Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 11, 2023

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

RE: CCN: 245252
Cycle Start Date: December 28, 2022

Dear Administrator:

On December 28, 2022, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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 March 28, 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 June 28, 2023 (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 Fax: (651) 215-9697
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 12/28/2022

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

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F 000	INITIAL COMMENTS On 12/27/22-12/28/22, 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: H52527038C (MN84889), with no deficiency cited due to actions taken by the facility prior to the survey. H52527037C (MN84962), with deficiencies cited at F600, F610. H52526601C (MN89160), with deficiencies cited at F600, F610. 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 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from	F 600		2/1/23

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

Electronically Signed | 01/19/2023

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 600	Continued From page 1 corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement interventions to reduce the risk for abuse for 4 of 7 residents (R1, R2, R6, and R7) reviewed for abuse and who were identified at risk for abuse in the facility. Findings include: R1's significant change Minimum Data Set (MDS) dated 9/30/22, identified severe cognitive impairment and indicated R1 displayed no behaviors during the assessment period. R1's MDS indicated he required limited assistance for locomotion on and off the unit. R1's care plan dated 12/28/22, indicated physical aggression toward others, and directed staff to maintain a consistent routine. R2's quarterly MDS indicated she was severely cognitively impaired and displayed wandering behaviors. The MDS indicated R2 required supervision with locomotion. R2's care plan dated 12/6/22, identified a risk for injury due to wandering, and not liking women near her husband on the other wing. The care plan directed staff to perform hourly safety checks while awake, and to keep the doors to the east	F 600	F600 Free From Abuse and Neglect The resident has the right to be free from abuse. TRCC failed to keep R1 & R2 free from physical abuse and free from verbal abuse. TRCC staff were to provide redirection and keep R1 & R2 on their side of the building and that didn't happen. R3 & R4 are no longer at the facility. To ensure that residents were not abused again, TRCC monitored R1 & R2 whereabouts and train staff to look for opportunities for redirection. TRCC staff will monitor and document R1 & R2 for triggers around behaviors. Recognition of intervention prior to behaviors will be communicated to all staff. – Failed to implement interventions to reduce the risk for abuse 1. All residents identified in the survey will have behavior assessments completed and that will include identifying risks, triggers, and interventions. 2. Any other resident with any known agitation or evidence in the medical record over the last quarter will be assessed to determine if they have the potential to be aggressors toward other residents. If any other residents are	

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F 600	Continued From page 2 wing closed after supper. R6's quarterly MDS dated 10/13/22, identified intact cognition, no behaviors, and R6 required extensive assistance from staff for locomotion. R6's care plan dated 12/12/22, identified behaviors that included crying out, and directed staff to provide scheduled medications. R7's quarterly MDS dated 10/18/22, identified severe cognitive impairment and indicated she displayed no behaviors. R7's MDS indicated she required supervision for locomotion on the unit. R7's care plan dated 12/29/22, indicated she was vulnerable due to cognitive status. A report to the State Agency (SA) dated 7/8/22, indicated R1 was upset about something unknown and swung at R3 and hit him in the right temporal area. No injuries were sustained. A facility investigation submitted 7/11/22, indicated R1 was agitated during supper and was trying to get to another resident (R7) stating, "You better listen to me." Staff separated the residents. Later, R1 grabbed yet another residents arm twice (did not hurt her, just scared her). R1 then said to R3 "I own this place and you're out of here." then punched R3 in the right temporal area. A report to the SA dated 12/6/22, indicated R4 was rolling by when R2 grabbed R4's wheelchair, shaking it, and started yelling at her, cursing and calling her names. R1 told R2 her to leave R4 alone and was trying to pull R4 away from R2. R2 turned toward R1 yelling and cursing at him, and hit out with both hands waving in the air, not connecting but slapping and waving her hands at R1. R1 retaliated and hit R2 one the side of the face loosely with a closed fist. R2 was checked	F 600	identified they will be assessed to ensure that risks, triggers and interventions are identified and care planned. 3. All nursing staff will be educated on the following policies, “Nursing Assessment” , “Care Planning” , “Maltreatment Prohibition” policy which describes what information needs to be included in a the care plan, behavior assessment, including triggers, risks and interventions. All nursing staff will be educated on the assessment findings including risks, triggers and interventions. Resident triggers and interventions will be clearly communicated with all staff and updated daily or as often as needed and printed on the nursing assistants care guide. 4. DON or designee will complete two random documentation audits from residents who have behavior assessments active to ensure care plans, assessment, triggers, risks and interventions are documented. Following the documentation audit, two random observation audits to verify the interventions are being followed in real time. Audits will be completed for 6 weeks. Audits will resume for an additional 6 weeks at intervals of one of each audit (instead of two). Findings will be brought forward to the QAPI Committee for further recommendations and monitoring. 5. Completion Date: 2/1/2023	

