DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Thief River Care Center

Facility Address:
2001 Eastwood Drive

Facility City:
Thief River Falls

State: Minnesota | **ZIP:** 56701 | **County:** Pennington

Report Number:
H5252025

Time of Visit:
9:30 a.m. to 4:00 p.m.
3:00 a.m. to 11:30 a.m.

Date of Visit:
November 1 and 2, 2017

Date Concluded:
January 10, 2018

Investigator's Name and Title:
Jane Aandal, RN, Special Investigator

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was neglected when the facility did not provide adequate assessment, monitoring and cares to prevent pressure ulcers. The resident sustained a pressure ulcer that lead to amputation of a limb. The resident also sustained additional pressure ulcers on the buttocks and back of head.

- ☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect occurred when the resident developed an unstageable (Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) left calf pressure ulcer. The pressure ulcer was avoidable and the resident required an above the knee amputation. In addition, the resident developed a pressure ulcer on his/her right calf, coccyx, buttocks, and back of head. The facility failed to adequately assess the resident when s/he developed pressure ulcers and implement additional interventions to minimize the risk of additional pressure ulcer development.

The resident was diagnosed with a stroke and was cognitively intact. The resident required extensive assistance with bed mobility and was dependent on staff for transfers. The resident was identified at risk for pressure ulcer development. The interventions included a turning program and a pressure-reducing mattress for the bed and chair. The resident's care plan indicated an every three-hour repositioning schedule.

One day, the facility documented on an appointment transfer sheet that the resident had an open area on the lower left leg. The physician described the area as eschar (black) associated with redness around it and diagnosed the area as a wound infection with surrounding cellulitis (infection of the tissue just below the skin). The physician prescribed cephalexin (an antibiotic) 250 milligrams three times a day for seven days. Six days later the dietitian assessed the resident and did not address the acquired left leg pressure ulcer.

Three days later the nurse documented on a form that was faxed to the resident's primary physician. The documentation indicated the resident had a wound on his/her left calf with eschar surrounded by cellulitis that was worsening. The wound measured 3 centimeters (cm) by 2 cm black, surrounded by black tissue that was not yet open for a size of 12 cm, around this was redness extending 2 cm. The physician returned the fax three days later and wanted the resident to be seen at the clinic. The resident was seen at the clinic and then brought to the emergency room. The physician completed ultrasound studies and the resident was noted to have decreased vascular flow of the lower extremities. The resident had an approximate 6 cm by 2 cm ulceration to the left calf and was transferred to a hospital for a vascular surgeon consult. The day after the resident was hospitalized the wound documentation indicated the resident had a pressure ulcer to the coccyx area measuring 1.2 cm by .2 cm by .1 cm partial thickness wound with a pink moist wound bed. The resident was hospitalized for ten days and required an above the knee amputation for the left calf pressure ulcer. The hospital discharge summary indicated the resident's left calf wound had probably been present for a few weeks.

The resident returned to the facility with a left stump dressing and intact skin. The resident had severe cognitive impairment and remained on an every three-hour repositioning schedule. The resident developed multiple superficial open areas to the buttocks 15 days later and a dressing was applied. Four days later the resident developed a pressure ulcer to the upper back of the head. The resident was seen at the clinic three days later. The physician documented the buttock ulcer and a right lower leg pressure ulcer measuring approximately 15 cm by 3 cm with a shallow abrasion on the scalp. The physician ordered every two hour repositioning, dressing changes to the buttocks and right calf, and antibiotic ointment to the scalp wound. The resident's care plan was not updated to reflect the every two-hour repositioning schedule. Two days later the resident developed a pressure ulcer on the coccyx.

Documentation indicated none of the resident's pressure ulcers were comprehensively assessed.

Family stated during an interview that they were concerned the resident did not receive timely repositioning.

Some staff stated during an interview that the resident did not receive timely repositioning due to staffing needs.

The vascular surgeon stated during interview that the resident's left calf was an unstageable pressure ulcer. S/he stated the pressure ulcer developed due to lack of repositioning and was avoidable. The surgeon stated the resident would not have required the above the knee amputation if the pressure ulcer had not developed. The surgeon stated the resident had vascular disease, however; there was no ischemic issues

(restriction in blood supply to tissues) going on with the left foot, which meant the vascular disease did not cause the wound. The surgeon stated the early stage coccyx pressure ulcer was also due to lack of repositioning.

The resident died approximately six weeks after the above the knee amputation.

The death certificate indicated the resident's cause of death was peripheral vascular disease, heart valve disease, and chronic kidney disease.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility failed to consistently implement a repositioning program. The facility failed to comprehensively assess the resident's pressure ulcers and implement appropriate interventions.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records

Other pertinent medical records:

[x] Hospital Records [x] Death Certificate

Additional facility records:

[x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Two

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A

Specify: Deceased

Interviews: The following interviews were conducted during the investigation:

Interview with reporter(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact reporter, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

○ Yes ◉ No ○ N/A Specify: Deceased

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Six

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Eleven

Physician Interviewed: ◉ Yes ○ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: Not Identified

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Wound Care
☒ Nursing Services
☒ Call Light
☒ Infection Control
☒ Facility Tour
☒ Incontinence

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Pennington County Medical Examiners

Thief River Falls Police Department

Pennington County Attorney

Thief River Falls City Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 16, 2018

Ms. Michele Halvorson, Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

RE: Project Number H5252025

Dear Ms. Halvorson:

On January 3, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective January 8, 2018. (42 CFR 488.422)

On January 3, 2108, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Civil money penalty for the deficiency cited at F314, effective December 15,2017. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on December 15, 2017 that included an investigation of complaint number H5252025 . The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On February 12, 2018, the Minnesota Department of Health , Office of Health Facililty Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on December 15, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 26, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of :

- Civil money penalty for the deficiency cited at F314 effective December 15, 2017. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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 _____	R-C 02/12/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A Post Certification revisit was conducted on February 12, 2018, to follow up on deficiencies issued related to complaint #H5252025. Thief River Care Center is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. 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.	{F 000}		

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

Electronically Signed | 02/20/2018

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.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 16, 2018

Ms. Michele Halvorson, Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

Re: Reinspection Results - Complaint Number H5252025

Dear Ms. Halvorson:

On February 12, 2018 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on December 15, 2017. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Please feel free to call me with any questions.

Sincerely,

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	R-C 02/12/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A licensing order follow-up was completed to follow up on correction orders issued related to complaint #H5252025. Thief River Care Center was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first	{2 000}		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/20/18

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	R-C 02/12/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Continued From page 1 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.	{2 000}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 3, 2018

Ms. Michele Halvorson, Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

RE: Project Number H5252025

Dear Ms. Halvorson:

On December 15, 2017, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: annette.m.winters@state.mn.us
Phone: (651) 201-4204
Fax: (651) 281-9796

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective January 8, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Per day civil money penalty at cited at F314 (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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, Office of Health Facility Complaints, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 15, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 June 15, 2018 (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 Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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 Fil

