DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 4, 2020

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

RE: CCN: 245252
Survey Start Date: June 4, 2020

Dear Administrator:

On July 31, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 10, 2020. Per the CMS Memo QSO-20-20-All, enforcement remedies were suspended from March 23, 2020 to May 31, 2020 and will be evaluated at a later date.

The CMS Region V Office may notify you of their determination regarding any 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 File

Electronically delivered
June 22, 2020

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

SUBJECT: SURVEY RESULTS
CCN: 245252
Cycle Start Date: June 4, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On June 4, 2020, the Minnesota Department of Health completed a complaint investigation at Thief River Care Center to determine if your facility was in compliance with Federal requirements related to the complaint. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the June 4, 2020 survey. Thief River Care Center may choose to delay submission of an ePOC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit an ePOC. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your

facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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

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

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:

Lyla Burkman, Unit Supervisor
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the June 4, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Lyla Burkman, Unit Supervisor
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Thief River Care Center may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

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 _____	C 06/04/2020

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

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F 000	INITIAL COMMENTS On June 2, 2020 through June 4, 2020, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5052111C. Deficiency cited at F686. In addition a deficiency was cited at F880 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		7/10/20

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

Electronically Signed | 07/02/2020

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F 686	Continued From page 1 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 interview and document review, the facility failed to notify the primary physician regarding the development of a newly formed wound and obtain treatment of the wound in a timely manner for 1 of 2 residents (R1) reviewed. This resulted in actual harm when R1's wound had deteriorated to a necrotic (dead tissue) state, required emergency intervention and hospitalization. In addition, the facility failed to assess, provide and document treatment of a buttocks wound for R1 that was evident upon admission to the facility. Findings include: R1's admission Minimum Data Set (MDS) dated 4/6/20, indicated he had intact cognition and required extensive assistance from staff for bed mobility, transfers and toileting. The MDS indicated R1 was frequently incontinent of bowel and bladder. R1's MDS identified he was at high risk for pressure ulcer development, however, did not have an active pressure ulcer present. The MDS indicated R1's diagnoses included heart disease, diabetes mellitus, coronary artery disease, chronic obstructive heart disease, acute and chronic kidney disease. R1's care plan dated 4/17/20, identified R1 as cognitively intact and able to express his needs.	F 686	F686 TRCC will ensure a resident with a pressure ulcer receives the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. The DON/designee will review all residents at moderate to high risk for PUs to ensure they are assessed and preventive measures are in place, and if have a pressure ulcer, ensure the MD is informed and treatment orders are received and implemented, and there is a Root Cause analysis (RCA) and weekly wound round notes documented in the EMR. The PU protocol will be reviewed and revised prn, to specify who will contact the MD to receive orders for treatment of a skin ulcer. Appropriate nursing staff will be re-educated on the care center's "Pressure Ulcer protocol'. DON/designee will conduct random audits 3XwkX2, 2XwkX2, weekly X2, then monthly thereafter of residents with skin ulcers, to ensure they are assessed, monitored and treatment orders from the MD are received, added to the eTAR and	

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F 686	Continued From page 2 R1 required assistance with bed mobility, transfers, dressing, grooming, and toileting, was unable to ambulate, was occasionally incontinent of bladder and used incontinence briefs or pads to manage with assistance. The care plan indicated an ulcer was identified on his buttock and directed staff to encourage fluid intake, keep clean and dry, observe skin for signs of redness, blistering, shearing, blanching and skin tears, use pressure reducing cushion in wheelchair and on bed and to reposition every two hours and as needed (prn). On 5/15/20, the care plan identified an open area to R1's left heel, with a goal to be healed within next 90 days. The care plan directed staff to observe weekly and prn, turn and reposition every two hours and prn, treatment as indicated and to float heels when in bed. Buttocks wound A progress note (PN) dated 3/31/20, indicated R1 had an open area on his right gluteal cleft with orders to wash with soap and water, to apply a sacral Mepilex dressing and to change every three days. Review of R1's April and May 2020 treatment record lacked staff direction to care for R1's open area to his right gluteal cleft. Review of R1's PN's for the month of April 2020 lacked documentation related to R1's open area to his right gluteal cleft, that was identified in progress note dated 3/31/20. A nurses's observation note dated 4/6/20, indicated R1's Braden Scale for Predicting Pressure Sore Risk indicated R1 was at risk for skin breakdown. Observations of the area on	F 686	are implemented. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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F 686	Continued From page 3	F 686		

buttock were described as a cyst like area that was present on admission.

