DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PD5Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00448

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245252**
2.STATE VENDOR OR MEDICAID NO.
(L2) **591605000**

3. NAME AND ADDRESS OF FACILITY
(L3) **THIEF RIVER CARE CENTER**
(L4) **2001 EASTWOOD DRIVE**
(L5) **THIEF RIVER FALLS, MN** (L6) **56701**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2006**

6. DATE OF SURVEY **08/19/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
04/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **70** (L18)
13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Jamie Boser, HFE - NE II 09/24/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/01/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

September 8, 2021

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

RE: CCN: 245252
Cycle Start Date: August 19, 2021

Dear Administrator:

On August 13, 2021, we informed you that we may impose enforcement remedies.

On August 19, 2021, the Minnesota Department(s) of Health and Public Safety completed a revisit/survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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:

- Directed plan of correction, Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 29, 2021

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 29, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 29, 2021.

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)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 29, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Thief River Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 29, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 January 29, 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	08/19/2021

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
E 000	Initial Comments On 8/17/21 through 8/19/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/17/21 through 8/19/21, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 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	F 684		9/29/21

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

Electronically Signed | 09/17/2021

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

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F 684	Continued From page 1 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 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 comprehensively assess and implement interventions to ensure proper wheelchair positioning and prevent potential complications for 1 of 1 resident (R37) reviewed with positioning concerns. Findings include: R37's significant change Minimum Data Set (MDS) dated 7/27/21, indicated R37 had intact cognition and diagnoses which included cancer, chronic pain, localized edema, and venous insufficiency. The MDS identified R37 did not walk, required limited assistance with locomotion on unit, had functional limitations in range of motion to the lower extremities on one side and used a wheelchair. R37 required extensive assistance with all other activities of daily living (ADL) except only required supervision with eating. R37's ADL Care Area Assessment (CAA) dated 7/28/21, indicated R37 spent the majority of his day in his wheelchair and had full range of motion in both upper and lower extremities bilaterally. R37 was unable to walk due to weakness and open areas to foot and used a gait belt with assist of a PAL lift [patient assist lift (sit-to-stand lift)]	F 684	F684 1. Corrective action: communicated with Hospice and a new wheel chair was ordered and a new cushion. 2. This could affect all residents that can□t reposition selves. Will have therapy screen all residents That cannot reposition themselves That they are sitting correctly as they cannot repositions selves 3. Staff meeting education provided to the licensed nurses to put in a therapy screening form when changes are noted in resident transfers and chair positioning. Education provided to NAR□s to report skin conditions and to report positioning problems immediately to the charge 4. Random audits done on residents that cannot reposition selves 3 x a week for 3 weeks 2 times a week for 2 weeks and weekly for 3 weeks. 5. Results of the Audits will be shared with the next Quarterly QAPI committee meeting for further recommendations and further monitoring.	

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F 684	Continued From page 2	F 684		

and two assist with transfers, and was weaker recently.

R37's care plan dated 5/21/21, identified R37 required assistance with transfers and was able to propel his wheelchair about the facility.

On 8/17/21, at 10:54 a.m. R37 stated his wheelchair wasn't very comfortable and gave him a back ache once in a while. R37 mentioned to one of the nursing staff "a little bit ago" he couldn't sit up straight and was told they would have to "put in a work order". However, he was not able to determine how long ago this had occurred and had not heard back from staff. R37 was observed to sit in a standard wheelchair in a leaned back, semi-reclined posture. The chair back was at the height of R37's mid back and the vinyl fabric of the back was stretched and bowed outward and was bent and creased under R37's weight. R37's thighs were tight to the sides of the chair with no space between R37's body and the sides of the chair. R37 stated the chair was from the facility and he had used the chair as long as he had been there.

During observation on 8/18/21, at 12:31 p.m. R37 sat in the same wheelchair at a table in the dining room. R37 leaned back approximately 15 degrees past an upright, vertical position with the vinyl back of the chair creased under the weight of R37's upper body. There was an approximate four to five inch gap noted between R37's buttocks and the back of the chair. R37's upper back and head were unsupported as he sat in the chair. R37 pulled himself forward with effort, using the arm of the wheelchair to pull himself upright and reach the beverages on the table and then fell back into chair to drink them. This

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F 684	Continued From page 3	F 684		

occurred multiple times throughout the meal. R37 consumed his meal in this semi-reclined position. R37 did not have any difficulties during the meal such as coughing; however, R37 did drop food onto his chest several times.

-At 1:10 p.m. R37 requested staff lift him back in his chair. Activity aid (AA)-A stepped behind R37's wheelchair and grasped him by the waistband of his pants and pulled R37 back in his chair, dragging his buttocks along the seat of the chair. R37 remained semi-reclined in the wheelchair with his upper body approximately 15 degrees past a vertical position, even after assistance to move back in his chair.

On 8/18/21, at 06:07 p.m. R37 sat in his room in the same semi-reclined position, in his wheelchair.

During observation on 8/19/21, at 7:49 a.m. nursing assistant (NA)-B and NA-C transferred R37 from the bed to the wheelchair with the use of a standing lift. After R37 was lowered into the chair, both of his thighs were tight to the sides of the chair with no space between R37's body and the sides of the chair and he sat in a semi-reclined position approximately 15 degrees past an upright, vertical posture.

-At 8:23 a.m. R37 wheeled himself from his room in his wheelchair. He remained in the semi-reclined position. The handles of the wheelchair were up into his armpits and his elbows moved well behind the arm rests and handles of the wheelchair as he wheeled the chair. The back of wheelchair was depressed and creased under weight of R37's upper body. R37's upper body was held tense and stiff as he

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F 684	Continued From page 4	F 684		

wheeled himself down hallway. AA-A stopped R37's in hall, locked the wheelchair's brakes and grasped R37 under his arms and slid him back in chair dragging his buttocks along the seat of the wheelchair.

During interview on 8/19/21, at 8:32 a.m. AA-A stated she thought R37 might have received a new chair as she didn't used to have to reposition him in his chair as often. She thought it might be a bad chair for him.

During interview on 8/19/21, at 10:28 a.m. NA-C stated there was a mix up when R37 was in the hospital the previous month. It was her understanding he might have received the wrong wheelchair upon returning to the facility. The nursing assistant staff requested a physical therapy evaluation for a new chair and brought it up every couple of days due to his position in the wheelchair. R37's positioning scared her as she felt he was going to tip over and felt it couldn't be comfortable for R37. R37 was going to end up with a backache. NA-C thought it had been about three weeks or so since they had been working to figure out the issue with R37's wheelchair.

During interview on 8/19/21, at 2:20 p.m. registered nurse (RN)-B stated to her knowledge the wheelchair R37 was currently using was his wheelchair. She acknowledged there was a mix up with the wheelchair at the hospital but stated they did get it back, so this was the correct wheelchair. She talked to therapy this week about his positioning and R37's possible need for a high-backed chair but did not put in a referral.