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5252025. As a result, the following deficiencies are issued. 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. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,	F 309		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 1 and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 1 resident (R3) reviewed for non-pressure related skin issues. In addition, the facility failed to comprehensively assess R3's open area according to the facility's policy. Findings include: R3's medical record was reviewed. R3's face sheet indicated R3 was diagnosed with a cerebral aneurysm (a weakened area in the wall of an artery in the brain). R3's cognitive assessment dated 9/5/17, indicated R3 was cognitively intact. R3's care plan reviewed 9/13/17, indicated R3 was to be repositioned every two hours and R3 would refuse at times as she prefers to lay on her back, encourage side to side. R3's tissue tolerance repositioning documentation dated 10/4/17, indicated R3 required every two hour repositioning to promote skin integrity. On 10/4/17, registered nurse (RN)-H documented that R3 had what appeared to be a pilonidal cyst to the inner portion of her buttock cheek	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 2 measuring approximately .2 centimeters (cm) deep. A dressing was applied to the area and the primary care provider was updated. On 10/11/17, R3 was seen by a surgeon and diagnosed with a natal cleft (the groove between the buttocks that runs just below sacrum to the perineum) open wound. The treatment orders were to pack the wound with gauze twice daily. R3's surgeon documentation on 10/11/17, indicated a mid cleft open wound which measured less than one centimeter with good granulation tissue. No evidence of cellulitis, bleeding or purulent drainage and was packed with a 2 x 2 gauze. R3's wound documentation dated 10/17/17, indicated R3's cyst was 1.2 cm by .5 cm by .3 cm. skin was blanchable, no odor was apparent, drainage consistency was thin, scant drainage was present, color was red-tinged, surrounding tissue was normal, skin tissue temperature was consistent with surrounding tissue. Area was cleaned with wound wash and packed with 2 x 2 wet to dry dressing. R3's next wound documentation was not completed until 10/27/17. The documentation indicated the cyst measured 1 cm by .3 cm by .3 cm. Continue to pack with wet to dry dressing per orders. According to the Bowel and Bladder Detailed Report (computer documentation), on 11/1/17, R3 was assisted with incontinence care at 9:15 p.m., however; the incontinence and reposition check handwritten sheet was documented as 10:30 p.m. On 11/2/17, according to the Bowel and Bladder	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 3 Detailed Report, R3 was assisted with incontinence care at 2:30 a.m. and 4:30 a.m. R3's wound documentation dated 11/2/17, indicated R3's site was cleaned with wound wash and packed with wet to dry dressings. The documentation did not give measurements of the wound. On 11/2/17, at 4:25 a.m. nursing assistant (NA)-Q and NA-R changed R3 who had been incontinent of urine and R3 received repositioning. R3's wound documentation dated 11/9/17, indicated the cyst measured .8 cm by .3 cm by .3 cm. An interview with NA-P was conducted on 11/2/17, at 4:59 a.m. NA-P stated she arrived at 10:35 p.m. and went into R3's room about 1:40 a.m. and R3 was on her back. NA-P stated she changed R3's brief and then licensed practical nurse (LPN)-S assisted her to boost R3 up in the bed. NA-P stated the previous repositioning for R3 would have been done by the evening staff between 10:30 p.m. and 11:00 p.m. NA-P stated R3 was to be repositioned every two hours. (3 hours & 10 minutes). An interview with NA-Q was conducted on 11/2/17, at 7:00 a.m. NA-Q stated there were night shifts when there was not enough time to get everything done. An interview with R3 was conducted on 11/2/17, at 11:15 a.m. R3 stated staff were the busiest prior to lunch, doing other things, and were not always available to reposition her.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 4 An interview with registered nurse (RN)-H was conducted on 11/16/17, at 3:02 p.m. RN-H stated it was her expectation that R3 would be repositioned every two hours. RN-H stated she had not done any recent audits of repositioning on her unit. RN-H stated if a RN did work on the evening or the night shift they would be responsible for passing medications. At 3:41 p.m. RN-H stated she would have to look at the policy to know how often the wound should be measured. An interview was conducted with the director of nursing (DON) on 12/12/17, at 9:25 a.m. The DON stated R3 was to be repositioned every two hours according to her care plan. R3 did like to lie on her back and was encouraged to turn side to side. The facility's repositioning policy reviewed 10/23/16, indicated all resident would be repositioned according to their individualized assessment. At shift change, the nursing assistants would communicate the actual time the resident was last repositioned to the oncoming shift so a seamless transition occurs and the resident's repositioning schedule would continue. The facility's Optimus for Skin policy updated 4/25/17, indicated if a new skin condition (open area) was identified, notify the wound nurse/nurse manager ASAP, initiate a tissue tolerance and complete a root cause analysis, a Braden scale, and weekly wound round documentation.	F 309		
F 314 SS=G	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1)	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 5 (b) Skin Integrity - (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 adequately assess residents who developed pressure ulcers and implement additional interventions to minimize the risk of additional pressure ulcer development for 2 of 2 residents (R1, R2) reviewed who developed pressure ulcers. R2 developed a right ear pressure ulcer. The failure of the facility to consistently implement a repositioning program, resulted in harm, when R1 acquired an unstageable pressure ulcer on the left leg which required an above the knee amputation. In addition, R1 developed a pressure ulcer on her right leg, a stage 2 pressure ulcer on her right buttocks, a pressure ulcer on her coccyx, and a pressure ulcer on the right side of her head. Findings include: R1's medical record was reviewed. R1's face	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 6 sheet indicated R1 was diagnosed with a stroke with left sided paralysis. R1's quarterly Minimum Data Set (MDS) dated 4/20/17, indicated R1 was cognitively intact, and required extensive assistance with bed mobility and was dependent on staff for transfers. R3 was identified at risk for development of pressure ulcers with no pressure ulcers noted. Interventions identified were a turning program and a pressure reducing mattress for the bed and chair. On 5/25/17, registered nurse (RN)-B documented on an appointment transfer sheet that R1 had not been feeling well, did not have much of an appetite the last couple of days, and had an open area on the lower left leg that required a diagnosis. The physician documented R1 had noticed a sore on her left leg. The physician described the area as eschar (black) associated with redness around it and diagnosed the area as a wound infection with surrounding cellulitis (an infection of the tissue just below the skin). The physician ordered cephalexin (an antibiotic) 250 milligrams three times a day for seven days. R1's dietary documentation by the dietitian dated 5/30/17, indicated R1 had an overall decline in eating and had lost nine pounds in the last 30 days. Nutritional supplements had been ordered in the past and R1 refused them. Continue to offer her favorite foods and provide encouragement at meals and snack time. R1's weight loss was not desirable and she was at higher nutritional risk. No new nutrition interventions recommended at this time. The documentation did not address the acquired left leg pressure ulcer.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 7 R1 lacked any further documentation from the dietitian when additional pressure ulcers developed. R1's care plan dated 6/1/17, indicated R1 was at risk for skin breakdown related to immobility. R1 was to be assisted with repositioning every three hours and as needed. On 6/2/17, registered nurse (RN)-N documented on a nurse communication form that was faxed to R1's primary physician. R1 had a wound on lateral left calf with eschar surrounded by cellulitis that was worsening. R1 was seen in urgent care by a physician on 5/25/17, and started on cephalexin for infection. Today the wound was 3 centimeters (cm) by 2 cm, black surrounded by black tissue that was not yet open for a size of 12 cm. Around this was redness extending 2 cm. It was painful. The physician sent the fax back to the facility on 6/5/17, and requested R1 be seen at the clinic. On 6/2/17, RN-N documented on R1's skin and wound log at 3:43 p.m. RN-N indicated the left middle calf was a new ulcer with cellulitis that was unable to be accurately staged due to slough and/or eschar 3 cm by 2 cm. The facility lacked any documentation that R1's left calf pressure ulcer wound had been comprehensively assessed. On 6/5/17, documentation from R1's physician indicated R1 was brought to the emergency department from the clinic for a left calf ulcer. Onset of the ulcer was unknown. R1 was noticed to have decreased vascular flow to the extremities and an arterial duplex ultrasound of the lower extremities as well as venous studies	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 8 were completed. R1 had an approximate 6 cm by 2 cm ulceration to her left calf. R1 was transferred to a hospital for a vascular surgeon consult. R1's hospital admission history and physical dated 6/5/17, indicated R1 had a left calf ulcer with unknown onset. R1 stated the wound started a few weeks ago. R1's vascular surgery consult documentation dated 6/5/17, indicated R1 had a left leg pressure ulcer and the left foot showed no sores or ulcers. R1 was diagnosed with an occlusion (blockage) of the left distal common femoral artery and the superficial femoral artery. R1's wound consult documentation dated 6/6/17, identified a lower left leg ulcer measuring 12 centimeters (cm) by 3 cm wound bed with black eschar and white non viable tissue, edges with deep maroon and dark purplish discoloration and tan-serosanguineous drainage. R1 had a pressure ulcer to the coccyx area measuring 1.2 centimeters (cm) by .2 cm by .1 cm partial thickness wound with a pink moist wound bed. The facility lacked any documentation that R1's coccyx pressure ulcer had been comprehensively assessed. R1's physician documentation dated 6/13/17, indicated R1 was diagnosed with a stable chronic deep vein thrombosis (blood clot in a vein) to the left lower extremity and a complete occlusion (blockage) to the left distal common femoral artery (gives oxygenated blood to the leg) and proximal superficial femoral artery. R1's hospital discharge summary dated 6/15/17, indicated R1's left calf wound had probably been	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 9	F 314		

present for a few weeks.

R1's nursing progress notes dated 6/15/17, documented by registered nurse (RN)-A indicated R1 returned from the hospital. R1 had a left above the knee amputation (AKA) due to circulatory issues. R1 had a dressing over the coccyx area that was removed and the area was clear. Will continue with good turning and repositioning.

R1's Braden Scale (a tool for predicting pressure ulcer risk) dated 6/21/17, indicated R1 was at moderate risk for pressure ulcer development.

R1's significant change MDS dated 6/22/17, indicated R1 had severe cognitive impairment, required extensive assistance with bed mobility and was dependent on staff for transfers.

R1's nursing progress notes dated 6/22/17, documented by RN-A, indicated R1 was to be repositioned every two to three hours with positioning pillows. However, R1's care plan still directed staff to reposition R1 every three hours.

R1's consent for hospice admission was dated 6/27/17.

R1's skin condition/wound progression documentation dated 6/30/17, was documented by licensed practical nurse (LPN)-J. New, first recording present on the right lower buttocks were superficial open areas. Skin was blanchable, no odor was apparent, no drainage was apparent. Multiple superficial open areas noted to buttocks. Applied Allevyn dressing times two for protection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 10 The facility lacked documentation that a RN was notified of the new open areas. The facility policy was not followed and a comprehensive assessment of the areas was not completed. R1's care plan dated 7/1/17, indicated R1 was at risk for skin breakdown related to immobility. R1 was to be assisted with repositioning every three hours and as needed. R1's skin condition/wound progression documentation dated 7/4/17, was documented by licensed practical nurse (LPN)-J. New, first recording, present on the upper back of the head was a reddened area. Skin was blanchable, no odor was apparent, no drainage was apparent. This wound was not present on admission. The facility lacked documentation that a RN was notified of the new area. The facility policy was not followed and a comprehensive assessment of the area was not completed. R1 was seen in the clinic on 7/7/17, by her primary physician. R1's family was concerned about a sore on her right lower leg that she had for the last week. R1's family was also concerned about a sore on her buttocks for the last couple of weeks and an area on her head for four days. R1's family was concerned R1 was not repositioned regularly. The physician documented the buttock ulcer and the right lower leg pressure ulcer measuring approximately 15 cm by 3 cm with a shallow abrasion on R1's scalp. The physician ordered R1 to be repositioned every two hours, mepilex dressing to buttocks pressure ulcer change daily and when soiled, mepilex dressing to right calf pressure ulcer, change every five days, triple antibiotic ointment to scalp	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 11 wound, and off load pressure from all wounds. The facility lacked documentation that a RN was notified of the new area. The facility policy was not followed and a comprehensive assessment of the area was not completed. R1's care plan was never updated to reflect the physican order to reposition every two hours. R1's skin condition/wound progression documentation dated 7/9/17, was documented by licensed practical nurse (LPN)-J. Present on the right buttocks were superficial open areas. Three open areas noted to resident's buttocks. Largest open area was on the coccyx. One small area to each buttock. The facility lacked any documentation that R1's coccyx pressure ulcer had been comprehensively assessed. R1's skin condition/wound progression documentation dated 7/10/17, was documented by RN-G. Present on the right lower buttocks was superficial open areas. Stage 2, skin was not blanchable, no odor was apparent, drainage consistency was thin, scan drainage was present, color was yellow. The wound was not present on admission. This site had a round open area in the middle. It was a stage 2, base was red with some scant amount of yellow slough. The dressing applied was foam. It was placed over the coccyx to protect the site. Resident had very poor circulation, abnormal labs including albumin level, and was currently a hospice patient. She had orders to reposition every two hours and had repositioning pillows, and a soft neck pillow. She did report pain with repositioning.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 12 R1's death certificate dated 7/16/17, indicated R1's cause of death was chronic peripheral vascular disease, heart valve disease, and chronic kidney disease. An interview was conducted with NA-D on 11/1/17, at 12:35 p.m. NA-D stated she observed R1's left calf area to be black, dry, and deep purple in color. NA-D stated after a couple of days the left calf was open and NA-D would place a pillow under the left calf and heel. NA-D stated after the left leg amputation, R1 developed a sore on her right calf that was purple, black, and then doubled in size. NA-D stated R1 then developed a red area on the side of her head that was open and bleeding. NA-D stated the area on R1's head was touching the pillow, so she would roll up a towel to prop under R1's head. NA-D stated they reported the area on R1's head to the nurses and it took a few days before that information was documented on the 24 hour report. NA-D stated when R1 developed the open area on her left calf, she had told the nurses for a week before the nurses were talking about the area. NA-D also stated the report between the nurses and the NA's needed to improve. NA-D stated repositioning was not getting done timely and it could be 30-45 minutes later due to staffing needs. NA-D stated the NAs receive a sheet of information about the residents, however; NA-D stated it was not the resident's full care plan. NA-D stated the resident's care plan was to be posted in their closet and that was not happening. NA-D stated the NA's can't improve the situation without the proper staffing and more education. An interview was conducted with registered nurse (RN)-B on 11/1/17, at 2:28 p.m. RN-B stated on bath day, the NA and the nurse would look at the	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 13	F 314		