R1's medical record lacked documentation of a skin assessment.

Heel wound

-R1's PN dated 5/9/20, with an entered date of 5/11/20, indicated R1 had a blister that popped on his heel, leaving an open area the size of a silver dollar. Skin prep was applied and the wound was covered with a dressing.

-Wound progression noted dated 5/15/20, indicated a new, first recording, of a pressure ulcer to R1's left heel. The note indicated R1 frequently rested pressure on his heel and had been educated to keep the heel elevated and to not rest on it. Documented wound measurements: 2.0 centimeters (cm) x 3.0 cm with eschar (dead or necrotic tissue) present.

-PN dated 5/17/20, indicated skin breakdown noted to R1's left heel. Area was cleansed and covered with a dressing. A pillow was placed under his heel to float and keep off the mattress. The note indicated R1 complained his tailbone was sore. The nurse assessed area and applied a dressing to the area per R1's request, however, no open area was identified.

-PN dated 5/20/20, indicated R1 complained of pain in his heel and rated it a three on a scale of one to 10 (10 worst pain).

-Wound progression note dated 5/22/20, indicated frequently rested pressure on his heel and had been educated to keep it elevated and to

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F 686	Continued From page 4	F 686		

not rest on it. R1 was encouraged not to wear shoes. The wound measured 2.0 cm x 2.0 cm and contained slough (dead skin tissue that may have a yellow or white appearance) and epithelial tissue (tissue regeneration) with slight drainage.

-PN dated 5/23/20, indicated R1 complained of pain in his heel and rated it a three on a scale of one to ten.

-PN dated 5/25/20, indicated a fax was sent to R1's physician regarding R1's wounds to his coccyx and left heel, 16 days after identification. The physician responded to schedule an appointment with a wound specialist.

-PN dated 5/26/20, indicated when R1's dressing was changed on his left heel he complained of pain with light touch along the back of his left lower leg. R1 voiced concerns about his open areas and was asking to see a wound doctor.

-PN dated 5/27/20, referred to a call from R1's family member asking if R1 had an appointment to have his heel and coccyx checked. The family member had been informed R1 would be seeing a physician that day.

-Wound progression noted dated 5/27/20, indicated the wound bed was dark red in color and moist with a 0.4 cm white circle of skin encircling the wound. The dressing was moderately saturated and exudate (drainage) on the dressing when removed, was almost black and malodorous. A small amount of thick white exudate was removed from the wound bed.

-PN dated 5/27/20, referred to a call from the emergency room. The emergency room nurse

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F 686	Continued From page 5	F 686		

informed the facility that R1 would be transferring to another hospital for his left heel due to his diagnosis and dialysis.

Although R1's 3/31/20, PN identified a right gluteal cleft open area with subsequent orders to wash with soap and water, apply a sacral Mepilex dressing and to change the dressing every three days, R1's wound progression notes lacked documented evidence of R1 having a buttock wound, monitoring and treatment.

Review of R1's medication record for May 2020, revealed there were no treatment orders for R1's wounds on his heel or his buttocks.

Review of R1's treatment record for May 2020, directed staff to check R1's blood sugars four times per day, check vital signs daily, draw lab one time per day for prothrombin (blood clotting) time on indicated ordered dates, administer R1's insulin, administer R1's nebulizer treatments, bladder scan when indicated, change nebulizer tubing, and run control for blood sugar machine one day monthly. However, the treatment record lacked any direction or indication to monitor or treat R1's wounds on his heel or his buttock.

Review of R1's physicians orders lacked any indication of physician involvement related to R1's wounds, as well as any treatment orders for R1's wounds even though a wound of R1's buttocks was identified on the care plan on 4/17/20, and a wound on R1's heel was identified on 5/9/20.

Review of R1's physician office visit progress note, dated 5/27/20, indicated R1 had a necrotic wound on his left heel. R1's wound was documented as a large necrotic area along the

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F 686	Continued From page 6	F 686		

medial calcaneus (back of heel) that was malodorous (unpleaseant smelling), non-tender to palpation. The wound measured four by five cm. Because of his comorbidities and the need for dialysis, possibly vascular consultation and wound debridement, the emergency room accepted the patient with the goal of transferring him to a higher level of care.