During interview on 8/19/21, at 2:31 p.m. NA-B and RN-B both stated it seemed R37's

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F 684	Continued From page 5	F 684		

positioning in the wheelchair was worse since he returned from the hospital on July 19th.

R37's medical record lacked evidence R37 was assessed or screened for his wheelchair positioning despite using the poor fitting wheelchair on a daily basis since his return from the hospital.

On 8/19/21, at 2:41 p.m. R37's wheelchair positioning was observed and reviewed with RN-B who described his posture as approximately 15 degrees past an upright vertical position with an unsupported upper back. RN-B thought it was the same wheelchair he used before his hospitalization but R37 stated it was not. R37 stated he thought the wheelchair was smaller. RN-B assisted R37 to sit forward and observed the seat back of the chair to be stretched and bowed out. R37 stated the wheelchair was not comfortable. Upon return to the nurse's station, RN-B filled out a PT request/referral for a wheelchair evaluation.

During interview on 8/19/21, at 4:52 p.m. the director of nursing stated they recently talked about a larger, taller chair for R37 and had discussed ordering one; however, had not done so.

The undated Adaptive and Positioning Equipment policy indicated the facility would provide equipment that allowed residents to achieve their highest most practicable level of function and directed the RN unit manager/nursing would make the referral to occupational therapy or physical therapy for wheelchair positioning, seating assessment or other adaptive equipment recommendation. Adaptive equipment dispersal

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F 684	Continued From page 6 was based on need.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure potential contributing risk factors for pressure ulcer development including friction and/or shear (forces moving in opposite directions are applied to tissues in the body) due to wheelchair positioning and repositioning practices were minimized for 1 of 1 resident (R37) who had impaired skin integrity and was at risk for pressure ulcer development or worsening. Findings include: R37's significant change Minimum Data Set (MDS) dated 7/27/21, indicated R37 had intact cognition and diagnoses which included cancer, chronic pain, localized edema, and venous insufficiency. The MDS identified R37 did not	F 686	F686 1. Corrective action: communicated with Hospice and a new wheel chair was ordered and a new cushion. 2. This could affect all residents that can□t reposition selves this could cause skin issues. Will have therapy screen all residents that cannot repositions selves. 3. Staff meeting education provided to the licensed nurses to put in a therapy screening form when changes are noted in resident transfers and chair positioning. Education provided to NAR□s to report skin conditions and to report positioning problems immediately to the charge Nurse. 4. DON or Designee will do Random audits done on residents that cannot	9/29/21

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F 686	Continued From page 7 walk, required limited assistance with locomotion on unit, had functional limitations in range of motion to the lower extremities on one side and used a wheelchair. R37 required extensive assistance with all other activities of daily living (ADL) except only required supervision with eating. The MDS further identified R37 had diabetic foot ulcers, moisture associated skin damage (a spectrum of injury characterized by the inflammation and erosion (or denudation) of the skin resulting from prolonged exposure to various sources of moisture and potential irritants such as urine, stool or perspiration) and was at risk for pressure ulcer development. He required a pressure reducing device for both chair and bed and a turning and repositioning program. R37's ADL Care Area Assessment (CAA) dated 7/28/21, indicated R37 spent the majority of his day in his wheelchair and had full range of motion in both upper and lower extremities bilaterally. R37 was unable to walk due to weakness and open areas to foot and used a gait belt with assist of a PAL lift [patient assist lift (sit-to-stand lift)] and two assist with transfers and was weaker recently. R37's Pressure Ulcer CAA dated 7/28/21, indicated R37's Braden (tool for predicting pressure ulcer risk) score was 13 (moderate risk). R37 would frequently offload and reposition throughout the day in the wheelchair. He required the assistance of PAL lift and two staff with transfers, toileting and bed mobility. He required the assist of one to two staff for ADLs. Skin was inspected weekly by licensed staff. He had open areas on toes and buttocks and was seen by the wound clinic for wounds on buttocks.	F 686	reposition selves 3 x a week for 3 weeks 2 times a week for 2 weeks and weekly for 3 weeks. 5. Results of the Audits will be shared with the next Quarterly QAPI committee meeting for further recommendations and further monitoring	

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R37's care plan dated 5/21/21, identified R37 required extensive assistance with bed mobility and directed staff to offer repositioning every two hours at night and every three hours during the day. R37 was to lay down on his side for two hours daily. Further, R37 had incontinence issues and was resistive to changing so staff were to explain the importance of toileting/need for being changed.

During interview on 8/17/21, at 10:54 a.m. R37 stated his wheelchair wasn't very comfortable and gave him a back ache once in a while. He had mentioned to one of the nursing staff "a little bit ago" that he couldn't sit up straight and was told they would have to "put in a work order". However, he was not able to determine how long ago this had occurred and had not heard back from staff. R37 sat in a standard wheelchair in a leaned back, semi-reclined posture. The chair back was at the height of R37's mid back and the vinyl fabric of the back was stretched and bowed outward and was bent and creased under R37's weight. R37's thighs were tight to the sides of the chair with no space between R37's body and the sides of the chair.

During observation on 8/18/21, at 12:31 p.m. R37 sat in the same wheelchair at a table in the dining room. R37 leaned back approximately 15 degrees past an upright, vertical position with the vinyl back of the chair creased under the weight of R37's upper body. There was an approximate four to five inch gap noted between R37's buttocks and the back of the chair. R37's upper back and head were unsupported as he sat in the chair. R37 pulled himself forward with effort, using the arm of the wheelchair to pull himself upright and reach the beverages on the table and

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then fell back into chair to drink them. This occurred multiple times throughout the meal. R37 consumed his meal in this semi-reclined position.

-At 1:10 p.m. R37 requested staff lift him back in his chair. Activity aid (AA)-A stepped behind R37's wheelchair and grasped him by the waistband of his pants and pulled R37 back in his chair, dragging his buttocks along the seat of the chair. R37 remained semi-reclined in the wheelchair with his upper body approximately 15 degrees past a vertical position, even after assistance to move back in his chair.

On 8/18/21, at 6:07 p.m. R37 sat in his room in the same semi-reclined position, in his wheelchair.

R37's Skin Condition/Wound Progression Notes dated 8/18/21, included the following:

-Coccyx: No odor apparent, no drainage is apparent. This wound was not present on admission. On coccyx 0.5 x 1 [centimeters (cm)] and 0.6 x 0.1 [cm]. Wound base was visible. Red wound base = 100%, surrounding tissue was reddened, skin tissue temperature was consistent with surrounding tissue. Resident had no pain, mucous membranes were dry. Skin turgor was fair. Deterioration noted in site. Likelihood of healing due to overall condition, fair.
Risk-factors: co-morbidities, end-stage disease, decreased mobility, refusal of care, inactivity, decreased blood flow, diabetes.