resident's skin. Also, if the NA's would notice a skin issue they would notify the nurse. RN-B stated the nurses have a 24 hour report they use to report to the next shift. RN-B stated the director of nursing indicated there was a high resident acuity and the NA's have a heavy resident assignment.

An interview was conducted with RN-A on 11/1/17, at 3:07 p.m. RN-A verified the only skin documentation for R1's left calf was on the clinic appointment sheet when R1 saw the physician. At 3:36 p.m. RN-A stated when R1 returned from the hospital on 6/15/17, her skin was intact. RN-A stated the RN's would look at any skin issues.

An interview was conducted with RN-B on 11/2/17, 8:44 a.m. RN-B stated R1's left calf should have been documented on the skin and wound log per policy. RN-B stated R1 was changed to an hourly repositioning schedule on 7/7/17. RN-B verified the hourly repositioning was never documented in R1's medical record.

An interview with family member (FM)-L was conducted on 11/15/17, at 5:03 p.m. FM-L stated three to four months prior to R1's death she did not want to get up so the facility did not get her up for meals. FM-L stated when R1 developed the sore on her left calf, the facility stated it had been there for a couple of days. FM-L stated the physician told family the left calf pressure ulcer had been there for 2-1/2 to 3 weeks. FM-L stated shortly after the left leg amputation, we noticed an area on her right leg. FM-L stated R1 had a big sore on her head from not being moved. FM-L stated the NA's were reporting R1's left leg to superiors and it was getting brushed off.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 14 An interview with LPN-J was conducted on 11/16/17, at 10:03 a.m. LPN-J stated there was a suspicious area on R1's left extremity that was monitored for quite awhile. LPN-J stated R1 would get suspicious areas quickly when there was any pressure on her skin and it would start breaking down. LPN-J stated the repositioning would make the areas go away. LPN-J stated any area of R1's skin that touched the bed would become red in minutes. LPN-J stated the RN should assess the open area within the same shift. LPN-J stated she did not document when she reported R1's skin areas to the RN. LPN-J stated the charting falls between the cracks. LPN-J stated there was no documentation to identify when staff would have provided repositioning for R1. LPN-J stated she observed R1's right leg and it looked like something more than a scab. LPN-J stated she had reported R1's right leg area to the RN. An interview with nursing assistant (NA)-I was conducted on 11/16/17, at 10:37 a.m. NA-I stated R1 was to be repositioned every two to three hours. NA-I stated towards the end of R1's life possibly the beginning of June the repositioning schedule was to be hourly. NA-I stated she did not know how R1 developed the sore on her head. NA-I stated the pillow may have caused more pressure and my feeling was that it was realized a little to late. NA-I stated they took a piece of wool and made it into a neck pillow. NA-I stated after they stopped using a pillow the sore did not get any bigger. An interview with RN-G was conducted on 11/16/17, at 11:27 a.m. RN-G stated she should have measured the coccyx area and the stage 2 pressure ulcer on the right buttocks. RN-G stated	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 15 her and RN-S had looked at R1's right leg. RN-G stated she was working on the medication cart that day and RN-T had updated the physician. RN-G stated she was not sure why the RN's were not assessing R1's wounds as nurses were aware of the areas. RN-G stated there were frequent discussions of R1's skin issues, however; the documentation was not put in writing. An interview with medical doctor MD-N was conducted on 11/29/17, at 1:07 p.m. The physician who was R1's vascular surgeon stated the wound on R1's left calf was an unstageable (a full thickness tissue loss in which the base of the ulcer was covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) pressure ulcer. MD-N stated the pressure ulcer developed due to lack of repositioning and was avoidable. MD-N also stated R1 would not have required the left above the knee amputation if the pressure ulcer would not have occurred. MD-N stated the standard of care when a wound was identified was to measure the wound, assess, and monitor to determine improvement or worsening of the wound. MD-N stated R1 had vascular disease, however; there was no ischemic issues (restriction in blood supply to tissues) going on with the left foot which meant the vascular disease did not cause the wound. MD-N stated R1 also had developed an early stage pressure ulcer on her coccyx that was due to lack of repositioning. An interview was conducted with FM-M on 12/6/17, at 4:32 p.m. FM-M stated he would visit R1 between 3:30 p.m. and 6:00 p.m. FM-M stated when R1 would put her call light on to be changed	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 16 or repositioned it would take from 20-25 minutes for the call light to be answered. FM-M stated this occurred on several occasions. FM-M stated the ulcer that developed on R1's left leg should have been addressed sooner. FM-M stated when R1 saw the surgeon, the surgeon looked shocked. FM-M stated the ulcer did not develop overnight. An interview was conducted with the director of nursing (DON) on 12/6/17, at 1:41 p.m. The DON indicated R1 would have been repositioned according to her care plan since there was documentation of a tissue tolerance being completed. An interview was conducted with the DON on 12/12/17, at 9:28 a.m. The DON stated during this time frame there would be no documentation of when the nursing assistants (NAs) repositioned R1. The DON stated the NAs would use their caregiver sheets and reposition per the schedule. The DON stated she had no concerns that the NAs did not have time to reposition R1. The DON stated there was no documentation that R1's skin was checked on bath day and their current policy did not require documentation. The DON stated the hospice staff ordered an air mattress for R1 on 7/3/17, however; there was no documentation it was ever placed. The DON stated she was frustrated that she could not find the lacking documentation in the medical record. R2's medical record was reviewed. R2's face sheet indicated R2 was diagnosed with a stroke and rheumatoid arthritis. During observiations on 11/2/17, at 3:19 a.m., R2 was asleep in bed with her right ear directly on the pillow. At 3:42 a.m. R2 remained the same. At	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 17 4:15 p.m. R2 remained asleep with her right ear directly on the pillow. At 4:39 a.m. NA-Q placed the bedpan for R2. R2 was positioned on her back. At 4:50 p.m. NA-R entered the room and took R2 off the bedpan. At this time, NA-R asked R2 how she wanted to be positioned and R2 requested to lay on her right side again. NA-Q did not educate R2 that she would once again be lying directly on her right ear. R2 was positioned on her right side. During observations on 11/2/17, at 6:30 a.m., R2 remained on her right side with her ear directly on the pillow. At 6:44 a.m. NA-Q and NA-R positioned R2 on her left side. R2's annual Minimum Data Set (MDS) dated 8/2/17, indicated R2 was cognitively intact and required extensive assistance with bed mobility. R2's care plan reviewed 8/9/17, indicated R2 was to be repositioned every two hours. Reposition side to side and limit/avoid repositioning on back. R2's nursing progress notes dated 10/18/17, documented by registered nurse (RN)-G indicated R2's right ear pressure ulcer measured 1.3 centimeters (cm) by .1 cm. 100% eschar (black). The physician was notified of the present status. R2's physican order dated 10/18/17, directed staff to apply silvasorb gel to R2's right ear one time daily. R2's nurse communication fax dated 10/18/17, written to the physician indicated R2 had a .1 cm by 1.4 cm stage 2 area to the right outer ear cartilage. On 10/20/17, the physician responded	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 18 that R2 should be seen un the clinic. R2's Braden scale (a tool for predicting pressure ulcer risk) dated 10/25/17, (7 days late) indicated R2 was at low risk for pressure ulcer development. R2's documentation dated 10/25/17, indicated the right ear pressure ulcer measured .8 cm by .5 cm by .1 cm. Continue with silvasorb gel and Allevyn dressing. Skin was blanchable, no odor was apparent, drainage consistency was thin, scant drainage was present, color was clear. Pink wound base was 75%, yellow wound base was 25%, granulation tissue was 75%, slough tissue was 25%, surrounding tissue was normal, mucous membranes were moist and pink, skin turgor was fair. R2's tissue tolerance repositioning observation dated 10/31/17, (13 days late) indicated R2 required repositioning every two hours. R2's care plan reviewed 11/1/17, indicated R2 was to be repositioned every two hours. Reposition side to side and limit/avoid repositioning on back. The care plan did not address R2's right ear pressure ulcer. R2's Braden scale dated 11/2/17, indicated R2 was at moderate risk for pressure ulcer development. R2's documentation dated 11/2/17, indicated the right ear pressure ulcer measured 3 cm by .2 cm by .2 cm. Skin was blanchable, no odor was present, drainage consistency was thick, scant drainage was present, color was yellow. The physician was notified of the present status of the	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 19 site, wound base was not visible. Yellow wound base was 100%, slough tissue was 100%. The wound was measured today, ear cleansed with wound wash, silvasorb gel applied and covered with dressing. Tissue tolerance completed, resident was to be repositioned every two hours, Braden score was 14 (moderate risk 13-14). Resident had a history of stroke affecting the right side, head would lie to right side and the ear flap caused pressure to the cartilage area. Resident was encouraged to lie on the left side, continue to reposition every two hours per the tissue tolerance. New mattress custom care air. Arginaid (liquid vitamin supplement) was started on 11/2/17. R2's skin progress note date 11/15/17, indicated R2's right ear was cleansed with soap and water, patted dry, scab was present over the site, and left open to air. The neck pillow was in place and the resident was educated on the importance of keeping her ear elevated off of the pillow to relieve pressure. The resident indicated understanding. An interview was conducted with nursing assistant (NA)-D on 11/1/17, at 12:35 p.m. NA-D stated R2 stayed in bed all the time. NA-D stated if R2 was repositioned the area on her right ear would not have developed. An interview was conducted with NA-P on 11/2/17, at 4:59 a.m. NA-P stated she placed R2 on the bedpan at 12:30 a.m. and then R2 was positioned on her right side. An interview was conducted with R2 on 11/2/17, at 11:02 a.m. R2 stated she did not know how she had developed the right ear sore. R2 stated the staff did not tell her the importance of not	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 20 being positioned on her right side. R2 stated she had not been offered a neck pillow and would be willing to try it. An interview was conducted with NA-K on 11/16/17, at 11:04 a.m. NA-K stated R2 had an area on her right ear. NA-K stated R2 had a neck pillow and she was unsure if the neck pillow was supposed to be used. An interview was conducted with RN-H on 11/16/17, at 3:17 p.m. RN-H stated R2's pressure ulcer developed on 10/18/17 to her right ear. RN-H stated the root cause analysis was not completed until 11/2/17, and should have been done on 10/18/17. RN-H stated R2 would rest her head to the right side. RN-H stated last week there was an interdisciplinary team meeting and that was not documented in the medical record. RN-H stated R2's ear was not healing, and they had tried a sheepskin on her regular pillow for 5-7 days with no improvement. RN-H stated on 11/9/17, R2's family was contacted and they brought in a neck pillow. RN-H stated the neck pillow helped to heal the ear and the physician discontinued the dressing change on 11/14/17. An interview was conducted with the director of nursing (DON) on 12/12/17, at 9:06 a.m. The DON stated R2 had a lot of pain related to her rheumatoid arthritis and therefore chose to be bedridden. The DON stated R2 was to repositioned every two hours and she would push herself back onto her back when side lying. The DON stated they tried using other pillows to brace R3 and rolled up blankets, and when the right ear had no healing they requested a neck pillow from the family. The DON verified R3's ear pressure ulcer and interventions were not addressed on	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 21 the care plan. The DON stated the nursing assistant care guides were not saved, so there was no documentation to identify if the nursing assistants knew R3's interventions. The facility's Skin Ulcer Protocol policy updated 11/7/16, indicated residents would not develop pressure ulcers unless it was clinically unavoidable and appropriate care and services would be provided to prevent, treat, and monitor progress of all healing ulcers. When an open area developed the following measures would be implemented. A. Report all open skin ulcers to the facility wound nurse. B. Remove source of any possible pressure or trauma. C. Keep area dry and clean. D. Refer to Dietitian for nutritional needs as needed. E. Improve circulation by changing position frequently. F. Repeat Tissue Tolerance (turn/reposition program according to results) G. Repeat Braden scale (address all identified areas-Care plan). H. Review all current interventions to ensure they remain appropriate including pressure relieving/reducing devices. I. Provide wound cares as indicated by facility wound care guidelines, wound care nurse recommendations and physician orders. Wound nurse to complete a Root Cause Analysis of any new skin issue. Daily documentation to address the following: an evaluation of the ulcer, if no dressing present, an evaluation of the status of the dressing (intact, or drainage), the status of the tissue surrounding the ulcer, the presence of possible complications, such as increasing size or infection, and presence of pain before, during and after dressing change. At a minimum weekly wound round documentation to include the following: A. type of wound. B. stage or classification. C. measurements. D. exudate. E. presence of pain. F. wound base tissue. G.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 22 description of wound edges and surrounding tissue. H. Interventions in place. I. Current treatment and response to treatment. J. Track wound status.	F 314		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 3, 2018