Review of R1's emergency room note dated 5/27/20, indicated R1's diagnosis of cellulitis of left lower extremity, diabetic ulcer of left heel and pressure injury of skin of buttock. R1 was stabilized and transferred to another facility.

On 6/4/20 at 9:00 a.m. certified nursing assistant(CNA)-A stated she had seen R1's ulcer on his left heel. She stated she thought it had started out as real small spot and then grew. CNA-A stated when she saw R1's heel it was black in color.

On 6/4/20 at 9:15 a.m. registered nurse (RN)-A stated R1 had gotten a blister on his heel. She stated the top layer had peeled off but the area was dry. RN-A stated she looked at it the next week and then over the weekend it fell apart and he was needing to be seen, so they sent him in. She stated R1 went to urgent care after his dialysis because they felt he could not wait for a wound specialist appointment. RN-A stated the facility had a policy that the physician was to be contacted regarding wounds and decubiti but did not specify who was to contact the physician. RN-A verified R1's primary physician should have been contacted when the wound was first discovered.

On 6/4/20 at 9:52 a.m. the director of nursing

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F 686	Continued From page 7	F 686		

(DON) stated there had been a break in communication. R1 had a blister and it had not been communicated to everybody, and in fact, she had been unaware of it. DON stated the physician should have been notified with the first assessment of the open area. The DON verified there was no treatment ordered for the care of R1's wound and R1's treatment record lacked any information related to R1's skin care, treatment or interventions.

The facility's Skin Ulcer Protocol policy, dated 11-1-15, indicated residents would receive appropriate care and services to prevent, treat, and monitor progress of all healing ulcers. The policy directed staff to report all open skin areas to the facility wound nurse. The staff were to provide wound cares as indicated by facility wound care guidelines, wound care nurse recommendations and physician orders. The policy further indicated wound care protocol was the physician must be notified of all stage two to stage four wounds, significant changes and non healing wounds. The policy directed staff when considering implementation of the wound care protocols, ensure an appropriate assessment and individualized interventions are in place. Update resident/family and obtain appropriate physician orders.

The facility's Significant Change policy, with a revised date 1/7/19, directs staff to immediately inform the resident, consult with the physician and notify the resident's representative, when the resident has a significant change. The policy defined a significant change as a change in a residents status, a need to alter treatment, an accident that results in injury, or a decision to transfer or discharge an individual.

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F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		7/10/20

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F 880	Continued From page 9 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement appropriate infection control practices related to Covid-19 by failing to conduct required health screenings for all who entered the facility. In addition the facility staff failed to utilized appropriate personal protective equipment (PPE) when providing personal care and treatment to residents as required. These practices had the potential to affect all 67 residents and staff in the facility.	F 880	F880 DON/designee will review and revise prn policies to ensure appropriate screening and wearing of PPE (goggles) with resident care. DON/designee will re-educated appropriate screening staff on the policy regarding Screening of Essential Visitors on 6/23/20. and the wearing of appropriate PPE (goggles) with resident care.	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 10 Findings include: During observation on 6/2/20, upon entrance to the facility, the state surveyor (SA) was asked to sign in and the SA's temperature was checked. The SA was not asked the required COVID-19 screening questions to assess for symptoms or possible exposure of COVID-19 as required. -On 6/3/20 the SA entered the facility and was asked to sign in and the SA's temperature was checked, however the SA was not asked the required COVID-19 screening questions to assess for symptoms and exposure of COVID-19 as required. -On 6/4/20 the SA entered the facility and was asked to sign in and the SA's temperature was checked, however the SA was not asked the required COVID-19 screening question to assess for symptoms and exposure of COVID-19 as required. On 6/2/20, the director of nursing (DON) confirmed the facility did not have any positive or suspected positive COVID cases in the facility at this time. R2's diagnosis report included bipolar disorder, history of falls, hypertension, lung disease, Parkinson's, and peripheral vascular disease. R2 had orders for wet to dry dressing change daily but was not on any special precautions. R2 did not exhibit any acute respiratory symptoms and was not COVID positive. On 6/3/20 at 9:00 a.m. Licensed practical nurse (LPN)-A was observed to change R2's wound dressings on her left leg. LPN-A was wearing a surgical mask, gathered supplies and applied gloves. LPN-A proceeded to remove the dressing	F 880	DON/designee to implement random audits to ensure ongoing screening compliance, daily X 1 week, 3XwkX2, then weekly thereafter. DON/designee will implement random audits of resident treatments to ensure compliance with wearing appropriate PPE (goggles) while providing resident care, 2XwkX2, weekly X2, then monthly thereafter.. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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F 880	Continued From page 11	F 880		