-Left lower buttocks: No odor apparent, no drainage is apparent. This wound was not present on admission. Left buttock 0.8 x 0.8 [cm]

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and one above it is 1.5 x 1 [cm]. Wound base was visible. Red wound base = 100%, no itching or discomfort, surrounding tissue was reddened, skin tissue temperature was consistent with surrounding tissue. Resident had no pain. Skin turgor was fair. Deterioration noted in site. Likelihood of healing due to overall condition, fair. Risk factors: co-morbidities, end-stage disease, decreased mobility, refusal of care, inactivity, decreased blood flow, diabetes.

-Right lower buttocks: 2 x 3 cm, no drainage was apparent. This wound was not present on admission. Wound base was visible. Pink wound base - 50%, red wound base 50%, surrounding tissue was reddened, skin tissue temperature was consistent with surrounding tissue. Resident had no pain. Skin turgor was fair. Likelihood of healing due to overall condition, fair. Risk factors: co-morbidities, end-stage disease, decreased mobility, refusal of care, inactivity, decreased blood flow, diabetes.

During observation on 8/19/21, at 7:27/21, nursing assistant, NA-B provided perineal cares for R37 while he was in bed. R37's buttocks was white in appearance with macerated skin. NA-B indicated R37 had three areas on his upper, mid and lower left buttock. The upper and lower areas were covered with soft, macerated scabs. However, the area to the mid left buttock was superficially open, bright red, and was approximately 1/2 cm round. The right buttock had two areas which were covered in soft, macerated scabs. The coccyx had a small open slit approximately 1/2 cm in length with white, macerated skin surrounding the slit. NA-B completed the remainder of R37's morning cares. NA-C then assisted NA-B to transfer R37 to a

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wheelchair with the use of a standing lift. The seat of R37's wheelchair contained two foam cushions with a piece of sheepskin between the two cushions. After R37 was lowered into the chair, both of his thighs were tight to the sides of the chair with no space between R37's body and the sides of the chair and he sat in a semi-reclined position approximately 15 degrees past an upright, vertical posture.

-At 8:23 a.m. R37 wheeled himself from his room in his wheelchair. He remained in the semi-reclined position. The handles of the wheelchair were up into his armpits and his elbows moved well behind the arm rests and handles of the wheelchair as he wheeled the chair. The back of wheelchair was depressed and creased under weight of R37's upper body. R37's upper body was held tense and stiff as he wheeled himself down hallway. AA-A stopped R37's in hall, locked the wheelchair's brakes and grasped R37 under his arms and slid him back in chair dragging his buttocks along the seat of the wheelchair.

During interview on 8/19/21, at 8:32 a.m. AA-A stated she thought R37 might have gotten a new chair as she didn't used to have to reposition him in his chair as often. She thought it might be a bad chair for him.

During interview on 8/19/21, at 10:28 a.m. NA-C stated there had been a mix up when R37 was in the hospital the previous month. It was her understanding he might have gotten the wrong wheelchair back. The nursing assistants requested a physical therapy evaluation be obtained for a new chair and brought it up every couple of days due to his position in the

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wheelchair. R37's positioning scared her as she felt he was going to tip over and felt it couldn't be comfortable for R37. He was going to end up with a backache. She thought it had been about three weeks or so since they had been working to figure out the issue with R37's wheelchair. His bottom had been an ongoing issue. They worked with him to reposition from side to side every one to two hours at night; however, he refused repositioning, as well as, toileting or changing during the day. She documented this and reported his refusals to the nurse. She also encouraged him to sit in his recliner. They used different types of creams such as protective creams or antifungal creams for his skin issues. R37 knew what he liked and what he didn't like. She had tried a wedge cushion behind his back at one time to get him better positioning but he didn't like it. She would also use flat pads instead of full incontinent briefs at night for better air flow on his skin.

During interview on 8/19/21, at 2:20 p.m. registered nurse (RN)-B stated to her knowledge the wheelchair R37 was currently using was his wheelchair. She acknowledged there was a mix up with the wheelchair at the hospital but stated they did get it back, so this was the correct wheelchair. She talked to therapy this week about his positioning and R37's possible need for a high-backed chair but had not put in a referral. R37's bottom had healed at one time and the open areas healed and reopened, and were ongoing. They were currently using a barrier cream twice daily and with brief changes. She felt the areas were pressure related. However, R37 didn't want to go to bed. She made a point to have him lay down for at least an hour every afternoon. He would also sometimes sit in his

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recliner but would often refuse repositioning. He no longer saw the wound clinic as he was now on Hospice.

On 8/19/21, at 2:41 p.m. R37's wheelchair positioning was observed and reviewed with RN-B who described his posture as approximately 15 degrees past an upright vertical position with an unsupported upper back. She stated she thought it was the same wheelchair he had used before his hospitalization but R37 stated it was not. R37 stated he thought the wheelchair was smaller. RN-B assisted R37 to sit forward and observed the seat back of the chair to be stretched and bowed out. R37 stated the wheelchair was not comfortable. Upon return to the nurse's station, RN-B stated R37's positioning could be contributing to resident skin breakdown due to shearing forces.

During follow-up interview on 8/19/21, at 4:39 p.m. RN-B stated repositioning a resident by pulling a resident back in chair by their pants or arms in a way in which they buttocks drags along the seat of the chair would not be a good method and would increase the risk of shearing.

During interview on 8/19/21, at 4:52 p.m. the director of nursing stated staff should have used a PAL lift to reposition R37 rather than to pull on his pants or slide the resident. Sitting in the reclined positioned would put additional pressure on R37's coccyx and buttocks and increase the risk of pressure ulcer development or worsening.

The Skin Ulcer Protocol dated 7/1/20, directed risk factors for the development of pressure ulcers need to be evaluated for each skin assessment. Decide which risk factors increase

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F 686	Continued From page 14 the potential to develop pressure ulcers for the resident and care plan interventions for each risk factor. Decide whether any of the risk factors can be modified, stabilized or removed. Remove the source of any possible pressure or trauma. Monitor interventions to be started if an open area is noted on any shift. Review all current interventions to ensure they remain appropriate. Consider the following causes: sitting or positioned too long on a static surface, slouching in a chair, friction and shearing caused by tight or wrinkled bedding, or sliding resident up in bed.	F 686		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 758		9/29/21

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F 758	Continued From page 15 contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a gradual dose reduction was attempted or contraindication to dose reduction was documented and a rationale for the continued use of psychotropic medications was completed for 1 of 5 residents (R14). In addition, the facility failed to provide a rationale for the extended used of an as needed (PRN) psychotropic medication beyond 14 days for 1 of 5 residents (R21) whose medication regimens were reviewed. Findings include:	F 758	F758 1. MD did not put a rational as to why he continued a psychotropic medication. R21 Klonopin was discontinued due to not using this for more than 62days. 2. This would affect all residents that have psychotropic medications. Orders will be reviewed to make sure that all psychotropics have an end date or rationale on why to continue, or a GDR if warranted. 3. Administration met with clinic leadership about this. On 9/8/2021 Education was provided to nurse	

