DEPARTMENT OF HEALTH

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

DEPARTMENT OF HEALTH

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 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:

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

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 12/16/2021

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 12/14/21 through 12/16/21, 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: H5252063C (MN79174), with a deficiency cited at F689. The IJ began on 12/1/21 when R1's WanderGuard was tested and determined to not be functioning but was not replaced, nor was additional interventions put in to place to keep R1 safe until the WanderGuard could be replaced. Then on 12/8/21 R1 eloped out of the building and was found by a visitor/contractor lying in a snowbank unharmed. The facility failed to place immediate interventions to prevent a future elopement when it was again determined R1's WanderGuard was not functioning, which resulted in R1 eloping out of the building again an hour later (on 12/8/21), and was found by another visitor outside (on campus) unharmed. In addition, there were no immediate interventions placed after the second elopement. On 12/15/21, at 3:30 p.m. administrator, director of nursing (DON), and consultant were notified of the IJ. The IJ was removed on 12/16/21, at 1:46 p.m. but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. The above findings constituted substandard quality of care, and an extended survey was	F 000		

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

Electronically Signed | 12/29/2021

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F 000	Continued From page 1 conducted on 12/16/21. 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 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident identified as elopement risk had a functioning WanderGuard unit or other interventions were implemented to prevent elopements for 1 of 3 residents (R1) reviewed for elopements. This resulted in an immediate jeopardy (IJ) for R1. The IJ began on 12/1/21 when R1's WanderGuard was tested and determined to not be functioning but was not replaced, nor was	F 689	F689: Thief River Care Center will ensure all residents with wander guards, will have functioning wander guards daily to prevent future elopements. Update elopement policy to include what to do if the wander guard does not work. Educated staff of facility0020elopement risk policy, including policy updates. Educated staff on use of and initiating wander guard when the wander guard is not working. There are binders on both	1/19/22

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F 689	Continued From page 2 additional interventions put in to place to keep R1 safe until the WanderGuard could be replaced. Then on 12/8/21 R1 eloped out of the building and was found by a visitor/contractor lying in a snowbank unharmed. The facility failed to place immediate interventions to prevent a future elopement when it was again determined R1's WanderGuard was not functioning, which resulted in R1 eloping out of the building again an hour later (on 12/8/21), and was found by another visitor outside (on campus) unharmed. In addition, there were no immediate interventions placed after the second elopement. On 12/15/21, at 3:30 p.m. administrator, director of nursing (DON), and consultant were notified of the IJ. The IJ was removed on 12/16/21, at 1:46 p.m. but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Review of facility report number 345259 to the State Agency (SA) dated 12/8/21, indicated R1 "went outside wearing 2 tee-shirts and sweatpants. He subsequently fell on the ice as he tried to stand and into the snow bank. Staff was notified that the resident was outside in the snow bank by a pharmacy tech that was delivering medications to the facility." Review of the 5-day investigation to the SA dated 12/9/21, indicated "replaced wanderguard bracelet as his was not in working condition" as the action taken to prevent reoccurrence to resident. R1's annual Minimal Data Set (MDS) dated 10/21/21, indicated R1's diagnoses included Alzheimer's, dementia and had severe cognitive	F 689	ends of the building (both pods) on how to program and utilize the wander guard checker to ensure they are working daily. If there are no wander guard bracelets available, staff will initiate 30 minute checks until the resident can have the new wander guard placed. Facility has established a protocol to ensure back-up wander guards are available/reduced time in shipping in the facility. Educate staff checking the wander guard placement and working ability, they are to use the free text in the order administration that they are working or not. Educate staff on maltreatment policy and that if not following elopement policy and a resident elopes, that it is maltreatment and reportable to the state. Nurse Manager will be checking the daily wander guard bracelet functionality tests every 3 weeks and to keep them in a soft file for compliance checking. DON or designee will complete audits of functioning wander guards every day until 12/24/2021, three times a week for two weeks, two times a week for two weeks and once a week for two weeks to ensure compliance. Report findings to QA and update as needed. Will address in staff meeting and in the meeting minutes. Completion date of January 19th, 2022. Audit results will be brought to QAPI and update for review and further recommendations.	

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impairment. R1 required extensive assistance from one staff for activities of daily living, however, was able to utilize wheelchair independently for mobility. Further review of MDS, indicated R1 had delusions but did not exhibit any wandering behaviors.

