Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 13, 2023

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

RE: CCN: 245252
Cycle Start Date: August 30, 2023

Dear Administrator:

On August 30, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 30, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 1, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING ______ B. WING ______	C 08/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/29/23 through 8/30/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H52524828C (MN96249) H52525014C (MN94827) H52524975C (MN93522) with a deficiency issued at F690. As a result of the investigation deficiencies were also issued at F684 and F689. 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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		10/23/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/25/2023

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

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F 684	Continued From page 1 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely repositioning and failed to monitor non pressure related skin concerns for 1 of 3 residents (R5) reviewed for repositioning. Findings include: R5's significant change Minimum Data Set (MDS) dated 8/10/23, identified severe cognitive impairment and indicated she required extensive assistance from two staff for transfers and toileting. The MDS indicated R5 was frequently incontinent of bowel and bladder and was at risk for pressure ulcers. R5's care plan dated 4/18/23, indicated R5 was frequently incontinent of bowel and bladder and was at risk for skin breakdown. The care plan directed staff to check and change "per pad protocol." The care plan did not identify a schedule for repositioning. During observation on 5/29/23, at 1:35 p.m. R5 was seated in a reclining chair in the common area of the unit where she remained until 4:17 p.m. when staff transferred her from the recliner to her wheel chair. At 4:22 p.m. R5 had a visitor talking to her in the common area. At 4:30 p.m. staff escorted R5 to the dining room. R5 was escorted from the dining room back to the unit at 5:33 p.m. At 5:44 p.m. R5 was observed trying to climb out of her wheel chair.	F 684	F684 Quality of Care: Non-pressure related skin injury The resident has the right to be free from skin breakdown or skin injury related to repositioning or moisture related injury. TRCC failed to observe, prevent, and document skin injury, reposition times, or toileting schedule. R5 has skin issue due to lack of assessments and no monitoring was set up. To prevent this R5 will have documentation of skin assessment weekly, interventions in place to prevent skin breakdown; including repositioning and toileting schedules. To prevent this from happening to all residents; nursing staff will do skin inspection & assessment and documentation on all residents who are at high risk for skin breakdown. Nursing staff will complete documentation for skin breakdown intervention- such as dressings, orders, repositioning or additional prevention devices. RN managers will update Care Plans with reposition schedule for residents at risk of skin breakdown. Care Plans update with toileting schedule for each resident, Care Plans updated with need for skin breakdown prevention/intervention for residents at risk. TRCC is contracted with Restorix Health for skin and wound management. Training on appropriate incontinence wear, skin	

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F 684 Continued From page 2

At 5:40 p.m. nursing assistant (NA)-A stated the toileting plans were listed on the care sheets. NA-A said if a toileting plan was not identified on the care sheet the the resident was not on a toileting schedule and they would just ring when they needed to go. NA-A confirmed the care sheet did not include a toileting schedule for R5.

At 5:41 p.m. NA-B stated staff randomly took R5 to the toilet and said she did not know when R5 was last toileted or repositioned.

At 5:55 p.m. NA-A and NA-B assisted R5 to her room. NA-A stated R5 had not been toileted or repositioned during the p.m. shift and said the first shift usually changed her prior to leaving. R5's incontinent brief was saturated with urine and R5's bottom was noted to be red with some excoriation. R5 had a foam dressing on her left hip. NA-B stated R5 had a sore on her hip from laying on it.

During interview on 8/30/23, at 7:56 a.m. registered nurse (RN)-A, nurse manager stated R5 was a "check and change" and required assistance from two staff. RN-A stated R5's toileting and repositioning schedule was not identified on the care plan and said she should be toileted every three hours or if she got "antsy." RN-A said R5 was not able to tell staff when she needed to use the bathroom. RN-A stated R5 had some moisture associated skin damage (MASD) but said it had improved. RN-A stated she did not know why R5 had a bandage on her hip.