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F 758	Continued From page 16 R14's quarterly Minimum Data Set (MDS) dated 6/1/21, indicated R14 had intact cognition and diagnoses included anxiety and depression. The MDS identified R14 experienced feeling down, depressed or hopeless one day of the assessment period and took antianxiety and antidepressant medication daily. R14's Physicians Order Sheet dated 8/19/21, included the following orders: -Ativan (lorazepam) 0.5 milligrams (mg): Administer 0.5 mg by mouth two times per day for generalized anxiety disorder. The order start date was identified as 12/2/20. -mirtazapine (Remeron) 30 mg: Administer 1 tablet by mouth one time per day for major depressive disorder, increase appetite. The start date was identified as 10/23/20. During observation on 8/18/21, at 12:45 p.m. R14 sat in an electric wheelchair in the dining room eating the noon meal independently. R14 sat quietly and calmly with no adverse mood or behaviors observed. During interview on 8/19/21, at 1:07 p.m. R14 stated his medication regimen had be been pretty good after previous issues with obtaining scheduled pain medications from the pharmacy. There were no further concerns after resolution of the pharmacy issues. He took Ativan for his nerves and identified certain types of movies as triggers for his mood which he tried to avoid. He also took antidepressants for his mood which he reported had been good and did not identify any current issues with his medications.	F 758	managers to make sure that rationales for med is received, end dates or GDRs are done. 4. Will provide the regulation to the current MD regarding this issue. 5. Don or Designee will do Random Audits on the GDR□s 3 times a week for 3 weeks, 2 times a week for 3 weeks and once a week for 3 weeks. 6. Results will be shared with the next Quarterly QAPI committee meeting for further recommendations and monitoring.	

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R14's Consultant Pharmacist's Medication Review dated 2/11/21, included the following pharmacist recommendations: Please assess whether a dose reduction is appropriate for mirtazapine at this time. The IDT [interdisciplinary team] would recommend no dose reduction at this time. Patient was currently stable and appetite was perhaps slightly improved. The physician follow-up or action taken dated 3/18/21, included a handwritten note to "continue current order"; however, the physician did not include a rationale for the continued use of the medication.

R14's Nursing Home Note dated 3/16/21, identified R14 was seen by the physician on nursing home rounds and his medications and allergies were reviewed. The note did not address R14's depression or appetite and did not provide a rationale for R14's continued use of mirtazapine.

R14's Consultant Pharmacist's Medication Review dated 6/10/21, included the following pharmacist recommendations: Please assess whether a dose reduction is appropriate for lorazepam at this time. The IDT would not recommend a reduction at this time. Discussions indicated R14 continued to be anxious, including about getting this medication. The physician follow-up or action taken section was blank. The implementation timeframe directed the physician to address as soon as possible but no later than 60 days. The review was signed by registered nurse (RN)-B on 6/15/21. A handwritten note on the bottom of the page indicated "please fax back to [facility fax number]".

R14's record lacked physician documentation of a

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clinical rationale for the continued use of mirtazapine or lorazepam.

During interview on 8/19/21, at 3:37 p.m. RN-B stated they had a hard time getting a response back from physicians on pharmacist medication recommendations at times and would often have to make multiple requests or fax the information to their offices multiple times. After review of R14's aforementioned Consultant Pharmacist Medication Reviews and Nursing Home Notes, RN-B stated while the physician approved the order to continue R14's mirtazapine, they did not provide a rationale for the continued use. Regarding, the lorazepam, R14 was seen by the physician in July. She reviewed the physician's documentation via remote computer access and stated the physician didn't address R14's lorazepam at the July visit. The physician had not addressed the recommendation in the progress note. She also stated the facility had not received a faxed response to the pharmacist's recommendation.

R21's quarterly MDS dated 6/17/21, indicated R21 had moderate cognitive impairment and diagnoses included dementia and anxiety. The MDS identified R21 exhibited no mood symptoms, psychosis, or behavioral symptoms and received antipsychotic medication daily; however, had not received antianxiety medication during the assessment period.

R21's Psychotropic Drug Use Care Area Assessment (CAA) dated 3/26/21, indicated R21 had diagnoses of generalized anxiety disorder and an order for risperidone (antipsychotic) 0.25 mg daily. Target behaviors were 1) hears voices 2) paranoia 3) increased verbiage.

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Non-pharmacological interventions included 1) 1:1 [visit] 2) offer activity 3) offer snack. R21 enjoyed talking to her family on the phone and visiting with staff. R21 was pleasantly confused with a PHQ-9 (patient health questionnaire - a tool for screening, diagnosing, monitoring and measuring the severity of depression) score of 2 (minimal depression).

R21's Physicians Order Sheet printed 8/20/21, included the following order:
-Klonopin (clonazepam) 0.5 mg: Administer 0.5 mg by mouth as needed 1 timer per day for 62 days, for generalized anxiety disorder. The order start date was 6/25/21. The order finish date was 8/25/21.

R21's EMAR [electronic medication administration record] Monthly Report dated May 2021,, included the following orders:
-Klonopin (clonazepam) 0.5 mg; Administer 0.5 mg by mouth 1 time per day for generalized anxiety disorder. The order was discontinued 5/25/21.
-Klonopin (clonazepam) 0.5 mg; Administer 0.5 mg by mouth as needed 1 time per day for generalized anxiety disorder. The date ordered was 5/25/21.
No doses of as needed Klonopin were recorded

R21's EMAR Monthly Report dated June 2021, included the following:
-Klonopin (clonazepam) 0.5 mg; Administer 0.5 mg by mouth as needed 1 time per day for generalized anxiety disorder. The date ordered was revised 6/25/21 to include a duration of 62 days.
No doses of as needed Klonopin were recorded

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R21's EMAR Monthly Report dated July 2021, included the following:
-Klonopin (clonazepam) 0.5 mg; Administer 0.5 mg by mouth as needed 1 time per day for 62 days for generalized anxiety disorder. No doses of as needed Klonopin were recorded

R21's EMAR Monthly Report dated August 2021,
-Klonopin (clonazepam) 0.5 mg; Administer 0.5 mg by mouth as needed 1 time per day for 62 days for generalized anxiety disorder. No doses of as needed Klonopin were recorded through 8/19/21

During observation on 8/18/21, at 12:47 p.m. R21 sat in a wheelchair at a table in the dining room eating the noon meal independently. No adverse mood or behavior observed. R21 was seated at a table with one other female resident; however, they were not engaged in conversation. Music played softly in the background.