R1's Elopement Risk Assessment dated 10/21/21, identified R1 as an elopement risk related to "decreased motivation and cognitive status, has attempted to leave in the past." However, assessment lacked information related 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

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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 something about a man in a wheelchair outside. The delivery man assisted with resident getting into the wheelchair and back into the facility. I did bring him down to his room so he could use the bathroom. He is sitting at the nursing station with me now. He has no bruises or scratches from falling sideways into snowbank." Further review of incident report, lacked evidence of immediate interventions placed 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 and helped him back in through the front doors." This incident report indicated staff reoriented R1, offered food and R1 went to his room.

Review of licensed nurses' 24-hour report sheet dated 12/1/21, indicated R1's "WG [WanderGuard] not working." In addition, review of the 24-hour report sheets lacked evidence of R1's WanderGuard being addressed.

On 12/14/21, at 1:50 p.m. R1 was observed to be sitting at the edge of his bed and a WanderGuard bracelet was on his left wrist. R1 stated he had just woken up from a nap and appeared to be

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mildly confused when responding to surveyors questions.

On 12/14/21, at 3:18 p.m. licensed practical nurse (LPN)-A indicated R1 was known to "get agitated and concerned about things and he won't forget about it." Further, LPN-A indicated prior to R1's two elopements on 12/8/21, R1 required a WanderGuard bracelet, however, "it hasn't been working for a week if not more. Everybody knew it wasn't working so we were watching him closely." In addition, LPN-A indicated R1 was noted to wander "nearly every day" and has attempted to exit the building in the past.

On 12/14/21, at 3:51 p.m. registered nurse (RN)-A indicated R1 had no short-term memory and will often get fixated on something and "there is only so much you can do." On 12/8/21, R1 was noted to be fixated on his glasses and would not eat the supper meal. R1 left the dining room and ended up outside in 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 indicated she re-orientated R1 and notified the DON. RN-A then noted R1 fixated on finding his car and wheeling past the nursing station in the hallway and called for a CNA to get R1. By the time the CNA reached R1, R1 was being brought back into the facility by a visitor. RN-A then indicated she re-orientated R1 once again and the staff got him ready for bed. RN-A indicated R1 had a WanderGuard on, however, after the first and second incident RN-A did not check the WanderGuard, but it did not sound the alarm for both incidents. RN-A stated, "I didn't put any extra monitoring in place. I just passed it on in the 24-hour report, so everyone knew what was going

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on with him [R1]."

On 12/15/21, at 8:16 a.m. LPN-B indicated R1 will "persistently ask where he should be or what he should be doing" and "we [staff] use a lot of reassurance but its very difficult to redirect and reorient due to poor short-term memory." Further, LPN-B indicated she checked R1's WanderGuard for functioning a week or week and a half ago and it was not functioning, "so I passed it through report, and I believe we didn't have it [new WanderGuard] in the building. I believe we ordered some."

On 12/15/21, at 8:43 a.m. nursing assistant (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 R1is 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, however, as of 12/15/21, the care guide 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

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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, as 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 not 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 they were out. I think it's a lack of communication. I should check to make sure they don't run out." In addition, ESD stated, "She [RN-B] said one was outdated and I think that was [R1]'s."

On 12/15/21, at 10:48 a.m. director of nursing (DON) indicated WanderGuards were being monitored on the overnight shift but after R1's incidents was changed 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 process is when the WanderGuards are identified as not working and no extras are found, DON stated, "communicate to the am staff so that they can get more. There is nothing in place at this time to be frank with you." DON indicated staff know who an elopement risk is by knowing who has a WanderGuard on and the licensed nursing staff are able to look in the care plans to identify and what interventions are in place. However, DON confirmed R1's care plan was updated on 12/14/21, with elopement risk and interventions. DON indicated on 12/8/21, R1 "eloped outside

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looking for his glasses and he tried to stand and fell on the ice." There was no injury noted. DON indicated she was aware R1's WanderGuard was not working that night, so DON directed staff to "keep eyes on him until he went to bed." DON left for the evening and was not aware of the second incident until the following morning on 12/9/21. DON was unsure what was put into place after the second incident. Once DON was aware of the second incident on 12/9/21, DON stated, "I asked [Maintenance] for a WanderGuard to replace it and we found out we didn't have any so then they were ordered." When asked what was put into place until the new WanderGuard arrived, DON stated, "check on him more frequently" and to know where R1 is at "every hour." DON indicated she verbally updated staff but, "I didn't document it anywhere looking back I should have done a one-hour safety check." Further, DON indicated she was not aware that the WanderGuard was not working on 12/1/21, and you can assume that it was not working from 12/1/21 through 12/8/21.