During observation on 8/30/23, at 9:00 a.m. RN-A assessed R5's skin and said it was red and had MASD. RN-A said the NA's told her one of the nurses had put the bandage on R5's hip but did

F 684

assessment and wound care will commence on week of Sept 18th with TENA and Restorix Health Inservice.
Review of skin assessment policy, and documentation of skin condition including any new skin breakdown TRCC will conduct weekly audits of skin assessment completed by nursing. All staff will be re-educated on skin assessment or a skin inspection as designated by scope of practice. The findings on the weekly assessments will also be part of the education to be held on the week of 9/11/23.
NARs received EMR Care Stream (electronic care sheet) training at meetings the week of 9/11/23.
The DON or designee will monitor if interventions are being followed and that no additional skin breakdown is being overlooked or not documented on. Audits of the weekly skin assessment will take place as follows:
2 random residents (1 from each unit) weekly for 3 months
2 random residents (1 from each unit) monthly for 6 months
Results will be taken to qtrly QAPI meetings for review for possible QI project
Completion date 10/2/23

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F 684	Continued From page 3 not know who. RN-A removed the bandage and identified a reddened area approximately 2.5 centimeters (cm) x 1.5 cm with a dark spot in the center. RN-A stated it was possibly a previous open area. At 9:09 a.m. RN-A stated she usually completed skin assessments weekly and documented in the progress notes. RN-A stated R5 received her baths on the weekends and staff should be documenting on bath day as well. RN-A stated the skin concerns and the dressing should have been documented and staff should have reported it to her. RN-A acknowledged there was no documentation related to R5's bottom or the dressing on her hip. At 9:43 a.m. the director of nursing (DON) stated skin assessments were done on bath days and said if the NA's saw a concern they would let the nurse know. The DON stated the nurses should be looking at residents skin but said if there were no issues they had a tendency to not document. A policy was requested but not received.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		10/23/23

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F 689	Continued From page 4 Based on observation, interview and document review the facility failed to ensure appropriate sling size for 1 of 2 residents (R5) reviewed who used a mechanical lift for transfers. Findings include: R5's significant change Minimum Data Set (MDS) dated 8/10/23, identified severe cognitive impairment and indicated she required extensive assistance from two staff for transfers and toileting. R5's care plan dated 4/18/23, indicated she required assistance from two staff using a mechanical lift for transfers. The care plan did not identify which type or size sling should be used. During observation on 8/29/23, at 5:50 p.m. nursing assistants (NA)-A and NA-B assisted R5 to the toilet using the mechanical lift and a split leg sling. R5's bottom was hanging down far out of the bottom of the sling. NA-B stated the slings were universal and said the residents did not have their own. The mechanical lift used during the transfer had a key to determine which size sling to use based on height and weight of the resident. At 6:15 p.m. when asked about the sling, NA-B said she had brought to another residents room because she also used the mechanical lift. The sling was observed to be a size extra large. During interview on 8/30/23, at 7:56 a.m. registered nurse (RN)-A stated R5 weighed 120 pounds. RN-A stated the staff should be using the color coded chart on the mechanical lift to determine which sling size was appropriate. At 8:21 a.m. RN-A stated she had reviewed the chart and said staff should have been using a small sling for R5.	F 689	F 689 Free of Accident Hazards/Devices/Supervision Personal fit and device condition. Residents at TRCC have the right to have appropriate sized slings for lifts. TRCC failed to provide a resident with an appropriate sized slings to use with hoyer lift. Staff did not know what sized sling was appropriate to use for each resident and when slings required to be washed, additional slings of appropriate size were not available. R5 was not placed in an appropriate sized sling during toileting care. NARs could not verbalize how to determine the sling size. To prevent this from happening to R5, sling size was determined based on weight and new slings of appropriate size were ordered and added to the care plan. To prevent this from happening to any resident at TRCC, chart for weight based sling size was placed in storage area with extra slings. Staff education on the sling size selection process was conducted. Sling size will be added to Care Plans of residents utilizing hoyer or PALs slings. The DON or designee will monitor sling size documentation in the care plan with audits of the care plan as follows: 2 random residents (1 from each unit) weekly for 3 months 2 random residents (1 from each unit) monthly for 6 months Results will be taken to qtrly QAPI meetings for review for possible QI project Audit of NAR utilization of the Care Stream (electronic care sheet) to check for knowledge of toileting & reposition schedules, transfer and sling size	