wrap from around R2's lower leg. LPN-A attempted to remove the 4 by 4 gauze that directly covered the open wounds. The gauze was adhered to the wound and difficult to remove, so LPN-A sprayed the dressing directly with a saline spray. LPN-A then proceeded to remove the 4 by 4 dressing and cleanse the wound. The wounds were moist appearing and had moist drainage present in the wound and on the soiled dressings. LPN-A applied new dressings to the wounds on R2's left leg and secured the dressings with tape. LPN-A discarded the old dressings, removed her gloves and sanitized her hands with alcohol based hand rub.

On 6/3/20 at 9:30 a.m. LPN-A verified the treatment observed with R2's dressing change was direct patient care. LPN-A stated she would only wear goggles for treatment if there would be some sort of splashing or something of that nature.

On 6/4/20 at 9:35 a.m. RN-A stated staff were required to wash hands, and wear mask and goggles for all patient care. RN-A stated this applied to licensed staff as well as direct care staff. RN-A verified LPN-A should wear goggles while doing treatments.

On 6/4/20 at 9:52 a.m. the DON stated she would have to look at the policy but she was sure staff were told to wear goggles for patient care. She stated each worker had their own goggles or face shield that they were responsible to care for. The DON verified LPN-A should have worn goggles to perform dressing changes. The DON further verified visitor screening should have included the COVID-19 screening questions to assess for exposure and symptoms of COVID-19.

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F 880	Continued From page 12 The facility's Coronavirus Prevention, Screening, and Identification policy, with a revision date of 5/20/20, identified a breach of PPE can result in the spread of infectious pathogens. Breach of PPE can include but is not limited to: inappropriate use of facial mask, poor hand hygiene, improper don/doff of PPE, not using appropriate PPE for the infectious agent and tears or damage to PPE and need to be reported immediately to supervisor. The policy indicated personnel would be assigned to monitor the visitor entrance and evaluate appropriateness of any visitor, utilizing a visitor screening tool. The policy directed staff to do careful screening of visitors for fever or respiratory symptoms and remind visitors to frequently perform hand hygiene.	F 880		

Electronically delivered
June 22, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: DG0T11

Dear Administrator:

The above facility was surveyed on June 2, 2020 through June 4, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lyla Burkman, Unit Supervisor
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On June 2, 2020 through June 4, 2020 , a surveyor of this Department's staff visited the above provider for a complaint investigation and the following correction order was issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint(s) were found to be substantiated: H5252036C. Correction order(s) issued at MN Rule 4658.0525 subp.3 In addition a correction order was written at MN Rule 4658.0800 subp.1 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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 to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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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 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 interview and document review, the facility failed to notify the primary physician regarding the development of a newly formed wound and obtain treatment of the wound in a timely manner for 1 of 2 residents (R1) reviewed. This resulted in actual harm when R1's wound had deteriorated to a necrotic (dead tissue) state, required emergency intervention and hospitalization. In addition, the facility failed to assess, provide and document treatment of a buttocks wound for R1 that was evident upon admission to the facility. Findings include: R1's admission Minimum Data Set (MDS) dated 4/6/20, indicated he had intact cognition and	2 900	F686 TRCC will ensure a resident with a pressure ulcer receives the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. The DON/designee will review all residents at moderate to high risk for PUs to ensure they are assessed and preventive measures are in place, and if have a pressure ulcer, ensure the MD is informed and treatment orders are received and implemented, and there is a Root Cause analysis (RCA) and weekly wound round notes documented in the EMR.	7/10/20