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F 600	Continued From page 3 just prior to sending this report and there were no marks or redness on her left cheek. The facility investigation submitted to the SA on 12/9/22, indicated at the time of the incident R4 was wheeling by R2's husbands room on the east unit of the facility, and R2 got upset with staff when they assisted her husband with cares. The report indicated housekeeping (HK) staff and a nursing assistant (NA) were in the hallway when R2 grabbed R4's wheel chair and began screaming at her. R1 told R2 to let R4 go and R2 came at R1 with her arms and hands flapping, swearing and screaming at him at the top of her lungs. The report further indicated R1 put his hands up to defend himself and R2 bumped into his hand as she was going toward him. The report indicated when R2 was out of her room, staff were to keep the doors to her wing closed as she would propel herself around the building. Further, staff were to bring R2's husband to the west side to visit and discourage R2 from going to the east wing. On 12/27/22, at 3:32 p.m. R2 was observed propelling herself independently from her unit on the west wing of the facility, toward the common area between the east and west wings. At 3:30 p.m. R2 continued toward the east wing where her husband resided. At 3:45 p.m. R2 was observed at the entrance to the east wing. Staff walked by and said hello to R2 but did not re-direct her back to her unit. At 3:54 p.m. R2 was propelling herself further into the east wing. Staff present made no attempts to re-direct her. At 3:57 p.m. R2 was at the medication cart asking the nurse for something then propelled herself to a table in the common area of the unit talking to no one in particular about cookies and stated "I'm so g** d*** mad." R7 and surveyor were both seated around the table. Two staff walked by and	F 600		

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F 600	Continued From page 4 said nothing nor made an attempt to re-direct R2 back to her wing. At 3:59 p.m. R1 was also at the table. At 4:02 p.m. a staff member walked over and assisted R2 back to her wing. At the same time, R1 and R7 left the table and were observed self-propelling toward the exit of the unit where they both continued to wander around until approximately 4:30 p.m. when staff began assisting residents to the dining room. On 12/28/22, at 9:43 a.m. R2 was observed propelling herself down the hall toward the exit of the west wing. At 10:00 a.m. R2 was observed in her husbands room on the east wing. On 12/28/22, at 7:54 a.m. NA-A stated for the most part R2 was usually in a good mood but said it "goes back and forth." NA-A stated when R2 was in the common area of the unit she displayed behaviors and would yell at people. NA-A said there was a lady on the east wing, R4, that R2 thought was her granddaughter, and R2 would get really mad and frustrated and anxious if R4 left the west unit because she was worried about her. NA-A described R2's behaviors as mostly swearing and yelling, but said she would hold onto R4's wheel chair. NA-A stated she was not aware of R2 being physical, but had heard about the incident in which R1 had hit R2 or slapped her on the face. NA-A stated they tried to keep the two residents on their own sides of the facility. On 12/28/22, at 8:46 a.m. NA-B stated R1 did not have many behaviors, and he was pretty friendly and outgoing. NA-B stated sometimes R1 would get upset when he thought something needed to be fixed and he would want to fix it. NA-B stated R1 looked out for other residents, and she was	F 600		

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F 600	Continued From page 5 not aware of any instance of R1 hitting another resident. On 12/28/22, at 8:48 a.m. NA-C stated she was working when R1 had struck another resident (R3) who was no longer at the facility. NA-A stated the incident occurred in the dining room and said R1 was "mad about something....Him and [R7] don't really get along." NA-C stated R1 started "targeting other residents, like going after them, trying to push them. These women were all scared of him." NA-C said she was standing right there when R1 hit R3, and said that was the only time she had seen him with behaviors like that other than when he was around R7. NA-C stated she used to "see fire in his eyes" when he would see R7 and he said things like, "You need to stay out of my room" and "She doesn't know what the hell she is doing." NA-C stated she was not aware of any other incidents other than the one with R3. NA-C stated staff tried to keep R1 and R7 away from each other, and they tried to keep R7 out of his bed because when R7 was tired she would lay in other residents beds. On 12/28/22, at 8:58 a.m. licensed practical nurse (LPN)-A stated R1's behaviors depended on the day, and if he felt like someone was going to be harmed he was going to try to help them out. LPN-A stated R1 had a couple of incidents. LPN-A stated recently they had a resident (R4) in the facility whom R1 felt protective of, and R2 felt the same way toward her. LPN-A stated R2 had come to the east wing and was trying to stop R4 by pulling on her wheel chair handle, and R1 went over to R2 and "clocked" her. LPN-A stated prior to that she had seen some verbal aggression from R1 but nothing physical. LPN-A stated following the incident staff tried to separate the	F 600		