Ms. Michele Halvorson, Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

Re: State Nursing Home Licensing Orders - Complaint Number H5252025

Dear Ms. Halvorson:

A complaint investigation was completed on December 15, 2017. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the licensing order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited violation. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the violation within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the enclosed Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: annette.m.winters@state.mn.us
Phone: (651) 201-4204
Fax: (651) 281-9796

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5252025. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 1 resident (R3) reviewed for non-pressure related skin issues. In addition, the facility failed to comprehensively assess R3's open area according to the facility's policy.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 2 Findings include: R3's medical record was reviewed. R3's face sheet indicated R3 was diagnosed with a cerebral aneurysm (a weakened area in the wall of an artery in the brain). R3's cognitive assessment dated 9/5/17, indicated R3 was cognitively intact. R3's care plan reviewed 9/13/17, indicated R3 was to be repositioned every two hours and R3 would refuse at times as she prefers to lay on her back, encourage side to side. R3's tissue tolerance repositioning documentation dated 10/4/17, indicated R3 required every two hour repositioning to promote skin integrity. On 10/4/17, registered nurse (RN)-H documented that R3 had what appeared to be a pilonidal cyst to the inner portion of her buttock cheek measuring approximately .2 centimeters (cm) deep. A dressing was applied to the area and the primary care provider was updated. On 10/11/17, R3 was seen by a surgeon and diagnosed with a natal cleft (the groove between the buttocks that runs just below sacrum to the perineum) open wound. The treatment orders were to pack the wound with gauze twice daily. R3's surgeon documentation on 10/11/17, indicated a mid cleft open wound which measured less than one centimeter with good granulation tissue. No evidence of cellulitis, bleeding or purulent drainage and was packed with a 2 x 2 gauze.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 R3's wound documentation dated 10/17/17, indicated R3's cyst was 1.2 cm by .5 cm by .3 cm. skin was blanchable, no odor was apparent, drainage consistency was thin, scant drainage was present, color was red-tinged, surrounding tissue was normal, skin tissue temperature was consistent with surrounding tissue. Area was cleaned with wound wash and packed with 2 x 2 wet to dry dressing. R3's next wound documentation was not completed until 10/27/17, (3 days late). The documentation indicated the cyst measured 1 cm by .3 cm by .3 cm. Continue to pack with wet to dry dressing per orders. According to the Bowel and Bladder Detailed Report (computer documentation), on 11/1/17, R3 was assisted with incontinence care at 9:15 p.m., however; the incontinence and reposition check handwritten sheet was documented as 10:30 p.m. On 11/2/17, according to the Bowel and Bladder Detailed Report, R3 was assisted with incontinence care at 2:30 a.m. and 4:30 a.m. R3's wound documentation dated 11/2/17, indicated R3's site was cleaned with wound wash and packed with wet to dry dressings. The documentation did not give measurements of the wound. On 11/2/17, at 4:25 a.m. nursing assistant (NA)-Q and NA-R changed R3 who had been incontinent of urine and R3 received repositioning. An interview with NA-P was conducted on 11/2/17, at 4:59 a.m. NA-P stated she arrived at 10:35 p.m. and went into R3's room about 1:40 a.m. and R3 was on her back. NA-P stated she changed R3's brief and then licensed practical	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 4 nurse (LPN)-S assisted her to boost R3 up in the bed. NA-P stated the previous repositioning for R3 would have been done by the evening staff between 10:30 p.m. and 11:00 p.m. NA-P stated R3 was to be repositioned every two hours. (3 hours & 10 minutes). An interview with NA-Q was conducted on 11/2/17, at 7:00 a.m. NA-Q stated there were night shifts when there was not enough time to get everything done. An interview with R3 was conducted on 11/2/17, at 11:15 a.m. R3 stated staff were the busiest prior to lunch, doing other things, and were not always available to reposition her. R3's wound documentation dated 11/9/17, indicated the cyst measured .8 cm by .3 cm by .3 cm. An interview with registered nurse (RN)-H was conducted on 11/16/17, at 3:02 p.m. RN-H stated it was her expectation that R3 would be repositioned every two hours. RN-H stated she had not done any recent audits of repositioning on her unit. RN-H stated if a RN did work on the evening or the night shift they would be responsible for passing medications. At 3:41 p.m. RN-H stated she would have to look at the policy to know how often the wound should be measured. An interview was conducted with the director of nursing (DON) on 12/12/17, at 9:25 a.m. The DON stated R3 was to be repositioned every two hours according to her care plan. R3 did like to lie on her back and was encouraged to turn side to side.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 The facility's repositioning policy reviewed 10/23/16, indicated all resident would be repositioned according to their individualized assessment. At shift change, the nursing assistants would communicate the actual time the resident was last repositioned to the oncoming shift so a seamless transition occurs and the resident's repositioning schedule would continue. The facility's Optimus for Skin policy updated 4/25/17, indicated if a new skin condition (open area) was identified, notify the wound nurse/nurse manager ASAP, initiate a tissue tolerance and complete a root cause analysis, a Braden scale, and weekly wound round documentation. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could establish a system to audit resident repositioning. The director of nursing could provide staff education related to the care of residents related to turning and repositioning. The quality assessment and assurance committee could audit care to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 6 pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately assess residents who developed pressure ulcers and implement additional interventions to minimize the risk of additional pressure ulcer development for 2 of 2 residents (R1, R2) reviewed who developed pressure ulcers. R2 developed a right ear pressure ulcer. The failure of the facility to consistently implement a repositioning program, resulted in harm, when R1 acquired an unstageable pressure ulcer on the left leg which required an above the knee amputation. In addition, R1 developed a pressure ulcer on her right leg, a stage 2 pressure ulcer on her right buttocks, a pressure ulcer on her coccyx, and a pressure ulcer on the right side of her head. Findings include: R1's medical record was reviewed. R1's face sheet indicated R1 was diagnosed with a stroke with left sided paralysis. R1's quarterly Minimum Data Set (MDS) dated 4/20/17, indicated R1 was cognitively intact, and required extensive assistance with bed mobility and was dependent on staff for transfers. R3 was identified at risk for development of pressure	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 7 ulcers with no pressure ulcers noted. Interventions identified were a turning program and a pressure reducing mattress for the bed and chair. On 5/25/17, registered nurse (RN)-B documented on an appointment transfer sheet that R1 had not been feeling well, did not have much of an appetite the last couple of days, and had an open area on the lower left leg that required a diagnosis. The physician documented R1 had noticed a sore on her left leg. The physician described the area as eschar (black) associated with redness around it and diagnosed the area as a wound infection with surrounding cellulitis (an infection of the tissue just below the skin). The physician ordered cephalexin (an antibiotic) 250 milligrams three times a day for seven days. R1's dietary documentation by the dietitian dated 5/30/17, indicated R1 had an overall decline in eating and had lost nine pounds in the last 30 days. Nutritional supplements had been ordered in the past and R1 refused them. Continue to offer her favorite foods and provide encouragement at meals and snack time. R1's weight loss was not desirable and she was at higher nutritional risk. No new nutrition interventions recommended at this time. The documentation did not address the acquired left leg pressure ulcer. R1 lacked any further documentation from the dietitian when additional pressure ulcers developed. R1's care plan dated 6/1/17, indicated R1 was at risk for skin breakdown related to immobility. R1 was to be assisted with repositioning every three hours and as needed.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 8 On 6/2/17, registered nurse (RN)-N documented on a nurse communication form that was faxed to R1's primary physician. R1 had a wound on lateral left calf with eschar surrounded by cellulitis that was worsening. R1 was seen in urgent care by a physician on 5/25/17, and started on cephalexin for infection. Today the wound was 3 centimeters (cm) by 2 cm, black surrounded by black tissue that was not yet open for a size of 12 cm. Around this was redness extending 2 cm. It was painful. The physician sent the fax back to the facility on 6/5/17, and requested R1 be seen at the clinic. On 6/2/17, RN-N documented on R1's skin and wound log at 3:43 p.m. RN-N indicated the left middle calf was a new ulcer with cellulitis that was unable to be accurately staged due to slough and/or eschar 3 cm by 2 cm. The facility lacked any documentation that R1's left calf pressure ulcer wound had been comprehensively assessed. On 6/5/17, documentation from R1's physician indicated R1 was brought to the emergency department from the clinic for a left calf ulcer. Onset of the ulcer was unknown. R1 was noticed to have decreased vascular flow to the extremities and an arterial duplex ultrasound of the lower extremities as well as venous studies were completed. R1 had an approximate 6 cm by 2 cm ulceration to her left calf. R1 was transferred to a hospital for a vascular surgeon consult. R1's hospital admission history and physical dated 6/5/17, indicated R1 had a left calf ulcer with unknown onset. R1 stated the wound started a few weeks ago. R1's vascular surgery consult documentation dated 6/5/17, indicated R1 had a	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 9 left leg pressure ulcer and the left foot showed no sores or ulcers. R1 was diagnosed with an occlusion (blockage) of the left distal common femoral artery and the superficial femoral artery. R1's wound consult documentation dated 6/6/17, identified a lower left leg ulcer measuring 12 centimeters (cm) by 3 cm wound bed with black eschar and white non viable tissue, edges with deep maroon and dark purplish discoloration and tan-serosanguineous drainage. R1 had a pressure ulcer to the coccyx area measuring 1.2 centimeters (cm) by .2 cm by .1 cm partial thickness wound with a pink moist wound bed. The facility lacked any documentation that R1's coccyx pressure ulcer had been comprehensively assessed. R1's physician documentation dated 6/13/17, indicated R1 was diagnosed with a stable chronic deep vein thrombosis (blood clot in a vein) to the left lower extremity and a complete occlusion (blockage) to the left distal common femoral artery (gives oxygenated blood to the leg) and proximal superficial femoral artery. R1's hospital discharge summary dated 6/15/17, indicated R1's left calf wound had probably been present for a few weeks. R1's nursing progress notes dated 6/15/17, documented by registered nurse (RN)-A indicated R1 returned from the hospital. R1 had a left above the knee amputation (AKA) due to circulatory issues. R1 had a dressing over the coccyx area that was removed and the area was clear. Will continue with good turning and repositioning.