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2 900	Continued From page 3 required extensive assistance from staff for bed mobility, transfers and toileting. The MDS indicated R1 was frequently incontinent of bowel and bladder. R1's MDS identified he was at high risk for pressure ulcer development, however, did not have an active pressure ulcer present. The MDS indicated R1's diagnoses included heart disease, diabetes mellitus, coronary artery disease, chronic obstructive heart disease, acute and chronic kidney disease. R1's care plan dated 4/17/20, identified R1 as cognitively intact and able to express his needs. R1 required assistance with bed mobility, transfers, dressing, grooming, and toileting, was unable to ambulate, was occasionally incontinent of bladder and used incontinence briefs or pads to manage with assistance. The care plan indicated an ulcer was identified on his buttock and directed staff to encourage fluid intake, keep clean and dry, observe skin for signs of redness, blistering, shearing, blanching and skin tears, use pressure reducing cushion in wheelchair and on bed and to reposition every two hours and as needed (prn). On 5/15/20, the care plan identified an open area to R1's left heel, with a goal to be healed within next 90 days. The care plan directed staff to observe weekly and prn, turn and reposition every two hours and prn, treatment as indicated and to float heels when in bed. Buttocks wound A progress note (PN) dated 3/31/20, indicated R1 had an open area on his right gluteal cleft with orders to wash with soap and water, to apply a sacral Mepilex dressing and to change every three days. Review of R1's April and May 2020 treatment	2 900	The PU protocol will be reviewed and revised prn, to specify who will contact the MD to receive orders for treatment of a skin ulcer. Appropriate nursing staff will be re-educated on the care center's "Pressure Ulcer protocol'. DON/designee will conduct random audits 3XwkX2, 2XwkX2, weekly X2, then monthly thereafter of residents with skin ulcers, to ensure they are assessed, monitored and treatment orders from the MD are received, added to the eTAR and are implemented. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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2 900	Continued From page 4 record lacked staff direction to care for R1's open area to his right gluteal cleft. Review of R1's PN's for the month of April 2020 lacked documentation related to R1's open area to his right gluteal cleft, that was identified in progress note dated 3/31/20. A nurses's observation note dated 4/6/20, indicated R1's Braden Scale for Predicting Pressure Sore Risk indicated R1 was at risk for skin breakdown. Observations of the area on buttock were described as a cyst like area that was present on admission. R1's medical record lacked documentation of a skin assessment. Heel wound -R1's PN dated 5/9/20, with an entered date of 5/11/20, indicated R1 had a blister that popped on his heel, leaving an open area the size of a silver dollar. Skin prep was applied and the wound was covered with a dressing. -Wound progression noted dated 5/15/20, indicated a new, first recording, of a pressure ulcer to R1's left heel. The note indicated R1 frequently rested pressure on his heel and had been educated to keep the heel elevated and to not rest on it. Documented wound measurements: 2.0 centimeters (cm) x 3.0 cm with eschar (dead or necrotic tissue) present. -PN dated 5/17/20, indicated skin breakdown noted to R1's left heel. Area was cleansed and covered with a dressing. A pillow was placed under his heel to float and keep off the mattress. The note indicated R1 complained his tailbone	2 900		

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2 900	Continued From page 5 was sore. The nurse assessed area and applied a dressing to the area per R1's request, however, no open area was identified. -PN dated 5/20/20, indicated R1 complained of pain in his heel and rated it a three on a scale of one to 10 (10 worst pain). -Wound progression note dated 5/22/20, indicated frequently rested pressure on his heel and had been educated to keep it elevated and to not rest on it. R1 was encouraged not to wear shoes. The wound measured 2.0 cm x 2.0 cm and contained slough (dead skin tissue that may have a yellow or white appearance) and epithelial tissue (tissue regeneration) with slight drainage. -PN dated 5/23/20, indicated R1 complained of pain in his heel and rated it a three on a scale of one to ten. -PN dated 5/25/20, indicated a fax was sent to R1's physician regarding R1's wounds to his coccyx and left heel, 16 days after identification. The physician responded to schedule an appointment with a wound specialist. -PN dated 5/26/20, indicated when R1's dressing was changed on his left heel he complained of pain with light touch along the back of his left lower leg. R1 voiced concerns about his open areas and was asking to see a wound doctor. -PN dated 5/27/20, referred to a call from R1's family member asking if R1 had an appointment to have his heel and coccyx checked. The family member had been informed R1 would be seeing a physician that day. -Wound progression noted dated 5/27/20,	2 900		

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indicated the wound bed was dark red in color and moist with a 0.4 cm white circle of skin encircling the wound. The dressing was moderately saturated and exudate (drainage) on the dressing when removed, was almost black and malodorous. A small amount of thick white exudate was removed from the wound bed.

-PN dated 5/27/20, referred to a call from the emergency room. The emergency room nurse informed the facility that R1 would be transferring to another hospital for his left heel due to his diagnosis and dialysis.

Although R1's 3/31/20, PN identified a right gluteal cleft open area with subsequent orders to wash with soap and water, apply a sacral Mepilex dressing and to change the dressing every three days, R1's wound progression notes lacked documented evidence of R1 having a buttock wound, monitoring and treatment.