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F 689	Continued From page 5 On 8/30/23, at 9:07 a.m. NA-C was asked how she knew which size slings to use. NA-C stated sling sizes were care planned and said typically the residents had slings in their rooms too. NA-C stated she could not remember what sling size was appropriate other than looking at care plans or asking other people. During interview on 8/30/23, at 9:43 a.m. the director of nursing (DON) stated the sling size was determined using the weight recommendation of the lift company. The DON stated the sling size should be on the care plan but said it did not always make it there. The DON said each residents had their own slings for transfers but said the bath slings were "community" and got washed between uses. A policy was requested but not received.	F 689	knowledge. The audits as follows: 2 random NARs (1 from each unit) weekly for 3 months 2 random NARs (1 from each unit) monthly for 6 months Completion date 10/2/23	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 690		10/23/23

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F 690	Continued From page 6 catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely toileting for 1 of 3 residents (R5) reviewed for toileting. Findings include: R5's significant change Minimum Data Set (MDS) dated 8/10/23, identified severe cognitive impairment and indicated she required extensive assitance from two staff for transfers and toileting. The MDS indicated R5 was frequently incontinent of bowel and bladder. R5's Admission/General Observation Assessment dated 8/10/23, indicated R5 was frequently incontinent of bowel and bladder and required assistance from two staff every 2-3 hours. The assessment indicated R5 was not always able to	F 690	F- 690 Bowel/Bladder Incontinence The resident has the right to care for incontinence or a toileting plan. TRCC failed to provide a personalized toileting schedule in the care plan or accessible knowledge to the NARs. R5 has ongoing incontinence and did not have a personalized toileting plan. To prevent this R5 will have a check and change incontinence plan documented in the care plan and care stream (electronic care sheets) for the NARs to access. To prevent this from happening to all residents; toileting schedules will be added to the care plans and the care stream (electronic care sheet) for the NARs to access. Toileting plans will be reviewed with each MDS assessment.	

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F 690	Continued From page 7 verbalize the need to use the toilet and required staff to prompt her. R5's care plan dated 4/18/23, indicated R5 was frequently incontinent of bowel and bladder and directed staff to check and change "per pad protocol." During observation on 5/29/23, at 1:35 p.m. R5 was seated in a reclining chair in the common area of the unit where she remained until 4:17 p.m. when staff transferred her from the recliner to her wheel chair. At 4:22 p.m. R5 had a visitor talking to her in the common area. At 4:30 p.m. staff escorted R5 to the dining room. R5 was escorted from the dining room back to the unit at 5:33 p.m. At 5:44 p.m. R5 was observed trying to climb out of her wheel chair. At 5:40 p.m. nursing assistant (NA)-A stated the toileting plans were listed on the care sheets. NA-A said if a toileting plan was not identified on the care sheet the the resident was not on a toileting schedule and they would just ring when they needed to go. NA-A confirmed the care sheet did not include a toileting schedule for R5. At 5:41 p.m. NA-B stated staff randomly took R5 to the toilet and said she did not know when R5 was last toileted. At 5:55 p.m. NA-A and NA-B assisted R5 to her room to use the toilet. NA-A stated R5 had not been toileted during the p.m. shift and said the first shift usually changed her prior to leaving. R5's incontinent brief was saturated with urine. During interview on 8/30/23, at 7:56 a.m. registered nurse (RN)-A, nurse manager stated	F 690	The DON or designee will monitor sling size documentation in the care plan with audits of the care plan as follows: 2 random residents (1 from each unit) weekly for 3 months 2 random residents (1 from each unit) monthly for 6 months Results will be taken to qtrly QAPI meetings for review for possible QI project Audit of NAR utilization of the Care Stream (electronic care sheet) to check for knowledge of toileting & reposition schedules, transfer and sling size knowledge. The audits as follows: 2 random NARs (1 from each unit) weekly for 3 months 2 random NARs (1 from each unit) monthly for 6 months Completion date 10/2/23	