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F 600	Continued From page 6 residents. On 12/28/22, at 9:07 a.m. registered nurse (RN)-A stated there were some people R1 had no tolerance for, and one of them would be R7 with the wandering. RN-A stated if R7 went into R1's room he got pretty upset so they tried to keep and eye on her. RN-A stated R1 also had issues with R2, and he referred to R2 as "that red haired b****." RN-A stated she had seen it a few times, "It sounds like they have quite a history." RN-A stated staff tried to keep them as far apart as possible, and after the recent incident staff make sure R2 stayed on her wing and R1 stayed on his wing. On 12/28/22, at 9:55 a.m. LPN-B stated R2 would get a little forceful with R4 and would grab her wheel chair. LPN-B said R2 liked to "mother her [R4]." LPN-B stated she was not aware of any incidents with other residents, but she had heard about the incident where R1 had hit R2. LPN-B stated staff tried to keep R2 on the west wing but the problem was that R2 would wheel herself. LPN-B verified R2 was currently on the other wing. On 12/28/22, at 10:08 a.m. HK-A stated she was present when the incident with R1 and R2 occurred. HK-A stated the incident happened by the nurses station on the east wing and no staff were present in the area. HK-A stated herself and another HK staff came in in the middle of the incident. HK-A stated R2 was being mean to R4 and R1 and another resident were trying to protect her. HK-A said R2 said something to R1 and he "smacked" her. On 12/28/22, at 12:20 p.m. RN-B, the DON and	F 600		

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F 600	Continued From page 7 the administrator were interviewed. RN-B stated she had completed the investigation for the incident with R1 and R2. RN-B stated from what she understood, there were no other residents present during the incident. RN-B stated R2 grabbed R4's chair and R1 saw it and was trying to intervene on R4's behalf. RN-B said R2 was flailing her arms and R1 put his hands up. RN-B stated no one could really say R1 had hit R2 and said "someone" said R1 was holding his arms up and R2 made contact. When asked who the "someone" was, and what other staff interviews were completed, RN-B said when she talked to staff she only asked a few questions. The administrator stated they had determined R2 needed to stay on her wing and have staff bring her husband to her wing to visit with her, and re-direct her if she headed to the east wing. The administrator stated staff were also supposed to close the doors to the wing around 3:00 p.m. The administrator stated the interventions had not been clearly communicated to staff in this case. The DON stated the care plan did not have any interventions specific to the incidents. Facility policy Maltreatment Prohibition dated 10/18/21, directed St. Francis Health Services of Morris, Inc. (SFHS) has established safeguards to prohibit Maltreatment (Abuse, Neglect and Financial Exploitation) of any Vulnerable Adult in SFHS' care center. These safeguards will adhere to the Federal and State requirements, whichever is most stringent. Facility policy Protecting Victims of Maltreatment dated 10/3/16, directed once an incident is reported, our care center needs to take immediate action to protect the vulnerable adult from further abuse.	F 600		

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F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate allegations of resident to resident abuse for 4 of 7 residents (R1, R2, R3, and R6) reviewed for alleged abuse. Findings include: R1's significant change Minimum Data Set (MDS) dated 9/30/22, identified severe cognitive impairment and indicated he displayed no behaviors during the assessment period. R1's MDS indicated he required limited assistance for locomotion on and off the unit. R2's quarterly MDS indicated she was severely cognitively impaired and displayed wandering behaviors. The MDS indicated R2 required	F 610	1. The residents identified in the 2567 will have a behavior assessment completed, including risks, triggers and interventions. 2. Any other resident with any known agitation or evidence in the medical record over the last quarter will be assessed to determine if they have the potential to be aggressors toward other residents. If any other residents are identified they will be assessed to ensure that risks, triggers and interventions are identified and care planned 3. .The care center will investigate all incidents and allegations of maltreatment	2/1/23