Review of R1's medication record for May 2020, revealed there were no treatment orders for R1's wounds on his heel or his buttocks.

Review of R1's treatment record for May 2020, directed staff to check R1's blood sugars four times per day, check vital signs daily, draw lab one time per day for prothrombin (blood clotting) time on indicated ordered dates, administer R1's insulin, administer R1's nebulizer treatments, bladder scan when indicated, change nebulizer tubing, and run control for blood sugar machine one day monthly. However, the treatment record lacked any direction or indication to monitor or treat R1's wounds on his heel or his buttock.

Review of R1's physicians orders lacked any indication of physician involvement related to R1's

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2 900	Continued From page 7	2 900		

wounds, as well as any treatment orders for R1's wounds even though a wound of R1's buttocks was identified on the care plan on 4/17/20, and a wound on R1's heel was identified on 5/9/20.

Review of R1's physician office visit progress note, dated 5/27/20, indicated R1 had a necrotic wound on his left heel. R1's wound was documented as a large necrotic area along the medial calcaneus (back of heel) that was malodorous (unpleasant smelling), non-tender to palpation. The wound measured four by five cm. Because of his comorbidities and the need for dialysis, possibly vascular consultation and wound debridement, the emergency room accepted the patient with the goal of transferring him to a higher level of care.

Review of R1's emergency room note dated 5/27/20, indicated R1's diagnosis of cellulitis of left lower extremity, diabetic ulcer of left heel and pressure injury of skin of buttock. R1 was stabilized and transferred to another facility.

On 6/4/20 at 9:00 a.m. certified nursing assistant(CNA)-A stated she had seen R1's ulcer on his left heel. She stated she thought it had started out as real small spot and then grew. CNA-A stated when she saw R1's heel it was black in color.

On 6/4/20 at 9:15 a.m. registered nurse (RN)-A stated R1 had gotten a blister on his heel. She stated the top layer had peeled off but the area was dry. RN-A stated she looked at it the next week and then over the weekend it fell apart and he was needing to be seen, so they sent him in. She stated R1 went to urgent care after his dialysis because they felt he could not wait for a wound specialist appointment. RN-A stated the

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2 900	Continued From page 8	2 900		

facility had a policy that the physician was to be contacted regarding wounds and decubiti but did not specify who was to contact the physician. RN-A verified R1's primary physician should have been contacted when the wound was first discovered.

On 6/4/20 at 9:52 a.m. the director of nursing (DON) stated there had been a break in communication. R1 had a blister and it had not been communicated to everybody, and in fact, she had been unaware of it. DON stated the physician should have been notified with the first assessment of the open area. The DON verified there was no treatment ordered for the care of R1's wound and R1's treatment record lacked any information related to R1's skin care, treatment or interventions.

The facility's Skin Ulcer Protocol policy, dated 11-1-15, indicated residents would receive appropriate care and services to prevent, treat, and monitor progress of all healing ulcers. The policy directed staff to report all open skin areas to the facility wound nurse. The staff were to provide wound cares as indicated by facility wound care guidelines, wound care nurse recommendations and physician orders. The policy further indicated wound care protocol was the physician must be notified of all stage two to stage four wounds, significant changes and non healing wounds. The policy directed staff when considering implementation of the wound care protocols, ensure an appropriate assessment and individualized interventions are in place. Update resident/family and obtain appropriate physician orders.

The facility's Significant Change policy, with a revised date 1/7/19, directs staff to immediately

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	00448	A. BUILDING: _____ B. WING _____	C 06/04/2020

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 inform the resident, consult with the physician and notify the resident's representative, when the resident has a significant change. The policy defined a significant change as a change in a residents status, a need to alter treatment, an accident that results in injury, or a decision to transfer or discharge an individual. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents to determine if at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers, ensure the MD is informed of these ulcers and treatment orders are received and implemented. The director of nursing or designee could review and revise pressure ulcer policies to ensure identification of pressure ulcers is done, comprehensive assessments and weekly monitoring are completed, and orders for treatment are received and educate staff on those policies. The director of nursing or designee, could conduct random audits of the delivery of care, assessments, and monitoring to ensure appropriate care and services are implemented to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and	21375		7/10/20