During interview on 8/18/21, at 6:43 p.m. R21 rested on her back on her bed with family member (FM)-A seated at her bedside. FM-A stated she was satisfied with R21's medication regimen and care while at the facility. R21 used to hear voices but did not hear them since she was at the facility and FM-A didn't think R21 took any antipsychotic medication. FM-A felt R21 was not as isolated at the nursing home as she was previously at the assisted living facility as she had more activities and interaction with facility staff. FM-A expressed no concerns regarding R21's medications and stated the facility called her to discuss or inform her of any medication changes. She felt R21 was doing well on her current medication, experienced no further voices and seemed to be happy and content.

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R21's Consultant Pharmacist's Medication Review dated 6/9/21, identified the following irregularity or comment regarding clonazepam: since this medication is used for a psychological condition and due to updated CMS [Centers for Medicare and Medicaid Services] regulations, this PRN [as needed] medication has to be re-evaluated within the first 14 days of starting. If the medication is to be continued a re-evaluation date is needed. The review included the following pharmacist recommendations: In order to continue clonazepam, please add a re-evaluation date to re-assess, i.e. continue x 60 days then re-evaluate, etc.

- The physician follow-up or action taken section included a handwritten note to "continue another 60 days". The review did not include a rationale for the continued use of the medication. The review was signed by registered nurse RN-B on 6/10/21. The review was unsigned by the attending physician.

During interview on 8/19/21, RN-B stated R21 just saw her physician the previous day who did not address the pharmacy recommendation from June. She obtained a verbal order in June to continue the as needed order for another 60 days but they did not have a rationale for the extended use of the medication. The physician had not yet signed the recommendation. Further, R21 did not use the medication and had not used it since it was changed from a scheduled to as needed medication.

During interview on 8/19/21 at 4:14 p.m. the consulting pharmacist (CP) stated it had been a problem generally that physicians may not

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F 758	Continued From page 22 provide a rationale for the continued use of psychotropic medications and it got to be a frustrating problem. They had been dealing with the problem for a few years. They should have a rationale for the continued use of psychotropic medications if a gradual dose reduction was not attempted and for the continued use of as needed psychotropic medications beyond 14 days. During interview on 8/19/21, at 4:47 p.m. the director of nursing (DON) stated she would have expected staff ensured a rationale be provided for R14's continued use of mirtazapine and lorazepam and would have expected staff either ensured R21's Klonopin be discontinued for lack of use or ensured a rationale for it's continued as needed use beyond 14 days be provided. The Psychotropic Medications policy dated 10/2015, directed the primary care physician, physician's assistant or nurse practitioner would document rationale and diagnosis for the use and identify target behavior symptoms for the reason the medication was being used. The policy also directed new orders for PRN [as needed] psychotropic medications would be time limited (i.e. times two weeks) and only for specific clearly documented circumstances.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		9/29/21

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F 761	Continued From page 23 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safe medication refrigerator temperatures were maintained in 1 of 2 nursing units (Evergreen) to ensure medication efficacy was maintained for 3 of 3 residents (R18, R37, R30) who's individual medications were stored in the refrigerator. This had the potential to affect all 19 residents who resided on the unit and had the potential to receive stock medications stored in the refrigerator. Findings include: During an observation of the Evergreen unit medication room on 8/19/21, at 12:57 p.m. licensed practical nurse (LPN)-A and registered nurse (RN)-B stated the night shift cleaned the	F 761	F761. 1. Opened vials in fridge were not label when they would expire after opening. Fridge temps were not recorded routinely. And when they were there were temps that did not fall into the proper temperature zone to ensue medication efficacy. 2. This could affect all residents that have medications stored in the refrigerators in our med rooms. All medication fridges were looked at to ensure that temperatures are at the correct temperature zone. All medications in the fridge were gone through and labeled correctly. Any expired meds were destroyed and replaced. 3. Education was provided to the	

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F 761	Continued From page 24 refrigerator weekly. The temperature log for the medication refrigerator log was reviewed and identified the medication refrigerator was to be maintained between 36-46 degrees Fahrenheit (F). However, the log also indicated no temperature were documented on 8/19/21 and the current temperature was 50 degrees F. LPN-A stated the refrigerator was probably warm due to having the door open and shut the door. Both nurses stated the staff would adjust the refrigerator temperature gauge and recheck the temperature later that day. The Evergreen unit fridge log between 7/2/21 to 8/19/21, identified the following temperatures either were not documented or were not within range: 7/7/21, at 10:30 p.m. no temperature was documented. 7/12/21, at 6:30 a.m. no temperature was documented. 7/12/21, at 7:30 p.m. no temperature was documented. 7/13/21, at 6:30 a.m. no temperature was documented. 7/14/21, at 6:30 a.m. no temperature was documented. 7/15/21, at 6:00 a.m. 32 degrees F (below range). 7/16/21, at 6:30 a.m. no temperature was documented. 7/26/21, at 7:00 a.m. no temperature was documented. 7/26/21, at 2:50 p.m. no temperature was documented. 7/27/21, at 2:00 p.m. no temperature was documented. 7/28/21, at 4:00 p.m. 34 degrees F (below range). 7/30/21, at 6:30 a.m. no temperature was documented.	F 761	licensed staff on the fridge temp policy and the procedure to correct the temp if a variance is detected. Staff were also educated on putting expiration dates on vials after they are opened. 4. DON or Designee will do random audits of expiration dates on opened vials and expired medications. Will audit the temperature logs. 3 times a week for 3 weeks. 3 times a week for 3 weeks and once a week for 3 weeks. 5. Results will be shared with the next Quarterly QAPI committee meeting for further recommendations and monitoring. 6. Will be corrected by Sept 29th.	

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8/7/21, at 6:20 a.m. 35 degrees F (below range).
8/7/21, at 4:00 p.m. 34 degrees F (below range).
8/7/21, at 10:40 p.m. 35 degrees F (below range).
8/11/21, at 3:00 p.m. 35 degrees F (below range).
8/12/21, at 4:00 p.m. 35 degrees F (below range).
8/13/21, at 10:30 p.m. 35 F degrees (below range).
8/16/21, at 6:30 a.m. no temperature was documented.
8/19/21, at 6:30 a.m. no temperature was documented.