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 10 R1's Braden Scale (a tool for predicting pressure ulcer risk) dated 6/21/17, indicated R1 was at moderate risk for pressure ulcer development. R1's significant change MDS dated 6/22/17, indicated R1 had severe cognitive impairment, required extensive assistance with bed mobility and was dependent on staff for transfers. R1's nursing progress notes dated 6/22/17, documented by RN-A, indicated R1 was to be repositioned every two to three hours with positioning pillows. However, R1's care plan still directed staff to reposition R1 every three hours. R1's consent for hospice admission was dated 6/27/17. R1's skin condition/wound progression documentation dated 6/30/17, was documented by licensed practical nurse (LPN)-J. New, first recording present on the right lower buttocks were superficial open areas. Skin was blanchable, no odor was apparent, no drainage was apparent. Multiple superficial open areas noted to buttocks. Applied Allevyn dressing times two for protection. The facility lacked documentation that a RN was notified of the new open areas. The facility policy was not followed and a comprehensive assessment of the areas was not completed. R1's care plan dated 7/1/17, indicated R1 was at risk for skin breakdown related to immobility. R1 was to be assisted with repositioning every three hours and as needed. R1's skin condition/wound progression documentation dated 7/4/17, was documented by	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 11 licensed practical nurse (LPN)-J. New, first recording, present on the upper back of the head was a reddened area. Skin was blanchable, no odor was apparent, no drainage was apparent. This wound was not present on admission. The facility lacked documentation that a RN was notified of the new area. The facility policy was not followed and a comprehensive assessment of the area was not completed. R1 was seen in the clinic on 7/7/17, by her primary physician. R1's family was concerned about a sore on her right lower leg that she had for the last week. R1's family was also concerned about a sore on her buttocks for the last couple of weeks and an area on her head for four days. R1's family was concerned R1 was not repositioned regularly. The physician documented the buttock ulcer and the right lower leg pressure ulcer measuring approximately 15 cm by 3 cm with a shallow abrasion on R1's scalp. The physician ordered R1 to be repositioned every two hours, mepilex dressing to buttocks pressure ulcer change daily and when soiled, mepilex dressing to right calf pressure ulcer, change every five days, triple antibiotic ointment to scalp wound, and off load pressure from all wounds. The facility lacked documentation that a RN was notified of the new area. The facility policy was not followed and a comprehensive assessment of the area was not completed. R1's care plan was never updated to reflect the physican order to reposition every two hours. R1's skin condition/wound progression documentation dated 7/9/17, was documented by licensed practical nurse (LPN)-J. Present on the right buttocks were superficial open areas. Three	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 12 open areas noted to resident's buttocks. Largest open area was on the coccyx. One small area to each buttock. The facility lacked any documentation that R1's coccyx pressure ulcer had been comprehensively assessed. R1's skin condition/wound progression documentation dated 7/10/17, was documented by RN-G. Present on the right lower buttocks was superficial open areas. Stage 2, skin was not blanchable, no odor was apparent, drainage consistency was thin, scan drainage was present, color was yellow. The wound was not present on admission. This site had a round open area in the middle. It was a stage 2, base was red with some scant amount of yellow slough. The dressing applied was foam. It was placed over the coccyx to protect the site. Resident had very poor circulation, abnormal labs including albumin level, and was currently a hospice patient. She had orders to reposition every two hours and had repositioning pillows, and a soft neck pillow. She did report pain with repositioning. R1's death certificate dated 7/16/17, indicated R1's cause of death was chronic peripheral vascular disease, heart valve disease, and chronic kidney disease. An interview was conducted with NA-D on 11/1/17, at 12:35 p.m. NA-D stated she observed R1's left calf area to be black, dry, and deep purple in color. NA-D stated after a couple of days the left calf was open and NA-D would place a pillow under the left calf and heel. NA-D stated after the left leg amputation, R1 developed a sore on her right calf that was purple, black, and then doubled in size. NA-D stated R1 then developed	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 13 a red area on the side of her head that was open and bleeding. NA-D stated the area on R1's head was touching the pillow, so she would roll up a towel to prop under R1's head. NA-D stated they reported the area on R1's head to the nurses and it took a few days before that information was documented on the 24 hour report. NA-D stated when R1 developed the open area on her left calf, she had told the nurses for a week before the nurses were talking about the area. NA-D also stated the report between the nurses and the NA's needed to improve. NA-D stated repositioning was not getting done timely and it could be 30-45 minutes later due to staffing needs. NA-D stated the NAs receive a sheet of information about the residents, however; NA-D stated it was not the resident's full care plan. NA-D stated the resident's care plan was to be posted in their closet and that was not happening. NA-D stated the NA's can't improve the situation without the proper staffing and more education. An interview was conducted with registered nurse (RN)-B on 11/1/17, at 2:28 p.m. RN-B stated on bath day, the NA and the nurse would look at the resident's skin. Also, if the NA's would notice a skin issue they would notify the nurse. RN-B stated the nurses have a 24 hour report they use to report to the next shift. RN-B stated the director of nursing indicated there was a high resident acuity and the NA's have a heavy resident assignment. An interview was conducted with RN-A on 11/1/17, at 3:07 p.m. RN-A verified the only skin documentation for R1's left calf was on the clinic appointment sheet when R1 saw the physician. At 3:36 p.m. RN-A stated when R1 returned from the hospital on 6/15/17, her skin was intact. RN-A stated the RN's would look at any skin issues.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 14 An interview was conducted with RN-B on 11/2/17, 8:44 a.m. RN-B stated R1's left calf should have been documented on the skin and wound log per policy. RN-B stated R1 was changed to an hourly repositioning schedule on 7/7/17. RN-B verified the hourly repositioning was never documented in R1's medical record. An interview with family member (FM)-L was conducted on 11/15/17, at 5:03 p.m. FM-L stated three to four months prior to R1's death she did not want to get up so the facility did not get her up for meals. FM-L stated when R1 developed the sore on her left calf, the facility stated it had been there for a couple of days. FM-L stated the physician told family the left calf pressure ulcer had been there for 2-1/2 to 3 weeks. FM-L stated shortly after the left leg amputation, we noticed an area on her right leg. FM-L stated R1 had a big sore on her head from not being moved. FM-L stated the NA's were reporting R1's left leg to superiors and it was getting brushed off. An interview with LPN-J was conducted on 11/16/17, at 10:03 a.m. LPN-J stated there was a suspicious area on R1's left extremity that was monitored for quite awhile. LPN-J stated R1 would get suspicious areas quickly when there was any pressure on her skin and it would start breaking down. LPN-J stated the repositioning would make the areas go away. LPN-J stated any area of R1's skin that touched the bed would become red in minutes. LPN-J stated the RN should assess the open area within the same shift. LPN-J stated she did not document when she reported R1's skin areas to the RN. LPN-J stated the charting falls between the cracks. LPN-J stated there was no documentation to identify when staff would have provided	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 15 repositioning for R1. LPN-J stated she observed R1's right leg and it looked like something more than a scab. LPN-J stated she had reported R1's right leg area to the RN. An interview with nursing assistant (NA)-I was conducted on 11/16/17, at 10:37 a.m. NA-I stated R1 was to be repositioned every two to three hours. NA-I stated towards the end of R1's life possibly the beginning of June the repositioning schedule was to be hourly. NA-I stated she did not know how R1 developed the sore on her head. NA-I stated the pillow may have caused more pressure and my feeling was that it was realized a little to late. NA-I stated they took a piece of wool and made it into a neck pillow. NA-I stated after they stopped using a pillow the sore did not get any bigger. An interview with RN-G was conducted on 11/16/17, at 11:27 a.m. RN-G stated she should have measured the coccyx area and the stage 2 pressure ulcer on the right buttocks. RN-G stated her and RN-S had looked at R1's right leg. RN-G stated she was working on the medication cart that day and RN-T