He has Further, administrativanderGuard's avawanderGuard's avawan	back I should have done a eck." Further, DON indicated that the WanderGuard was 1/21, and you can assume that rom 12/1/21 through 12/8/21.  14 a.m. administrator was not ere no WanderGuard's was she aware the not working on 12/1/21. In stor indicated when staff uard is not functioning they change it" and if there were no hilable "they should call as back ups in his office." tor indicated if there were no hilable in the building at that ed to do safety checks.					
	were to check on the Wanderguard funct WanderGuard is ide report it to the next find the new ones. I and let them know.' incident she knew he functioning and "I he probably weeks befexact date but I had RN-C stated, "The working and I don't know if it was reportimes I think I just go Review of facility por 10/23/17, indicated for risk of wandering resident is identified."	4 p.m. RN-C indicated staff the overnight shift for ioning. RN-C indicated if a centified as not working, "I will shift. I don't know where to I just report it to the next shift RN-C confirmed prior to R1's his WanderGuard was not ceard it wasn't working fore that. I can't tell you the d known it wasn't working." hight before he got out I was believe it was working. I don't ted. It was reported so many ave up on it."  plicy titled, Elopement revised all residents will be assessed g or elopement and if the d to be at risk for elopement e in place to prevent an					

Minnesota Department of Health

STATE FORM 6899 Y7F911 If continuation sheet 10 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00448	B. WING		12/1	; 6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THIEF R	IVER CARE CENTER		TWOOD DRI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	resident's care plan indicated nursing w (WanderGuard) daid damage to the brack lacked direction for bracelet is checked correctly and what implement to protect elopement.  The IJ which began 12/16/21, at 1:46 p. successfully implement included the following and the control of the control o	nurse will enter these into the a. Further review of policy ill test the notification bracelet ly for proper signaling and selet. However, the policy staff if the WanderGuard and is not functioning they are supposed to at the resident from an after the facility nented a removal plan which ng: equiring a WanderGuard were seed for functioning derGuard supply ng procedure to include the the resident's treatment ment policy statment policy to include steps anderGuard is not functioning to were to review both policies at shift; remained at the lower scope of D, which indicated no actual for more than minimal harm	21665			

Minnesota Department of Health

STATE FORM 6899 Y7F911 If continuation sheet 11 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
		00448	B. WING			C <b>16/2021</b>	
	PROVIDER OR SUPPLIER	2001 EAS	DRESS, CITY, S TWOOD DR /ER FALLS,		·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
21665	WanderGuards and appropriate interver WanderGuards are at risk. Results of the Quality Assurance F (QAPI) for determine compliance and the	d ensure all staff understand intions to implement if a not functioning for residents nose findings should go to the Performance Improvement nation of effectiveness, a need for further monitoring.  OR CORRECTION: 21 DAYS	21665				

6899

Minnesota Department of Health STATE FORM