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21375	Continued From page 10 sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement appropriate infection control practices related to COVID-19 by failing to conduct required health screenings for all who entered the facility. In addition the facility staff failed to utilized appropriate personal protective equipment (PPE) when providing personal care and treatment to residents as required. These practices had the potential to affect all 67 residents and staff in the facility. Findings include: During observation on 6/2/20, upon entrance to the facility, the state surveyor (SA) was asked to sign in and the SA's temperature was checked. The SA was not asked the required COVID-19 screening questions to assess for symptoms or possible exposure of COVID-19 as required. -On 6/3/20 the SA entered the facility and was asked to sign in and the SA's temperature was checked, however the SA was not asked the required COVID-19 screening questions to assess for symptoms and exposure of COVID-19 as required. -On 6/4/20 the SA entered the facility and was asked to sign in and the SA's temperature was checked, however the SA was not asked the required COVID-19 screening question to assess for symptoms and exposure of COVID-19 as required. On 6/2/20, the director of nursing (DON) confirmed the facility did not have any positive or suspected positive COVID cases in the facility at	21375	F880 DON/designee will review and revise prn policies to ensure appropriate screening and wearing of PPE (goggles) with resident care. DON/designee will re-educated appropriate screening staff on the policy regarding Screening of Essential Visitors on 6/23/20. and the wearing of appropriate PPE (goggles) with resident care. DON/designee to implement random audits to ensure ongoing screening compliance, daily X 1 week, 3XwkX2, then weekly thereafter. DON/designee will implement random audits of resident treatments to ensure compliance with wearing appropriate PPE (goggles) while providing resident care, 2XwkX2, weekly X2, then monthly thereafter.. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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21375	Continued From page 11	21375		

this time.

R2's diagnosis report included bipolar disorder, history of falls, hypertension, lung disease, Parkinson's, and peripheral vascular disease. R2 had orders for wet to dry dressing change daily but was not on any special precautions. R2 did not exhibit any acute respiratory symptoms and was not COVID positive.

On 6/3/20 at 9:00 a.m. Licensed practical nurse (LPN)-A was observed to change R2's wound dressings on her left leg. LPN-A was wearing a surgical mask, gathered supplies and applied gloves. LPN-A proceeded to remove the dressing wrap from around R2's lower leg. LPN-A attempted to remove the 4 by 4 gauze that directly covered the open wounds. The gauze was adhered to the wound and difficult to remove, so LPN-A sprayed the dressing directly with a saline spray. LPN-A then proceeded to remove the 4 by 4 dressing and cleanse the wound. The wounds were moist appearing and had moist drainage present in the wound and on the soiled dressings. LPN-A applied new dressings to the wounds on R2's left leg and secured the dressings with tape. LPN-A discarded the old dressings, removed her gloves and sanitized her hands with alcohol based hand rub.

On 6/3/20 at 9:30 a.m. LPN-A verified the treatment observed with R2's dressing change was direct patient care. LPN-A stated she would only wear goggles for treatment if there would be some sort of splashing or something of that nature.

On 6/4/20 at 9:35 a.m. RN-A stated staff were required to wash hands, and wear mask and goggles for all patient care. RN-A stated this

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21375	Continued From page 12	21375		

applied to licensed staff as well as direct care staff. RN-A verified LPN-A should wear goggles while doing treatments.

On 6/4/20 at 9:52 a.m. the DON stated she would have to look at the policy but she was sure staff were told to wear goggles for patient care. She stated each worker had their own goggles or face shield that they were responsible to care for. The DON verified LPN-A should have worn goggles to perform dressing changes. The DON further verified visitor screening should have included the COVID-19 screening questions to assess for exposure and symptoms of COVID-19.

The facility's Coronavirus Prevention, Screening, and Identification policy, with a revision date of 5/20/20, identified a breach of PPE can result in the spread of infectious pathogens. Breach of PPE can include but is not limited to: inappropriate use of facial mask, poor hand hygiene, improper don/doff of PPE, not using appropriate PPE for the infectious agent and tears or damage to PPE and need to be reported immediately to supervisor. The policy indicated personnel would be assigned to monitor the visitor entrance and evaluate appropriateness of any visitor, utilizing a visitor screening tool. The policy directed staff to do careful screening of visitors for fever or respiratory symptoms and remind visitors to frequently perform hand hygiene.

SUGGESTED METHOD OF CORRECTION:

The Director of Nursing or designee could develop, review, and/or revise policies and

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21375	Continued From page 13 procedures to ensure appropriate screening upon entrance into the facility and proper use of PPE related to COVID-19 requirements. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21375		