had updated the physician. RN-G stated she was not sure why the RN's were not assessing R1's wounds as nurses were aware of the areas. RN-G stated there were frequent discussions of R1's skin issues, however; the documentation was not put in writing. An interview with medical doctor MD-N was conducted on 11/29/17, at 1:07 p.m. The physician who was R1's vascular surgeon stated the wound on R1's left calf was an unstageable (a full thickness tissue loss in which the base of the ulcer was covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 16 black) in the wound bed) pressure ulcer. MD-N stated the pressure ulcer developed due to lack of repositioning and was avoidable. MD-N also stated R1 would not have required the left above the knee amputation if the pressure ulcer would not have occurred. MD-N stated the standard of care when a wound was identified was to measure the wound, assess, and monitor to determine improvement or worsening of the wound. MD-N stated R1 had vascular disease, however; there was no ischemic issues (restriction in blood supply to tissues) going on with the left foot which meant the vascular disease did not cause the wound. MD-N stated R1 also had developed an early stage pressure ulcer on her coccyx that was due to lack of repositioning. An interview was conducted with FM-M on 12/6/17, at 4:32 p.m. FM-M stated he would visit R1 between 3:30 p.m. and 6:00 p.m. FM-M stated when R1 would put her call light on to be changed or repositioned it would take from 20-25 minutes for the call light to be answered. FM-M stated this occurred on several occasions. FM-M stated the ulcer that developed on R1's left leg should have been addressed sooner. FM-M stated when R1 saw the surgeon, the surgeon looked shocked. FM-M stated the ulcer did not develop overnight. An interview was conducted with the director of nursing (DON) on 12/6/17, at 1:41 p.m. The DON indicated R1 would have been repositioned according to her care plan since there was documentation of a tissue tolerance being completed. An interview was conducted with the DON on 12/12/17, at 9:28 a.m. The DON stated during this time frame there would be no documentation	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 17 of when the nursing assistants (NAs) repositioned R1. The DON stated the NAs would use their caregiver sheets and reposition per the schedule. The DON stated she had no concerns that the NAs did not have time to reposition R1. The DON stated there was no documentation that R1's skin was checked on bath day and their current policy did not require documentation. The DON stated the hospice staff ordered an air mattress for R1 on 7/3/17, however; there was no documentation it was ever placed. The DON stated she was frustrated that she could not find the lacking documentation in the medical record. R2's medical record was reviewed. R2's face sheet indicated R2 was diagnosed with a stroke and rheumatoid arthritis. During observiations on 11/2/17, at 3:19 a.m., R2 was asleep in bed with her right ear directly on the pillow. At 3:42 a.m. R2 remained the same. At 4:15 p.m. R2 remained asleep with her right ear directly on the pillow. At 4:39 a.m. NA-Q placed the bedpan for R2. R2 was positioned on her back. At 4:50 p.m. NA-R entered the room and took R2 off the bedpan. At this time, NA-R asked R2 how she wanted to be positioned and R2 requested to lay on her right side again. NA-Q did not educate R2 that she would once again be lying directly on her right ear. R2 was positioned on her right side. During observations on 11/2/17, at 6:30 a.m., R2 remained on her right side with her ear directly on the pillow. At 6:44 a.m. NA-Q and NA-R positioned R2 on her left side. R2's annual Minimum Data Set (MDS) dated 8/2/17, indicated R2 was cognitively intact and required extensive assistance with bed mobility.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 18 R2's care plan reviewed 8/9/17, indicated R2 was to be repositioned every two hours. Reposition side to side and limit/avoid repositioning on back. R2's nursing progress notes dated 10/18/17, documented by registered nurse (RN)-G indicated R2's right ear pressure ulcer measured 1.3 centimeters (cm) by .1 cm. 100% eschar (black). The physician was notified of the present status. R2's physican order dated 10/18/17, directed staff to apply silvasorb gel to R2's right ear one time daily. R2's nurse communication fax dated 10/18/17, written to the physician indicated R2 had a .1 cm by 1.4 cm stage 2 area to the right outer ear cartilage. On 10/20/17, the physician responded that R2 should be seen un the clinic. R2's Braden scale (a tool for predicting pressure ulcer risk) dated 10/25/17, (7 days late) indicated R2 was at low risk for pressure ulcer development. R2's documentation dated 10/25/17, indicated the right ear pressure ulcer measured .8 cm by .5 cm by .1 cm. Continue with silvasorb gel and Allevyn dressing. Skin was blanchable, no odor was apparent, drainage consistency was thin, scant drainage was present, color was clear. Pink wound base was 75%, yellow wound base was 25%, granulation tissue was 75%, slough tissue was 25%, surrounding tissue was normal, mucous membranes were moist and pink, skin turgor was fair. R2's tissue tolerance repositioning observation	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 19 dated 10/31/17, (13 days late) indicated R2 required repositioning every two hours. R2's care plan reviewed 11/1/17, indicated R2 was to be repositioned every two hours. Reposition side to side and limit/avoid repositioning on back. The care plan did not address R2's right ear pressure ulcer. R2's Braden scale dated 11/2/17, indicated R2 was at moderate risk for pressure ulcer development. R2's documentation dated 11/2/17, indicated the right ear pressure ulcer measured 3 cm by .2 cm by .2 cm. Skin was blanchable, no odor was present, drainage consistency was thick, scant drainage was present, color was yellow. The physician was notified of the present status of the site, wound base was not visible. Yellow wound base was 100%, slough tissue was 100%. The wound was measured today, ear cleansed with wound wash, silvasorb gel applied and covered with dressing. Tissue tolerance completed, resident was to be repositioned every two hours, Braden score was 14 (moderate risk 13-14). Resident had a history of stroke affecting the right side, head would lie to right side and the ear flap caused pressure to the cartilage area. Resident was encouraged to lie on the left side, continue to reposition every two hours per the tissue tolerance. New mattress custom care air. Arginaid (liquid vitamin supplement) was started on 11/2/17. R2's skin progress note date 11/15/17, indicated R2's right ear was cleansed with soap and water, patted dry, scab was present over the site, and left open to air. The neck pillow was in place and the resident was educated on the importance of	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 20 keeping her ear elevated off of the pillow to relieve pressure. The resident indicated understanding. An interview was conducted with nursing assistant (NA)-D on 11/1/17, at 12:35 p.m. NA-D stated R2 stayed in bed all the time. NA-D stated if R2 was repositioned the area on her right ear would not have developed. An interview was conducted with NA-P on 11/2/17, at 4:59 a.m. NA-P stated she placed R2 on the bedpan at 12:30 a.m. and then R2 was positioned on her right side. An interview was conducted with R2 on 11/2/17, at 11:02 a.m. R2 stated she did not know how she had developed the right ear sore. R2 stated the staff did not tell her the importance of not being positioned on her right side. R2 stated she had not been offered a neck pillow and would be willing to try it. An interview was conducted with NA-K on 11/16/17, at 11:04 a.m. NA-K stated R2 had an area on her right ear. NA-K stated R2 had a neck pillow and she was unsure if the neck pillow was supposed to be used. An interview was conducted with RN-H on 11/16/17, at 3:17 p.m. RN-H stated R2's pressure ulcer developed on 10/18/17 to her right ear. RN-H stated the root cause analysis was not completed until 11/2/17, and should have been done on 10/18/17. RN-H stated R2 would rest her head to the right side. RN-H stated last week there was an interdisciplinary team meeting and that was not documented in the medical record. RN-H stated R2's ear was not healing, and they had tried a sheepskin on her regular pillow for 5-7 days with no improvement. RN-H stated on	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 21 11/9/17, R2's family was contacted and they brought in a neck pillow. RN-H stated the neck pillow helped to heal the ear and the physician discontinued the dressing change on 11/14/17. An interview was conducted with the director of nursing (DON) on 12/12/17, at 9:06 a.m. The DON stated R2 had a lot of pain related to her rheumatoid arthritis and therefore chose to be bedridden. The DON stated R2 was to repositioned every two hours and she would push herself back onto her back when side lying. The DON stated they tried using other pillows to brace R3 and rolled up blankets, and when the right ear had no healing they requested a neck pillow from the family. The DON verified R3's ear pressure ulcer and interventions were not addressed on the care plan. The DON stated the nursing assistant care guides were not saved, so there was no documentation to identify if the nursing assistants knew R3's interventions. The facility's Skin Ulcer Protocol policy updated 11/7/16, indicated residents would not develop pressure ulcers unless it was clinically unavoidable and appropriate care and services would be provided to prevent, treat, and monitor progress of all healing ulcers. When an open area developed the following measures would be implemented. A. Report all open skin ulcers to the facility wound nurse. B. Remove source of any possible pressure or trauma. C. Keep area dry and clean. D. Refer to Dietitian for nutritional needs as needed. E. Improve circulation by changing position frequently. F. Repeat Tissue Tolerance (turn/reposition program according to results) G. Repeat Braden scale (address all identified areas-Care plan). H. Review all current interventions to ensure they remain appropriate including pressure relieving/reducing devices. I.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 22 Provide wound cares as indicated by facility wound care guidelines, wound care nurse recommendations and physician orders. Wound nurse to complete a Root Cause Analysis of any new skin issue. Daily documentation to address the following: an evaluation of the ulcer, if no dressing present, an evaluation of the status of the dressing (intact, or drainage), the status of the tissue surrounding the ulcer, the presence of possible complications, such as increasing size or infection, and presence of pain before, during and after dressing change. At a minimum weekly wound round documentation to include the following: A. type of wound. B. stage or classification. C. measurements. D. exudate. E. presence of pain. F. wound base tissue. G. description of wound edges and surrounding tissue. H. Interventions in place. I. Current treatment and response to treatment. J. Track wound status. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could establish a system to ensure that the comprehensive pressure ulcer policy was followed. The director of nursing could provide staff education related to the policy for all nursing staff. The quality assessment and assurance committee could audit care to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act.	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 23 "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident was free from maltreatment when 1 of 2 residents (R1) acquired an avoidable unstageable pressure ulcer on the left leg which required an above the knee amputation. The failure of the facility to consistently implement a repositioning program, resulted in harm when the left leg pressure ulcer developed. In addition, R1 developed a pressure ulcer on her right leg, a stage 2 pressure ulcer on her right buttocks, a pressure ulcer on her coccyx, and a pressure ulcer on the right side of her head. Findings include: The facility's Skilled Nursing Facility Maltreatment Reporting Guidelines amended 11/18/16, indicated the organization would report any maltreatment or potential maltreatment of a vulnerable adult to the appropriate authorities, as required by the most stringent federal regulations and/or state rules and statutes. The care center administrator must also be notified of alleged	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 24 abuse/neglect situations immediately. The facility's Skin Ulcer Protocol policy updated 11/7/16, indicated residents would not develop pressure ulcers unless it was clinically unavoidable and appropriate care and services would be provided to prevent, treat, and monitor progress of all healing ulcers. When an open area developed the following measures would be implemented. A. Report all open skin ulcers to the facility wound nurse. B. Remove source of any possible pressure or trauma. C. Keep area dry and clean. D. Refer to Dietitian for nutritional needs as needed. E. Improve circulation by changing position frequently. F. Repeat Tissue Tolerance (turn/reposition program according to results) G. Repeat Braden scale (address all identified areas-Care plan). H. Review all current interventions to ensure they remain appropriate including pressure relieving/reducing devices. I. Provide wound cares as indicated by facility wound care guidelines, wound care nurse recommendations and physician orders. Wound nurse to complete a Root Cause Analysis of any new skin issue. Daily documentation to address the following: an evaluation of the ulcer, if no dressing present, an evaluation of the status of the dressing (intact, or drainage), the status of the tissue surrounding the ulcer, the presence of possible complications, such as increasing size or infection, and presence of pain before, during and after dressing change. At a minimum weekly wound round documentation to include the following: A. type of wound. B. stage or classification. C. measurements. D. exudate. E. presence of pain. F. wound base tissue. G. description of wound edges and surrounding tissue. H. Interventions in place. I. Current treatment and response to treatment. J. Track wound status.	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 25 R1's medical record was reviewed. R1's face sheet indicated R1 was diagnosed with a stroke with left sided paralysis. R1's quarterly Minimum Data Set (MDS) dated 4/20/17, indicated R1 was cognitively intact, and required extensive assistance with bed mobility and was dependent on staff for transfers. R3 was identified at risk for development of pressure ulcers with no pressure ulcers noted. Interventions identified were a turning program and a pressure reducing mattress for the bed and chair. On 5/25/17, registered nurse (RN)-B documented on an appointment transfer sheet that R1 had not been feeling well, did not have much of an appetite the last couple of days, and had an open area on the lower left leg that required a diagnosis. The physician documented R1 had noticed a sore on her left leg. The physician described the area as eschar (black) associated with redness around it and diagnosed the area as a wound infection with surrounding cellulitis. The physician ordered cephalexin (an antibiotic) 250 milligrams three times a day for seven days. R1's dietary documentation by the dietitian dated 5/30/17, indicated R1 had an overall decline in eating and had lost nine pounds in the last 30 days. Nutritional supplements had been ordered in the past and R1 refused them. Continue to offer her favorite foods and provide encouragement at meals and snack time. R1's weight loss was not desirable and she was at higher nutritional risk. No new nutrition interventions recommended at this time. The documentation did not address the acquired left leg pressure ulcer.	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 26 R1 lacked any further documentation from the dietitian when additional pressure ulcers developed. R1's care plan dated 6/1/17, indicated R1 was at risk for skin breakdown related to immobility. R1 was to be assisted with repositioning every three hours and as needed. On 6/2/17, registered nurse (RN)-N documented on a nurse communication form that was faxed to R1's primary physician. R1 had a wound on lateral left calf with eschar surrounded by cellulitis that was worsening. R1 was seen in urgent care by a physician on 5/25/17, and started on cephalexin for infection. Today the wound was 3 centimeters (cm) by 2 cm and black surrounded by black tissue that was not yet open for a size of 12 cm. Around this was redness extending 2 cm. It was painful. The physician sent the fax back to the facility on 6/5/17, and requested R1 be seen at the clinic. On 6/2/17, RN-N documented on R1's skin and wound log at 3:43 p.m. RN-N indicated the left middle calf was a new ulcer with cellulitis that was unable to be accurately staged due to slough and/or eschar. 3 cm by 2 cm. The facility lacked any documentation that R1's left calf pressure ulcer wound had been comprehensively assessed. On 6/5/17, documentation from R1's physician indicated R1 was brought to the emergency department from the clinic for a left calf ulcer. Onset of the ulcer was unknown. R1 was noticed to have decreased vascular flow to the extremities and an arterial duplex ultrasound of the lower extremities as well as venous studies were completed. R1 had an approximate 6 cm by	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 27 2 cm ulceration to her left calf. R1 was transferred to a hospital for a vascular surgeon consult. R1's hospital admission history and physical dated 6/5/17, indicated R1 had a left calf ulcer with unknown onset. R1 stated the wound started a few weeks ago. R1's vascular surgery consult documentation dated 6/5/17, indicated R1 had a left leg pressure ulcer and the left foot showed no sores or ulcers. R1 was diagnosed with an occlusion (blockage) of the left distal common femoral artery and the superficial femoral artery. R1's wound consult documentation dated 6/6/17, identified a lower left leg ulcer measuring 12 centimeters (cm) by 3 cm wound bed with black eschar and white non viable tissue, edges with deep maroon and dark purplish discoloration and tan-serosanguineous drainage. R1 had a pressure ulcer to the coccyx area measuring 1.2 centimeters (cm) by .2 cm by .1 cm partial thickness wound with a pink moist wound bed. The facility lacked any documentation that R1's coccyx pressure ulcer had been comprehensively assessed. R1's physician documentation dated 6/13/17, indicated R1 was diagnosed with a stable chronic deep vein thrombosis (blood clot in a vein) to the left lower extremity and a complete occlusion (blockage) to the left distal common femoral artery (gives oxygenated blood to the leg) and proximal superficial femoral artery. R1's hospital discharge summary dated 6/15/17, indicated R1's left calf wound had probably been present for a few weeks.	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 28 R1's nursing progress notes dated 6/15/17, documented by registered nurse (RN)-A indicated R1 returned from the hospital. R1 had a left above the knee amputation (AKA) due to circulatory issues. R1 had a dressing over the coccyx area that was removed and the area was clear. Will continue with good turning and repositioning. R1's Braden Scale (a tool for predicting pressure ulcer risk) dated 6/21/17, indicated R1 was at moderate risk for pressure ulcer development. R1's significant change MDS dated 6/22/17, indicated R1 had severe cognitive impairment, required extensive assistance with bed mobility and was dependent on staff for transfers. R1's nursing progress notes dated 6/22/17, documented by RN-A, indicated R1 was to be repositioned every two to three hours with positioning pillows. However, R1's care plan still directed staff to reposition R1 every three hours. R1's consent for hospice admission was dated 6/27/17. R1's skin condition/wound progression documentation dated 6/30/17, was documented by licensed practical nurse (LPN)-J. New, first recording present on the right lower buttocks were superficial open areas. Skin was blanchable, no odor was apparent, no drainage was apparent. Multiple superficial open areas noted to buttocks. Applied Allevyn dressing times two for protection. The facility lacked documentation that a RN was notified of the new open areas. The facility policy was not followed and a comprehensive	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 29 assessment of the areas was not completed. R1's care plan dated 7/1/17, indicated R1 was at risk for skin breakdown related to immobility. R1 was to be assisted with repositioning every three hours and as needed. R1's skin condition/wound progression documentation dated 7/4/17, was documented by licensed practical nurse (LPN)-J. New, first recording, present on the upper back of the head was a reddened area. Skin was blanchable, no odor was apparent, no drainage was apparent. This wound was not present on admission. The facility lacked documentation that a RN was notified of the new area. The facility policy was not followed and a comprehensive assessment of the area was not completed. R1 was seen in the clinic on 7/7/17, by her primary physician. R1's family was concerned about a sore on her right lower leg that she had for the last week. R1's family was