Electronically delivered
January 11, 2021

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

RE: CCN: 245252
Cycle Start Date: October 30, 2020

Dear Administrator:

On November 17, 2020, we informed you of imposed enforcement remedies.

On December 31, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 1, 2021, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 1, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 1, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of November 17, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from

conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 1, 2021.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Thief River Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 1, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 30, 2021 (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.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you

have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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 12/31/2020

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) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/30/20 and 12/31/20, an abbreviated survey was completed at your facility to conduct complaint investigation(s). Thief River Care Center was found not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5252044C (MN68513) with a deficiency cited at F728. As a result of the investigation an additional deficiency was cited at F550. 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		2/3/21

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

Electronically Signed | 01/19/2021

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

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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a dignified bathing experience for 1 of 3 residents (R1) reviewed with cognitive impairment and were dependent on	F 550	F550 483.10(a)(1) states that a facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	

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F 550	Continued From page 2 staff for bathing assistance. Findings include: R1's quarterly Minimum Data Set (MDS) dated 10/7/20, identified R1 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADL)'s, including bathing. Diagnoses included dementia, cerebral infarction (a brain lesion in which cluster of brain cells die when they do not get enough blood) and chronic pain. R1's care plan revised 11/30/20, indicated R1 required assistance with all bathing and could be non compliant at times. The care plan directed staff to take time when giving baths to avoid agitation, move slowly, avoid getting water into her face, and indicated R1 startled easily which would increase agitation. The care plan identified R1 experienced agitation and restlessness and directed staff to explain all cares prior to starting and during cares, maintain consistent routine, be positive in approach to resident, and engage in activity. A Common Entry Point intake form submitted to the state agency (SA) on 12/26/20, at 7:13 a.m. indicated nursing assistants (NA)-A and NA-B were behaving in an unprofessional manner while assisting R1 with her weekly tub bath. On 12/30/20, at 11:22 a.m. NA-C stated NA-A and NA-B were assisting R1 with her weekly bath and the aides were "kind of goofing off" while assisting R1. NA-C indicated they were making hair styles on R1 with the shampoo and laughing and joking around.	F 550	promotes maintenance or enhancement of his or her quality of life recognizing each resident□s individuality. The facility must protect and promote the rights of the resident. TRCC failed to meet this requirement by not providing a dignified bathing experience to R1. R1□s care plan will be reviewed and revised to ensure that the proper interventions are in place for bathing. NA-A, NA-B and NA-C will all be educated on the care plan, dignified bathing and Maltreatment policy, which differentiates between the different kinds of abuse. TRCC□s goal is to ensure that all residents are treated with respect and dignity despite the resident□s intellectual/cognitive/behavioral impairment. All staff will be educated on the Maltreatment policy, and Dignity policy. DON or designee will do random audits to ensure that dignified care is being done. Audits will be done 3x/week for 4 weeks, 2x/week for 4 weeks and then 1x/week for 4 weeks. Audit results will be brought to the QAPI Committee meeting for further evaluation and recommendations.	

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F 550	Continued From page 3	F 550		

During telephone interview on 12/30/20, at 12:41 p.m. NA-A stated she and NA-B had assisted R1 with her weekly bath on 12/21/20. R1 did not like baths and began hollering while washing her hair. NA-A stated they were careful not to spray any water in her face and NA-B was talking with R1 in soothing tones to try to keep R1 calm. NA-A indicated the bath took about 45 minutes and R1 acted her usual self.

During telephone interview on 12/30/20, at 12:51 p.m. NA-B stated she assisted NA-A to give R1 a tub bath on 12/21/20. NA-B indicated R1 did not like baths, so they tried to make the bath fun. NA-B indicated they talked and had a little fun. R1 liked to mimic staff, so they had a couple of laughs when R1 mimicked them. R1 was fussy and yelled during the bath but seemed to like it when they shampooed her hair. Further they had a "little fun with the shampoo", making different hair styles with it. R1 did not seem to mind it, but wanted to get out of the tub as the bath went on. They just kept reassuring her they would finish soon. Although R1 did not like baths and hollered and yelled during her baths, R1 reacted in her usual manner with the bath and did not appear upset once the bath was completed.