On 12/15/21, at 11:14 a.m. administrator was not aware that there were no WanderGuard's available for R1 nor was she aware the WanderGuard was not working on 12/1/21. In addition, administrator indicated when staff identify a WanderGuard is not functioning they were expected to "change it" and if there were no WanderGuards available "they should call maintenance. He has back ups in his office." Further, administrator indicated if there were no WanderGuard's available in the building at that point they would need to do safety checks.

On 12/15/21, at 1:14 p.m. RN-C indicated staff were to check on the overnight shift for Wanderguard functioning. RN-C indicated if a

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F 689	Continued From page 9	F 689		

WanderGuard is identified as not working, "I will report it to the next shift. I don't know where to find the new ones. I just report it to the next shift and let them know." RN-C confirmed prior to R1's incident she knew his WanderGuard was not functioning and "I heard it wasn't working probably weeks before that. I can't tell you the exact date but I had known it wasn't working." RN-C stated, "The night before he got out I was working and I don't believe it was working. I don't know if it was reported. It was reported so many times I think I just gave up on it."

Review of facility policy titled, Elopement revised 10/23/17, indicated all residents will be assessed for risk of wandering or elopement and if the resident is identified to be at risk for elopement interventions will be in place to prevent an elopement, and the nurse will enter these into the resident's care plan. Further review of policy indicated nursing will test the notification bracelet (WanderGuard) daily for proper signaling and damage to the bracelet. However, the policy lacked direction for staff if the WanderGuard bracelet is checked and is not functioning correctly and what they are supposed to implement to protect the resident from an elopement.

The IJ which began on 12/1/21, was removed on 12/16/21, at 1:46 p.m. after the facility successfully implemented a removal plan which included the following:
- All resident's requiring a WanderGuard were reviewed and checked for functioning
- Audits on WanderGuard supply
- Modified charting procedure to include the functional status in the resident's treatment record

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 12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10 - Updated elopement policy - Updated maltreatment policy to include steps to take when a WanderGuard is not functioning and - All staff/ nurses were to review both policies prior to working next shift; but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 689		

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: 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
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 12/16/2021

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 12/14/21 through 12/16/21, 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. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H5252063C (MN79174), with a licensing order issued at 1665. 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 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		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident identified as elopement risk had a functioning WanderGuard unit or other interventions were implemented to prevent elopements for 1 of 3 residents (R1) reviewed for elopements. This resulted in an immediate jeopardy (IJ) for R1. The IJ began on 12/1/21 when R1's WanderGuard was tested and determined to not be functioning but was not replaced, nor was additional intervention put in to place to keep R1 safe until the WanderGuard could be replaced. Then on 12/8/21 R1 eloped out of the building and was found by a visitor/contractor lying in a snowbank unharmed. The facility failed to place immediate interventions to prevent a future elopement when it was again determined R1's WanderGuard was not functioning, which resulted in R1 eloping out of the building again an hour later (on 12/8/21), and was found by another visitor outside (on campus) unharmed. In	21665	F689: Thief River Care Center will ensure all residents with wander guards, will have functioning wander guards daily to prevent future elopements. Update elopement policy to include what to do if the wander guard does not work. Educated staff of facility0020elopement risk policy, including policy updates. Educated staff on use of and initiating wander guard when the wander guard is not working. There are binders on both ends of the building (both pods) on how to program and utilize the wander guard checker to ensure they are working daily. If there are no wander guard bracelets available, staff will initiate 30 minute checks until the resident can have the new wander guard placed. Facility has established a protocol to ensure back-up wander guards are available/reduced time in shipping in the facility.	1/19/22