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 12/28/2022

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

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F 610	Continued From page 9 supervision with locomotion. R3's discharge MDS dated 7/27/22, identified severe cognitive impairment, no behaviors and indicated he required limited assistance for locomotion. R6's quarterly MDS dated 10/13/22, identified intact cognition, no behaviors and indicated she required extensive assistance from staff for locomotion. A report to the State Agency (SA) dated 7/8/22, indicated R1 was upset about something unknown and swung at R3 and hit him in the right temporal area. No injuries were sustained. A facility investigation submitted 7/11/22, indicated R1 was agitated during supper, and was trying to get to another resident stating, "You better listen to me." Staff separated the residents. Later, R1 grabbed yet another residents arm twice (did not hurt her, just scared her). R1 then said to R3, "I own this place and you're out of here," then punched R3 in the right temporal area. The investigations lacked evidence of interviews with staff or other residents involved. A report to the SA dated 12/6/22, indicated R4 was rolling by R2 when R2 grabbed R4's wheelchair, shaking it, and started yelling at her, cursing and calling her names. R1 told R2 her to leave R4 alone, and was trying to pull R4 away from R2. R2 turned toward R1 yelling, cursing at him, and hit out with both hands waving in the air, not connecting but slapping and waving her hands at R1. R1 retaliated and hit R2 one the side of the face loosely with a closed fist. R2 was checked just prior to sending this report and there were no marks or redness on her left cheek. The	F 610	to determine the cause, (if able), and to determine if the incident needs to be reported to the appropriate authorities or if interventions need to change. 4. All nursing staff will receive training on the facility Maltreatment Prohibition policy and the investigating component of the abuse policies. The social worker will be trained on resident interviews to support the investigation component. The DON/Administrator or designee will audit any new incident of alleged abuse, to ensure the investigation component is completed thoroughly and documented. Audits will be completed for any resident incident or allegation of abuse towards other residents for at least 3 months. Auditing findings will be presented to the QAPI Committee. Based on the findings, QAPI will make recommendations for future auditing and monitoring needs.	

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F 610	Continued From page 10 facility investigation submitted to the SA on 12/9/22, indicated at the time of the incident R4 was wheeling by R2's husbands room on the east unit of the facility, and indicated R2 got upset with staff when they assisted her husband with cares. The report indicated housekeeping (HK) staff and a nursing assistant (NA) where in the hallway when R2 grabbed R4's wheel chair and began screaming at her. R1 told R2 to let R4 go, and R2 came at R1 with her arms and hands flapping, swearing and screaming at him at the top of her lungs. The report further indicated R1 put his hands up to defend himself, and R2 bumped into his hand as she was going toward him. The report indicated when R2 was out of her room, staff were to keep the doors to her wing closed as she would propel herself around the building. Further, staff were to bring R2's husband to the west side to visit and discourage R2 from going to the east wing. The investigation lacked evidence of interviews with staff or residents. On 12/28/22, at 12:08 p.m. RN -B, the DON and the administrator were interviewed. The administrator stated in regard to the incident when R1 was "trying to get to "R7, and ended up grabbing R6 and striking R3," staff told him no. The administrator acknowledged no other interventions or plan had been implemented nor did the investigation include any interviews with staff or other residents involved. RN-B stated no assessments of resident behaviors had been completed, and she did not believe she had ever seen any behavior assessments. At 12:20 p.m. RN-B stated she had completed the investigation for the incident with R1 and R2. RN- B stated from what she understood, there were no other residents present during the incident. RN-B stated R2 grabbed R4's chair and R1 saw it and	F 610		

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F 610	Continued From page 11 was trying to intervene on R4's behalf. RN-B said R2 was flailing her arms and R1 put his hands up. RN-B stated no one could really say R1 had hit R2 and said "someone" said R1 was holding his arms up and R2 made contact. When asked who "someone" was or what staff interviews had been completed, RN-B said when she talked to staff she only asked a few questions and thought the DON had completed more thorough interviews. The DON stated she did not interview staff or other residents following the incident. Facility policy Maltreatment Investigation and Reporting dated 1/30/16, directed: Our care center will investigate all incidents and allegations of maltreatment to determine the cause (if able), and to determine if the incident needs to be reported to the appropriate authorities.	F 610		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 11, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: L80311

Dear Administrator:

The above facility was surveyed on December 27, 2022 through December 28, 2022 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

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
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
	00448	A. BUILDING: _____ B. WING _____	12/28/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/227/22-12/28/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints was found to be SUBSTANTIATED:, with a licensing orders issued at 144.651 Subd 14 H52526601C (MN89160) H52527037C (MN84962) H52527038C (MN84889) 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	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate allegations of resident to resident abuse for 4 of 7 residents (R1, R2, R3, and R6) reviewed for alleged abuse. Findings include:	21850	Corrected	2/1/23