During the same observation the following medications were identified as stored in the Evergreen unit medication fridge:
- 130 pre-dosed syringes of Fluarix Quadrivalent (a vaccine indicated for active immunization for the prevention of Influenza disease) NDC 58160-885-52 which expired on 6/30/21.
- 14 pre-dosed syringes of Influenza Vaccine Flublok Quadrivalent (a vaccine indicated for active immunization for the prevention of Influenza disease) which expired on 3/22/21
- 3 syringes of Fluarix influenza vaccine (a vaccine indicated for active immunization for the prevention of Influenza disease) which expired 6/2021.
- 2 unopened boxes and 1 opened vial of Tubersol (a protein deritive used in a skin test to diagnosis tuberculosis) NDC 42023-104-01 expired 2/22, and included two unopened vial and 1 opened vial
- 1 box of Tylenol suppositories (a medication to treat mild to moderate pain and to reduce fever) 650 mg
- 3 syringes of Prevnar-13 pneumococcal vaccine (a vaccine for the prevention of pneumococcal pneumonia) which expired 11/2020.
- 2 boxes of Bisacodyl suppositories (a laxative)

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- 3 boxes of Acetaminophen 650 mg (a medication to treat mild to moderate pain and to reduce fever) suppositories
- 1 unopened vial of Novolin R (an insulin used to control high blood sugar in people with diabetes) for stock use
- 2 pens of Novolog Flexpen (an insulin used to control high blood sugar in people with diabetes) for R18
- 4 pens of Levemir (a prescription medicine used to treat the symptoms of type I or 2 diabetes mellitus) for R18
- 6 pens of Lantus (a long-acting insulin used to treat adults with type 2 diabetes) for R37
- 4 boxes of Perforomist (an inhalation solution used to control the symptoms of chronic obstructive pulmonary disease (COPD) 4 boxes for R30

R18's admission Minimum Data Set (MDS) dated 6/24/21, indicated R18 had a diagnosis of diabetes. R18's Physician Order Sheet dated 6/17/21, included the following order: Novolog Flexpen U-100 insulin three times per day at 8:00 a.m., 12:00 p.m., and 5:00 p.m. Special instructions: if blood sugar is 120-149 give four units. If blood sugar 150-199 give five units. If blood sugar 200-249 give six units. If blood sugar 250-299 give 7 units. If blood sugar 300-349, give eight units. If blood sugar greater than 349, give nine units subcutaneous.

R37's significant change MDS dated 7/27/21, indicated R37 had a diagnosis of diabetes. R37's Physician Order Sheet dated 8/19/21, included the following order: Lantus Solostar one time per day at bedtime. Special instructions: Inject 50 units into skin at bedtime.

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R30's MDS dated 7/8/21, indicated R30 had a diagnosis of chronic obstructive pulmonary disease. R30's Physician Order Sheet dated 8/19/21, indicated R30 was not currently prescribed Perforomist.

On 8/19/21, at 1:17 p.m. LPN-A stated she would look for the medication's appearance and clarity to determine if a medication was usable after the refrigerator temperature was out of range; however, she did not know if the facility had a policy which provided staff direction on what to do if the temperatures were out of range. The staff would adjust the refrigerator temperature gauge and wait for 24 hours. If the refrigerator temperature was still out of range, maintenance would be notified.

During interview on 8/19/21, at 1:26 p.m. the director of nursing (DON) stated the facility was not able to have a second night nurse since the beginning of the pandemic due to low resident census and staffing shortages, but a second nurse would be available soon. Because of this, the medication refrigerator was not cleaned as usual. Upon review of the refrigerator temp log, the DON stated the staff were expected to know what to do when the refrigerator temperature was out of range and when to notify maintenance.

During a phone interview on 8/19/21, at 2:10 p.m. the consultant pharmacist stated the facility would not contact him for refrigerated medications not stored according to manufacturer recommendations, but would contact the local pharmacy. Additionally, the pharmacy tech was directed to perform an audit of the facility medication storage every three months and those audits were provided to the DON. Upon review of

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the expired medications and medications not stored in temperature range in the medication refrigerator, the consultant pharmacist stated facility staff as well as pharmacy staff were expected to follow policy and procedure and education/training would be provided.

- At 2:39 p.m. the DON stated the pharmacy had not conducted an audit of the facility medication storage for over one year due to the COVID-19 pandemic.

The facility policy Medication Storage Policy dated 7/27/16, indicated the facility stored all drugs and biological's in a safe, secure and orderly manner. The policy further indicated the facility did not use discontinued, outdated, or deteriorated drugs or biological's and all such drugs would be returned to the dispensing pharmacy or destroyed. Additionally, medications which required refrigeration must be stored separately from food and refrigerator temperatures were to be kept between 36-46 degrees Fahrenheit. The policy directed staff to ensure the temperature was in range one to two times daily. If the temperature was above 46 degrees F or below 36 degrees F, the refrigerator temp was adjusted and rechecked in one hour. If the temperature remained out of temperature range, a maintenance slip was filled out notifying maintenance to check the refrigerator due to temperature out of range. The DON was also notified. Medications and immunizations were discarded if stored out of temperature range per its manufacturer's recommendations.

The package inserts for the following medications directed the facility to store the medications as follows:

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F 761	Continued From page 29 - Insulin Humalog revised 3/13, identified unopened Humalog should be stored in a refrigerator at 36 to 46 degrees F and do not freeze. - Insulin Lantus revised 5/19, identified to store at 36 to 46 degrees F and do not freeze. - Novolog revised 2/15, identified to store at 36 to 46 degrees F until expiration.	F 761		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		9/18/21

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F 880	Continued From page 30 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 880	F880,	

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	245252	A. BUILDING _____ B. WING _____	08/19/2021

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F 880	Continued From page 31 facility failed to implement a comprehensive infection prevention and control program (IPCP) to include an ongoing data collection of actual and potential infections and complete a comprehensive analysis of the data to ensure patterns and trends were identified and acted upon to reduce the risk of infections spread within the facility. This had potential to affect all 46 residents residing in the facility. In addition, the facility failed to track and trend loose stools for 1 of 1 resident (R2) who was identified to have loose stools. Finding include: The facility form, Infection Surveillance Log tracked infections and antibiotic use included resident name, room number, date of onset, signs and symptoms, location/type of infection, identified pathogen, and treatments. The Infection Surveillance Log with analysis from May 2021, identified nine infections. Seven infections were treated with antibiotics and two entries were treated with antifungals. Infections listed included three urinary tract infections (UTI), two skin infections, one combination UTI/skin infection, one eye infection, and one dental prophylaxis, one infection was not identified. There were no resolution dates for any infections identified. Further, only infections treated with medications were included on the form. The corresponding analysis identified a trend of three residents on Blueberry Unit with UTI's with same pathogen; and did peri-care audits for nursing assistants (NA) and identified one NA who required further training and education. The Infection Surveillance Log with analysis from	F 880	1.Infection control tracking and trending. Root cause was new RN Managers on both pods. New IPC 2.This has the potential to affect all residents. 3.Don and IP have reviewed policies developed a new strategies See #5 4.Staff meeting were held 9/14 and 9/16 and education was provided and infection surveillance policy was reviewed with the licensed staff and management team. 5.2 Logs were placed on both sides to track residents and staff. With a guide for our expectations. 6.Surveillance logs that have been posted will be Audited daily By DON and IP with assistance of the Nurse manager for 3 weeks. 3 times a week for 3 weeks and 1 time week for 3 weeks. 7.Results of the Audits will be shared with the next Quarterly QAPI committee meeting for further recommendations and further monitoring.	