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21665	Continued From page 3 addition, there were no immediate interventions placed after the second elopement. On 12/15/21, at 3:30 p.m. administrator, director of nursing (DON), and consultant were notified of the IJ. The IJ was removed on 12/16/21, at 1:46 p.m. but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Review of facility report number 345259 to the State Agency (SA) dated 12/8/21, indicated R1 "went outside wearing 2 tee-shirts and sweatpants. He subsequently fell on the ice as he tried to stand and into the snow bank. Staff was notified that the resident was outside in the snow bank by a pharmacy tech that was delivering medications to the facility." Review of the 5-day investigation to the SA dated 12/9/21, indicated "replaced wanderguard bracelet as his was not in working condition" as the action taken to prevent reoccurrence to resident. R1's annual Minimal Data Set (MDS) dated 10/21/21, indicated R1's diagnoses included Alzheimer's, dementia and had severe cognitive impairment. R1 required extensive assistance from one staff for activities of daily living, however, was able to utilize wheelchair independently for mobility. Further review of MDS, indicated R1 had delusions but did not exhibit any wandering behaviors. R1's Elopement Risk Assessment dated 10/21/21, identified R1 as an elopement risk related to "decreased motivation and cognitive status, has attempted to leave in the past." However, assessment lacked information related	21665	Educate staff checking the wander guard placement and working ability, they are to use the free text in the order administration that they are working or not. Educate staff on maltreatment policy and that if not following elopement policy and a resident elopes, that it is maltreatment and reportable to the state. Nurse Manager will be checking the daily wander guard bracelet functionality tests every 3 weeks and to keep them in a soft file for compliance checking. DON or designee will complete audits of functioning wander guards every day until 12/24/2021, three times a week for two weeks, two times a week for two weeks and once a week for two weeks to ensure compliance. Report findings to QA and update as needed. If a lab/specimen is needed to be collected, it will be documented in the progress notes when the lab/specimen is collected, if it is not collected, it will be also documented in the progress notes. Education to staff members of lab/specimen stipulations. Will address in staff meeting and in the meeting minutes. Completion date of January 19th, 2022. Audit results will be brought to QAPI and update for review and further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21665	Continued From page 4 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 something about a man in a wheelchair outside. The delivery man assisted with resident getting	21665		

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21665	Continued From page 5	21665		

into the wheelchair and back into the facility. I did bring him down to his room so he could use the bathroom. He is sitting at the nursing station with me now. He has no bruises or scratches from falling sideways into snowbank." Further review of incident report, lacked evidence of immediate interventions placed 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 and helped him back in through the front doors." This incident report indicated staff reoriented R1, offered food and R1 went to his room.

Review of licensed nurses' 24-hour report sheet dated 12/1/21, indicated R1's "WG [WanderGuard] not working." In addition, review of the 24-hour report sheets lacked evidence of R1's WanderGuard being addressed.

On 12/14/21, at 1:50 p.m. R1 was observed to be sitting at the edge of his bed and a WanderGuard bracelet was on his left wrist. R1 stated he had just woken up from a nap and appeared to be mildly confused when responding to surveyors questions.

On 12/14/21, at 3:18 p.m. licensed practical nurse (LPN)-A indicated R1 was known to "get agitated and concerned about things and he won't forget about it." Further, LPN-A indicated prior to R1's two elopements on 12/8/21, R1 required a WanderGuard bracelet, however, "it hasn't been working for a week if not more. Everybody knew it wasn't working so we were watching him closely." In addition, LPN-A indicated R1 was noted to wander "nearly every day" and has attempted to exit the building in the past.

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

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21665	Continued From page 6 On 12/14/21, at 3:51 p.m. registered nurse (RN)-A indicated R1 had no short-term memory and will often get fixated on something and "there is only so much you can do." On 12/8/21, R1 was noted to be fixated on his glasses and would not eat the supper meal. R1 left the dining room and ended up outside in 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 indicated she re-orientated R1 and notified the DON. RN-A then noted R1 fixated on finding his car and wheeling past the nursing station in the hallway and called for a CNA to get R1. By the time the CNA reached R1, R1 was being brought back into the facility by a visitor. RN-A then indicated she re-orientated R1 once again and the staff got him ready for bed. RN-A indicated R1 had a WanderGuard on, however, after the first and second incident RN-A did not check the WanderGuard, but it did not sound the alarm for both incidents. RN-A stated, "I didn't put any extra monitoring in place. I just passed it on in the 24-hour report, so everyone knew what was going on with him [R1]." On 12/15/21, at 8:16 a.m. LPN-B indicated R1 will "persistently ask where he should be or what he should be doing" and "we [staff] use a lot of reassurance but its very difficult to redirect and reorient due to poor short-term memory." Further, LPN-B indicated she checked R1's WanderGuard for functioning a week or week and a half ago and it was not functioning, "so I passed it through report, and I believe we didn't have it [new WanderGuard] in the building. I believe we ordered some." On 12/15/21, at 8:43 a.m. nursing assistant	21665		

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(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 R1is 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, however, as of 12/15/21, the care guide 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, as 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 not 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 they were out. I think it's a lack of communication.