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F 690	Continued From page 8 R5 was a "check and change" and required assistance from two staff. RN-A stated R5's toileting schedule was not identified on the care plan and said she should be toileted every three hours or if she got "antsy." RN-A said R5 was not able to tell staff when she needed to use the bathroom. At 9:43 a.m. the director of nursing (DON) stated toileting plans were usually implemented on admission. The DON stated the facility standard was to check everyone every three hours. She stated the nurse manager should be doing an assessment quarterly to determine frequency. The DON stated if toileting was needed more frequently than every three hours it would be in the care plan. A policy was requested but not received.	F 690		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 13, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: HSWZ11

Dear Administrator:

The above facility was surveyed on August 29, 2023 through August 30, 2023 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 feel free to call me with any questions.

Sincerely,

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

Minnesota Department of Health

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 08/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments	2 000		

*****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 8/29/23 through 8/30/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H52524828C (MN96249) H52525014C (MN94827) H52524975C (MN93522), with a licensing order issued at 0830. 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	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely toileting for 1 of 3 residents (R5) reviewed for toileting. Findings include: R5's significant change Minimum Data Set (MDS) dated 8/10/23, identified severe cognitive impairment and indicated she required extensive assitance from two staff for transfers and toileting. The MDS indicated R5 was frequently	2 830	Plan of correction completed	9/25/23

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2 830		2 830		

Continued From page 3

incontinent of bowel and bladder.

R5's Admission/General Observation Assessment dated 8/10/23, indicated R5 was frequently incontinent of bowel and bladder and required assistance from two staff every 2-3 hours. The assessment indicated R5 was not always able to verbalize the need to use the toilet and required staff to prompt her.

R5's care plan dated 4/18/23, indicated R5 was frequently incontinent of bowel and bladder and directed staff to check and change "per pad protocol."

During observation on 5/29/23, at 1:35 p.m. R5 was seated in a reclining chair in the common area of the unit where she remained until 4:17 p.m. when staff transferred her from the recliner to her wheel chair. At 4:22 p.m. R5 had a visitor talking to her in the common area. At 4:30 p.m. staff escorted R5 to the dining room. R5 was escorted from the dining room back to the unit at 5:33 p.m. At 5:44 p.m. R5 was observed trying to climb out of her wheel chair.

At 5:40 p.m. nursing assistant (NA)-A stated the toileting plans were listed on the care sheets. NA-A said if a toileting plan was not identified on the care sheet the the resident was not on a toileting schedule and they would just ring when they needed to go. NA-A confirmed the care sheet did not include a toileting schedule for R5.

At 5:41 p.m. NA-B stated staff randomly took R5 to the toilet and said she did not know when R5 was last toileted.

At 5:55 p.m. NA-A and NA-B assisted R5 to her room to use the toilet. NA-A stated R5 had not

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2 830	Continued From page 4	2 830		

been toileted during the p.m. shift and said the first shift usually changed her prior to leaving. R5's incontinent brief was saturated with urine.

During interview on 8/30/23, at 7:56 a.m. registered nurse (RN)-A, nurse manager stated R5 was a "check and change" and required assistance from two staff. RN-A stated R5's toileting schedule was not identified on the care plan and said she should be toileted every three hours or if she got "antsy." RN-A said R5 was not able to tell staff when she needed to use the bathroom.

At 9:43 a.m. the director of nursing (DON) stated toileting plans were usually implemented on admission. The DON stated the facility standard was to check everyone every three hours. She stated the nurse manager should be doing an assessment quarterly to determine frequency. The DON stated if toileting was needed more frequently than every three hours it would be in the care plan.

A policy was requested but not received.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, should review all residents at risk for skin breakdown and residents who require assistance for toileting to assure they are receiving the necessary treatment/services. The director of nursing or designee could conduct audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented. The DON or designee could bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the

Minnesota Department of Health

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2 830	Continued From page 5 need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		