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F 880	Continued From page 32	F 880		

June 2021, identified seven infections. Six infections were treated with antibiotics and one infection indicated the resident was hospitalized and did not indicate if it was treated with an antibiotic. Further, the log identified four luminary tract infections (UTI), one skin issue, and one did not identify location/type of infection. None of the infections were identified as resolved. The log only identified infections treated with medications. There was no corresponding monthly analysis to identify if there were any patterns or trends identified and if so what the facility did to reduce infections.

The Infection Surveillance Log with analysis from July 2021, was requested but not received.

The current ongoing Infection Surveillance Log from August 1 through August 19 2021, identified three entries on the form and they were all UTI's, which did not list any signs or symptoms of the infections; however, identified the infections were treated with antibiotics. Further, the log did not identify any infections that were not treated with medication.

R2's quarterly Minimum Data Set (MDS) dated 8/5/21, indicated severe cognitive impairment and required extensive assist with toileting. R2's diagnosis included diverticulosis of the large intestine.

R2's progress notes identified the following:

- 6/9/21, R2 continued to have large gray/brown loose stools which are described as stringy and foul odor.

- 6/11/21, R2's Senna (a stool softener) had been

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held the past few days as R2 had been having loose stools and are described as stringy and foul odor.

- 8/13/21, R2 was identified as having loose stools.

The Infection Surveillance Logs from June and August 2021, did not identify R2 as having loose stools (diarrhea).

During interview on 8/19/21, at 2:48 p.m. registered nurse (RN)-A stated when a resident had loose stools, upset stomach, vomiting, or temperature they would discuss it during the morning IDT meeting and identify if any other residents were having the same symptoms. If the symptoms described indicated concerns according to the antibiotic use guidelines, they contact the provider and order a culture, then they put it onto the the Infection Surveillance Log. Not every symptom was tracked but was discussed during IDT every morning. They do not have documentation of discussing symptoms or looking for trends in illnesses which do not require antibiotics. RN-A stated the facility was getting a new charting system and should be able to track infections better. RN-A stated there was a lot to do, but they should be tracking the infections better.

The facility's Infection Surveillance policy dated 3/1/17, indicated the Infection Prevention and Control Officer (IPCO) or the designated infection control personnel will collect the following data on a daily log;
a. Identifying information (resident's name, room number, unit, and provider)
b. Admission date, date of onset of infection (list

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F 880	Continued From page 34 onset of symptoms, if known, or date of positive diagnostic test) c. Signs and Symptoms d. Infection Site (for example respiratory, left foot, gastro-instestinal, pressure ulcer) e. Identified Pathogen (date of diagnostic test) f. Risk factors or invasive procedures (surgery, indwelling tubes, fractured hip, altered mental status, etc...) g. If treated with an antibiotic (date/type/length of treatment.) h. Preventive measures and comments (interventions and steps taken that might have decreased risk, or would do so in the future) i. Resolution date, and if treatments used were effective.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement an antibiotic stewardship program which included development of protocols and a system to monitor antibiotic use, to ensure appropriate antibiotics were utilized to prevent antibiotic resistance. This deficient practice had the potential to affect all 46 residents who resided in	F 881	F881 1.Antibiotic stewardship. Root cause was a communication problem between shifts and between IPC we have hired numerous new staff and there has been a lapse in training. 2.IPC and DON reviewed Antibiotic stewardship policy. No changes made.	9/18/21

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F 881	Continued From page 35 the facility. Finding include: The facility form, Infection Surveillance Log tracked infections and antibiotic use included resident name, room number, date of onset, signs and symptoms, location/type of infection, identified pathogen, and treatments. The Infection Surveillance Log from May 2021, identified six antibiotics were prescribed. Two of the infections did not identify the pathogens. There was no evidence any of the antibiotics prescribed were reviewed for appropriate use. The Infection Surveillance Log from June 2021, identified six antibiotics were prescribed, one infection did not identify if an antibiotic was used but did indicate a culture was obtained and the pathogen was identified and the resident was hospitalized. Two of the infections did not identify the pathogen. There was no evidence any of the antibiotics prescribed were reviewed for appropriate use. The Infection Surveillance Log from July 2021, was requested but not received. The current ongoing Infection Surveillance Log from August 1 through August 19 2021, identified three antibiotics were prescribed for three UTI's. There was no evidence two of the three antibiotics prescribed were reviewed for appropriate use. During interview on 8/19/21, at 2:48 p.m. registered nurse (RN)-A stated she placed new antibiotic starts on the log once they were started	F 881	3.Developed and implemented a document on both sides for tracking signs and symptoms for both pods for residents and staff with. Also developed guideline as to what we need to track. Charting expectations were also discussed at the Staff meeting on -/15 & 9/16/21 4.Did Staff education on Antibiotic stewardship at 9/15 &9/16 staff meetings. Thiis is what is posted on the wings When a course of antibiotics is started there needs to be charting on every shift regarding the Signs symptom and any allergic response until the course of treatment is complete. And the 1 time follow up in 3 days after the course of TX . 5.DON or Designee will do a random audit or antibiotic charting 3 times a week for 3, 2 times a week for 3 weeks and I time a week for 3 weeks. 6.Results of the Audits will be shared with the next Quarterly QAPI committee meeting for further recommendations and further monitoring.	

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F 881	Continued From page 36 on an antibiotic. RN-A would check back in about three days and look for the cultures and sensitivities and compare it to what medication was ordered and then identify the pathogen on the tracker along with the sign and symptoms. If the culture came back as contaminated, they continued the same antibiotic as a repeat would be inaccurate due to being started on antibiotics and the providers did not like to repeat the culture once the residents were started on the medications. They would repeat the cultures once the resident was finished with the antibiotic, and if they were still having symptoms. The process for verifying the correct antibiotic was done with each infection; however, the process was not documented anywhere on the logs. The facility's Antibiotic Stewardship Program policy dated 6/5/17, identified the facility would assess appropriate diagnostic testing for various infections and evaluate the appropriateness of antibiotic per laboratory results. The infection control nurse and prescriber would conduct an antibiotic review process after and antibiotic is started, when the culture results are received, the nurse will contact the prescriber to review the results to ensure follow up on appropriate antibiotic therapy. The facility would implement a process to ensure that diagnostic testing, including microbiology results, are accessible in a timely manner for clinical decision making and infection surveillance.	F 881		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement	F 886		9/18/21

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F 886	Continued From page 37	F 886		

and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:

§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not
limited to:
(i) Testing frequency;
(ii) The identification of any individual specified in this paragraph diagnosed with
COVID-19 in the facility;
(iii) The identification of any individual specified in this paragraph with symptoms
consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the
transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate
to the resident's testing status), and the results of each test.