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I should check to make sure they don't run out." In addition, ESD stated, "She [RN-B] said one was outdated and I think that was [R1]'s."

On 12/15/21, at 10:48 a.m. director of nursing (DON) indicated WanderGuards were being monitored on the overnight shift but after R1's incidents was changed 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 process is when the WanderGuards are identified as not working and no extras are found, DON stated, "communicate to the am staff so that they can get more. There is nothing in place at this time to be frank with you." DON indicated staff know who an elopement risk is by knowing who has a WanderGuard on and the licensed nursing staff are able to look in the care plans to identify and what interventions are in place. However, DON confirmed R1's care plan was updated on 12/14/21, with elopement risk and interventions. DON indicated on 12/8/21, R1 "eloped outside looking for his glasses and he tried to stand and fell on the ice." There was no injury noted. DON indicated she was aware R1's WanderGuard was not working that night, so DON directed staff to "keep eyes on him until he went to bed." DON left for the evening and was not aware of the second incident until the following morning on 12/9/21. DON was unsure what was put into place after the second incident. Once DON was aware of the second incident on 12/9/21, DON stated, "I asked [Maintenance] for a WanderGuard to replace it and we found out we didn't have any so then they were ordered." When asked what was put into place until the new WanderGuard arrived, DON stated, "check on him more frequently" and to know where R1 is at "every hour." DON indicated she verbally updated staff but, "I didn't document

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it anywhere looking back I should have done a one-hour safety check." Further, DON indicated she was not aware that the WanderGuard was not working on 12/1/21, and you can assume that it was not working from 12/1/21 through 12/8/21.

On 12/15/21, at 11:14 a.m. administrator was not aware that there were no WanderGuard's available for R1 nor was she aware the WanderGuard was not working on 12/1/21. In addition, administrator indicated when staff identify a WanderGuard is not functioning they were expected to "change it" and if there were no WanderGuards available "they should call maintenance. He has back ups in his office." Further, administrator indicated if there were no WanderGuard's available in the building at that point they would need to do safety checks.

On 12/15/21, at 1:14 p.m. RN-C indicated staff were to check on the overnight shift for Wanderguard functioning. RN-C indicated if a WanderGuard is identified as not working, "I will report it to the next shift. I don't know where to find the new ones. I just report it to the next shift and let them know." RN-C confirmed prior to R1's incident she knew his WanderGuard was not functioning and "I heard it wasn't working probably weeks before that. I can't tell you the exact date but I had known it wasn't working." RN-C stated, "The night before he got out I was working and I don't believe it was working. I don't know if it was reported. It was reported so many times I think I just gave up on it."

Review of facility policy titled, Elopement revised 10/23/17, indicated all residents will be assessed for risk of wandering or elopement and if the resident is identified to be at risk for elopement interventions will be in place to prevent an

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elopement, and the nurse will enter these into the resident's care plan. Further review of policy indicated nursing will test the notification bracelet (WanderGuard) daily for proper signaling and damage to the bracelet. However, the policy lacked direction for staff if the WanderGuard bracelet is checked and is not functioning correctly and what they are supposed to implement to protect the resident from an elopement.

The IJ which began on 12/1/21, was removed on 12/16/21, at 1:46 p.m. after the facility successfully implemented a removal plan which included the following:
- All resident's requiring a WanderGuard were reviewed and checked for functioning
- Audits on WanderGuard supply
- Modified charting procedure to include the functional status in the resident's treatment record
- Updated elopement policy
- Updated maltreatment policy to include steps to take when a WanderGuard is not functioning and
- All staff/ nurses were to review both policies prior to working next shift;

but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.

SUGGESTED METHOD OF CORRECTION: The DON or designee could ensure staff are educated on policies and procedures to keep residents safe. The DON or designee could identify and audit all residents at risk for elopement, ensure WanderGuards are in good working order, ensure back up WanderGuards are accessible to all nursing staff responsible to test and replace

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21665	Continued From page 11 WanderGuards and ensure all staff understand appropriate interventions to implement if WanderGuards are not functioning for residents at risk. Results of those findings should go to the Quality Assurance Performance Improvement (QAPI) for determination of effectiveness, compliance and the need for further monitoring. TIME ALLOWED FOR CORRECTION: 21 DAYS	21665		