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21850	Continued From page 3 R1's significant change Minimum Data Set (MDS) dated 9/30/22, identified severe cognitive impairment and indicated he displayed no behaviors during the assessment period. R1's MDS indicated he required limited assistance for locomotion on and off the unit. R2's quarterly MDS indicated she was severely cognitively impaired and displayed wandering behaviors. The MDS indicated R2 required supervision with locomotion. R3's discharge MDS dated 7/27/22, identified severe cognitive impairment, no behaviors and indicated he required limited assistance for locomotion. R6's quarterly MDS dated 10/13/22, identified intact cognition, no behaviors and indicated she required extensive assistance from staff for locomotion. A report to the State Agency (SA) dated 7/8/22, indicated R1 was upset about something unknown and swung at R3 and hit him in the right temporal area. No injuries were sustained. A facility investigation submitted 7/11/22, indicated R1 was agitated during supper, and was trying to get to another resident stating, "You better listen to me." Staff separated the residents. Later, R1 grabbed yet another residents arm twice (did not hurt her, just scared her). R1 then said to R3, "I own this place and you're out of here," then punched R3 in the right temporal area. The investigations lacked evidence of interviews with staff or other residents involved. A report to the SA dated 12/6/22, indicated R4 was rolling by R2 when R2 grabbed R4's	21850		

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21850	Continued From page 4 wheelchair, shaking it, and started yelling at her, cursing and calling her names. R1 told R2 her to leave R4 alone, and was trying to pull R4 away from R2. R2 turned toward R1 yelling, cursing at him, and hit out with both hands waving in the air, not connecting but slapping and waving her hands at R1. R1 retaliated and hit R2 one the side of the face loosely with a closed fist. R2 was checked just prior to sending this report and there were no marks or redness on her left cheek. The facility investigation submitted to the SA on 12/9/22, indicated at the time of the incident R4 was wheeling by R2's husbands room on the east unit of the facility, and indicated R2 got upset with staff when they assisted her husband with cares. The report indicated housekeeping (HK) staff and a nursing assistant (NA) where in the hallway when R2 grabbed R4's wheel chair and began screaming at her. R1 told R2 to let R4 go, and R2 came at R1 with her arms and hands flapping, swearing and screaming at him at the top of her lungs. The report further indicated R1 put his hands up to defend himself, and R2 bumped into his hand as she was going toward him. The report indicated when R2 was out of her room, staff were to keep the doors to her wing closed as she would propel herself around the building. Further, staff were to bring R2's husband to the west side to visit and discourage R2 from going to the east wing. The investigation lacked evidence of interviews with staff or residents. On 12/28/22, at 12:08 p.m. RN -B, the DON and the administrator were interviewed. The administrator stated in regard to the incident when R1 was "trying to get to "R7, and ended up grabbing R6 and striking R3," staff told him no. The administrator acknowledged no other interventions or plan had been implemented nor did the investigation include any interviews with	21850		

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21850	Continued From page 5 staff or other residents involved. RN-B stated no assessments of resident behaviors had been completed, and she did not believe she had ever seen any behavior assessments. At 12:20 p.m. RN-B stated she had completed the investigation for the incident with R1 and R2. RN- B stated from what she understood, there were no other residents present during the incident. RN-B stated R2 grabbed R4's chair and R1 saw it and was trying to intervene on R4's behalf. RN-B said R2 was flailing her arms and R1 put his hands up. RN-B stated no one could really say R1 had hit R2 and said "someone" said R1 was holding his arms up and R2 made contact. When asked who "someone" was or what staff interviews had been completed, RN-B said when she talked to staff she only asked a few questions and thought the DON had completed more thorough interviews. The DON stated she did not interview staff or other residents following the incident. Facility policy Maltreatment Investigation and Reporting dated 1/30/16, directed: Our care center will investigate all incidents and allegations of maltreatment to determine the cause (if able), and to determine if the incident needs to be reported to the appropriate authorities. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise policies or procedures to ensure appropriate interventions and oversight is provided to prevent further abuse or neglect from occuring. The facility could educate staff on those policies and procedures. The facility could audit all complaints of abuse or neglect to ensure appropriate assessments, interventions, and monitoring occur to prevent further abuse or neglect and educate all staff on those policies. The results of those audits should be taken to the	21850		

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21850	Continued From page 6 Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	21850		