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F 886	Continued From page 38 §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide evidence of testing for unvaccinated staff who were required to have testing for COVID-19 according to the Centers for Disease Control (CDC) guidance for routine testing requirements. This deficient practice had the potential to affect all 46 residents residing in the facility Findings include: The CDC COVID-19 Nursing Home Data--County Positivity Rate from 6/8/21 through 7/27/21, identified Pennington County, Minnesota's COVID-19 positivity rate ranged from 0.00% through 1.7%. The facility provided testing logs identified: - 6/10/21, 14 of 27 unvaccinated staff did not	F 886	F886 1.covid-19 testing Root cause was IP and DON were not monitoring the missed tests 2.this could affect all residents in the facility. 3.Staff are expected to test and are notified of the dates by bright arrow and signs by the time clock, if the staff person misses a test date for a PCR test. Staff will come in and be tested by Rapid test. Rapid test are available in IPC office and in med rooms on both sides. A sign with the phone numbers of the pods will be available so they can call the nurse down to test at the door. Positive tests will be reported to DON and the Administrator immediately and that staff will not be allowed to work.	

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F 886	Continued From page 39 have evidence of monthly testing for COVID-19. - 7/8/21, 17 of 30 unvaccinated staff did not have evidence of monthly testing COVID-19. - 8/5/21, 16 of 36 unvaccinated staff did not have evidence of monthly testing COVID-19. During interview on 8/18/21, at 3:10 p.m. dietary aide (DA)-A stated they were unvaccinated and were not tested since June 2021. DA-A last worked 8/14/21, and 8/15/21. DA-A was casual on the schedule and worked two days every other weekend and had worked regularly since they were last tested. DA-A was waiting for the facility to contact them about the next testing time, but never received any information. During interview on 8/19/21, at 12:56 p.m. housekeeper (HSK)-A stated she was not vaccinated prior to the last routine testing on 8/5/21, and during the time she missed the routine testing; however, she was tested prior to returning to work. During interview on 8/19/21, at 1:03 p.m. nursing assistant (NA)-A stated they were unvaccinated and did not miss any routine testing. It was procedure if routine testing was missed the employee would need to have had a rapid COVID-19 test before starting their next shift. During interview on 8/19/21, at 3:00 p.m. registered nurse (RN)-A, who also was the infection preventionist, stated any employee who was unvaccinated needed to be tested routinely using CDC guidance. During the months of May, June and July of 2021, routine testing for unvaccinated employees was once a month. Staff who needed testing were notified by either a letter or a text message with the testing times. If staff	F 886	4.IP will monitor and report to Don if staff has not tested and they will be notified my Phone email or Test until a response is given. Options will be reinforced. 5.Don or Designee will audit 2 times a week for 12 weeks (this our testing schedule.) 6.Results of the Audits will be shared with the next Quarterly QAPI committee meeting for further recommendations and further monitoring.	

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missed the routine testing they would need to be rapid tested prior to their next shift. They monitored using a list of staff needing testing and as the staff came in on testing day a note would be made their name and identified the date they were tested. Currently the facility did not have a method of recording the staff who missed routine testing. RN-A stated they needed to have a better procedure for monitoring the rapid testing to identify staff who were tested and who would still need to be tested. She was unaware of any staff member who worked without testing and this posed a significant risk to the residents.

The facility's COVID-19 Testing Policy dated 8/3/21, identified routine staff testing for unvaccinated staff was to be done based on Center for Medicaid Services (CMS) data parameter for testing based on county prevalence in Minnesota. The policy also indicated for routine staff testing, documentation included the care center's county positivity rate and the date that testing was preformed for each staff and the results. Staff who miss or refuse testing may not work until routine testing was completed.

The CDC guidance People with Certain Medical Conditions dated 5/13/21, identified older adults were more likely to get seriously ill from COVID-19. More than 80 percent of COVID-19 deaths have occurred in people over the age of 65, and more than 95 percent of COVID-19 deaths have occurred in people older than 45. Further, among adults, the risk for severe illness from COVID-19 increases with age, with older adults at highest risk. Severe illness means that the person with COVID-19 may require hospitalization, intensive care, or a ventilator to help them breathe, or they may even die.

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F 886	Continued From page 41 CMS QSO 20-38-NH, revised 4/27/21, included routine testing of unvaccinated staff should be based on the extent of the virus in the community. Facilities should use their county positivity rate in the prior week as the trigger for staff testing frequency. The facility should test all unvaccinated staff at the frequency prescribed in the routine testing table based on the county positivity rate reported in the past week. Facilities should monitor their county positivity rate every other week (e.g., first and third Monday of every month) and adjust the frequency of performing staff testing according to the guidance. Routine Testing Intervals Vary by Community COVID-19 Activity Level...Low <5% once a month...Medium 5%-10% once a week...High >10% twice a week.	F 886		

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Thief River Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 Edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code (NFPA 99). THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/17/2021

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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
K 000	Continued From page 1 DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. This facility was inspected as one building: The Thief River Care Center is a 1-story building with no basement that was built in 2011 and was determined to be of Type II(000) construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING **02 - THEIF RIVER CARE CENTER NEW BLDG** B. WING _____	**08/18/2021**

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K 000	Continued From page 2 monitored for automatic fire department notification. The facility is protected throughout by a complete fire sprinkler system. The facility also has smoke detection throughout the corridors and spaces open to the corridors. The facility has a capacity of 70 beds. At the time of the survey the census was 46. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has failed to ensure that 2 of 12 monthly test/inspections of battery operated emergency lights in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 7.9.3.1.1 (1). This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/18/2021, at 11:42 AM, during the review of all available fire drill documentation and interview	K 291	K 291 ESD or designee will implement corrective action to prevent reoccurrence ESD and/or designee will implement measures to ensure this practice does not reoccur including: * ESD and ESD staff will be provided education on monthly testing of the battery operated emergency lights. * Testing will be completed by the ESD monthly and the testing forms will be reviewed by the administrator to ensure completion. * Monitoring will be reported to the Quality	9/29/21

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K 291	Continued From page 3 with the Maintenance Supervisor it was observed that the facility could not provide information or documentation for 2 of 12 monthly 30 second test/inspection for the batter powered emergency lights. This deficient condition was verified by the Maintenance Supervisor.	K 291	Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Environmental Services Director is responsible for the corrective actions and monitoring of compliance Completed Date: 9/29/2021	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2 and 19.7.1.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/18/2021, at 11:50 AM., during the review of all available fire drill documentation and interview	K 712	K 712 ESD or designee will implement corrective action to prevent reoccurrence ESD and/or designee will implement measures to ensure this practice does not reoccur including: * ESD and ESD staff will be provided education on proper variations of scheduling fire drills. * Audits will be completed for monitoring by the ESD and/or designee two times monthly to ensure future compliance.	9/29/21

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K 712	Continued From page 4 with the Maintenance Supervisor it was revealed that the facility failed to conduct 1 of 4 fire drills for the evening shift in the 4th quarter during the last 12 months. This deficient condition was verified by the Maintenance Supervisor.	K 712	These Audits will be reviewed by the administrator. * Monitoring will be reported to the Quality Assurance Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring. Environmental Services Director is responsible for the corrective actions and monitoring of compliance Completed Date: 9/29/2021	