also concerned about a sore on her buttocks for the last couple of weeks and an area on her head for four days. R1's family was concerned R1 was not repositioned regularly. The physician documented the buttock ulcer and the right lower leg pressure ulcer measuring approximately 15 cm by 3 cm with a shallow abrasion on R1's scalp. The physician ordered R1 to be repositioned every two hours, mepilex dressing to buttocks pressure ulcer change daily and when soiled, mepilex dressing to right calf pressure ulcer, change every five days, triple antibiotic ointment to scalp wound, and off load pressure from all wounds. The facility lacked documentation that a RN was notified of the new area. The facility policy was	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 30 not followed and a comprehensive assessment of the area was not completed. R1's care plan was never updated to reflect the physican order to reposition every two hours. R1's skin condition/wound progression documentation dated 7/9/17, was documented by licensed practical nurse (LPN)-J. Present on the right buttocks were superficial open areas. Three open areas noted to resident's buttocks. Largest open area was on the coccyx. One small area to each buttock. The facility lacked any documentation that R1's coccyx pressure ulcer had been comprehensively assessed. R1's skin condition/wound progression documentation dated 7/10/17, was documented by RN-G. Present on the right lower buttocks was superficial open areas. Stage 2, skin was not blanchable, no odor was apparent, drainage consistency was thin, scan drainage was present, color was yellow. The wound was not present on admission. This site had a round open area in the middle. It was a stage 2, base was red with some scant amount of yellow slough. The dressing applied was foam. It was placed over the coccyx to protect the site. Resident had very poor circulation, abnormal labs including albumin level, and was currently a hospice patient. She had orders to reposition every two hours and had repositioning pillows, and a soft neck pillow. She did report pain with repositioning. R1's death certificate dated 7/16/17, indicated R1's cause of death was chronic peripheral vascular disease, heart valve disease, and chronic kidney disease.	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 31 An interview was conducted with NA-D on 11/1/17, at 12:35 p.m. NA-D stated she observed R1's left calf area to be black, dry, and deep purple in color. NA-D stated after a couple of days the left calf was open and NA-D would place a pillow under the left calf and heel. NA-D stated after the left leg amputation, R1 developed a sore on her right calf that was purple, black, and then doubled in size. NA-D stated R1 then developed a red area on the side of her head that was open and bleeding. NA-D stated the area on R1's head was touching the pillow, so she would roll up a towel to prop under R1's head. NA-D stated they reported the area on R1's head to the nurses and it took a few days before that information was documented on the 24 hour report. NA-D stated when R1 developed the open area on her left calf, she had told the nurses for a week before the nurses were talking about the area. NA-D also stated the report between the nurses and the NA's needed to improve. NA-D stated repositioning was not getting done timely and it could be 30-45 minutes later due to staffing needs. NA-D stated the NAs receive a sheet of information about the residents, however; NA-D stated it was not the resident's full care plan. NA-D stated the resident's care plan was to be posted in their closet and that was not happening. NA-D stated the NA's can't improve the situation without the proper staffing and more education. An interview was conducted with registered nurse (RN)-B on 11/1/17, at 2:28 p.m. RN-B stated on bath day, the NA and the nurse would look at the resident's skin. Also, if the NA's would notice a skin issue they would notify the nurse. RN-B stated the nurses have a 24 hour report they use to report to the next shift. RN-B stated the director of nursing indicated there was a high resident acuity and the NA's have a heavy resident	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 32 assignment. An interview was conducted with RN-A on 11/1/17, at 3:07 p.m. RN-A verified the only skin documentation for R1's left calf was on the clinic appointment sheet when R1 saw the physician. At 3:36 p.m. RN-A stated when R1 returned from the hospital on 6/15/17, her skin was intact. RN-A stated the RN's would look at any skin issues. An interview was conducted with RN-B on 11/2/17, 8:44 a.m. RN-B stated R1's left calf should have been documented on the skin and wound log per policy. RN-B stated R1 was changed to an hourly repositioning schedule on 7/7/17. RN-B verified the hourly repositioning was never documented in R1's medical record. An interview with family member (FM)-L was conducted on 11/15/17, at 5:03 p.m. FM-L stated three to four months prior to R1's death she did not want to get up so the facility did not get her up for meals. FM-L stated when R1 developed the sore on her left calf, the facility stated it had been there for a couple of days. FM-L stated the physician told family the left calf pressure ulcer had been there for 2-1/2 to 3 weeks. FM-L stated shortly after the left leg amputation, we noticed an area on her right leg. FM-L stated R1 had a big sore on her head from not being moved. FM-L stated the NA's were reporting R1's left leg to superiors and it was getting brushed off. An interview with LPN-J was conducted on 11/16/17, at 10:03 a.m. LPN-J stated there was a suspicious area on R1's left extremity that was monitored for quite awhile. LPN-J stated R1 would get suspicious areas quickly when there was any pressure on her skin and it would start breaking down. LPN-J stated the repositioning	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 33 would make the areas go away. LPN-J stated any area of R1's skin that touched the bed would become red in minutes. LPN-J stated the RN should assess the open area within the same shift. LPN-J stated she did not document when she reported R1's skin areas to the RN. LPN-J stated the charting falls between the cracks. LPN-J stated there was no documentation to identify when staff would have provided repositioning for R1. LPN-J stated she observed R1's right leg and it looked like something more than a scab. LPN-J stated she had reported R1's right leg area to the RN. An interview with nursing assistant (NA)-I was conducted on 11/16/17, at 10:37 a.m. NA-I stated R1 was to be repositioned every two to three hours. NA-I stated towards the end of R1's life possibly the beginning of June the repositioning schedule was to be hourly. NA-I stated she did not know how R1 developed the sore on her head. NA-I stated the pillow may have caused more pressure and my feeling was that it was realized a little to late. NA-I stated they took a piece of wool and made it into a neck pillow. NA-I stated after they stopped using a pillow the sore did not get any bigger. An interview with RN-G was conducted on 11/16/17, at 11:27 a.m. RN-G stated she should have measured the coccyx area and the stage 2 pressure ulcer on the right buttocks. RN-G stated her and RN-S had looked at R1's right leg. RN-G stated she was working on the medication cart that day and RN-T had updated the physician. RN-G stated she was not sure why the RN's were not assessing R1's wounds as nurses were aware of the areas. RN-G stated there were frequent discussions of R1's skin issues, however; the documentation was not put in	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 34 writing. An interview with medical doctor MD-N was conducted on 11/29/17, at 1:07 p.m. The physician who was R1's vascular surgeon stated the wound on R1's left calf was an unstageable (a full thickness tissue loss in which the base of the ulcer was covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) pressure ulcer. MD-N stated the pressure ulcer developed due to lack of repositioning and was avoidable. MD-N also stated R1 would not have required the left above the knee amputation if the pressure ulcer would not have occurred. MD-N stated the standard of care when a wound was identified was to measure the wound, assess, and monitor to determine improvement or worsening of the wound. MD-N stated R1 had vascular disease, however; there was no ischemic issues (restriction in blood supply to tissues) going on with the left foot which meant the vascular disease did not cause the wound. MD-N stated R1 also had developed an early stage pressure ulcer on her coccyx that was due to lack of repositioning. An interview was conducted with FM-M on 12/6/17, at 4:32 p.m. FM-M stated he would visit R1 between 3:30 p.m. and 6:00 p.m. FM-M stated when R1 would put her call light on to be changed or repositioned it would take from 20-25 minutes for the call light to be answered. FM-M stated this occurred on several occasions. FM-M stated the ulcer that developed on R1's left leg should have been addressed sooner. FM-M stated when R1 saw the surgeon, the surgeon looked shocked. FM-M stated the ulcer did not develop overnight. An interview was conducted with the director of	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 12/15/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 35 nursing (DON) on 12/6/17, at 1:41 p.m. The DON indicated R1 would have been repositioned according to her care plan since there was documentation of a tissue tolerance being completed. An interview was conducted with the DON on 12/12/17, at 9:28 a.m. The DON stated during this time frame there would be no documentation of when the nursing assistants repositioned R1. The DON stated the NAs would use their caregiver sheets and reposition per the schedule. The DON stated she had no concerns that the NAs did not have time to reposition R1. The DON stated there was no documentation that R1's skin was checked on bath day and their current policy did not require documentation. The DON stated the hospice staff ordered an air mattress for R1 on 7/3/17, however; there was no documentation it was ever placed. The DON stated she was frustrated that she could not find the lacking documentation in the medical record. SUGGESTED METHOD OF CORRECTION: The administrator could review with staff the comprehensive pressure ulcer policy. In addition, the director of nursing could establish a policy for weekly skin documentation on bathing days. All nursing staff could receive education on the the pressure ulcer policies and procedures. The quality assessment and assurance committee could implement monitoring on all shifts of work to ensure all residents are receiving the appropriate care and treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		