During interview on 12/30/20, at 2:36 p.m. registered nurse (RN)-A stated she received a verbal report from NA-C that NA-A and NA-B were goofing around while assisting R1 with her weekly bath. RN-A spoke with NA-A and NA-B immediately and educated them on appropriate behavior around residents. The nursing assistants immediately stopped their behavior and proceeded with the bath without further incident. RN-A stated the two nursing assistants were fairly new and lacked training.

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F 550	Continued From page 4 When interviewed on 12/30/20, at 3:35 p.m. the director of nursing (DON) stated she had heard there were a couple nursing assistants assisting a resident with a bath and they were shampooing R1's hair up and being silly. The DON indicated the charge nurse immediately intervened and instructed the nursing assistants on proper resident care. The DON stated she did not feel the incident needed to be reported to the state agency (SA) as NA-A and NA-B did not act in a cruel or mean manner and were not berating or mistreating R1; however, the behavior was not appropriate and RN-A corrected their behavior. Further, facility wide education had not been provided to ensure all staff were providing dignified care to residents. The facility policy Maltreatment Prohibition Policy, reviewed 2/19/18, identified all staff are expected to be in control of their own behavior, are to behave professionally and should appropriately understand how to work with the nursing home population.	F 550		
F 728 SS=F	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the	F 728		2/3/21

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F 728	Continued From page 5 State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 4 nursing assistants (NA-A, NA-B) reviewed were deemed competent to complete cares for residents. This had the potential to affect all 45 residents residing in the facility. Findings include: The COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers dated 12/1/20, identified the Center for Medicare and Medicaid	F 728	As defined in 483.35(d)(1) a facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full time bases, unless the individual is competent and completed training. TRCC failed to ensure that 2 of 4 nursing assistants (NA-A, NA-B) reviewed were deemed competent. Nursing Assistants (NA-A, NA-B) will complete the online training and the competency training with an RN. DON or	

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F 728	Continued From page 6 Services (CMS) waived the requirement that a skilled nursing facility "may not employ anyone for longer than four months unless they met training and certification requirements to assist in potential staffing shortages seen with the COVID-19 pandemic. However, to ensure the health and safety of nursing home residents, CMS did not waive the requirement which requires facilities to not use any individual working as a nurse aide for more than four months, unless that individual is competent to provide nursing and nursing related services. CMS continues to require facilities to ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments and described in the plan of care." A Common Entry Point intake form submitted to the state agency (SA) on 12/26/20, at 7:13 a.m. indicated the facility had allowed student nursing assistants that were not trained to complete resident direct resident care. The facility provided an undated Nursing Assistant Job description. The job description identified nursing assistants education and experience requirements for the facility as one of the following: the NA was on the MN State Registry in good standing or the ability and plan to complete nursing assistant course work and/or complete skills and written competency testing in accordance with regulations and care center policy. In addition, the facility provided a blank NA Floor Orientation Checklist, to evaluate each person's nursing skills. The skills on the form were to be dated and initialed by the orientating person to	F 728	designee will review all NA's and those that are not registered to ensure that training is completed. This could affect the cares of all residents at TRCC. The DON or designee will ensure that all Current new nursing assistants, will complete the online training and competencies with a RN before they start their on the job training on the unit they are assigned to. On boarding will be scheduled for a 2 day event day 1 with HR and online training. Day 2 will continue online training with a 2 hour break out session with the Don or designee. A Competency training folder will be maintained in the DON office. When complete it will become a part of employee record. The DON or designee will monitor the competency training folders of the NAs hired within the last year, and all future new hires to ensure that they have completed their onboarding training. Current employees will be done weekly until complete, and within the first week of a new hire. Findings will be brought to the QAPI Committee meeting for further evaluation and recommendations.	

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F 728	Continued From page 7	F 728		

indicate the skills had been explained and had been observed by another staff to verify competency. The form did not identify a registered nurse (RN) would verify the skills were completed successfully. The form listed skills under resident care expectations, personal hygiene and grooming skills, elimination skills, nutrition and fluids, bed making and bathing, measurements and vital signs, feeding, diet cards, toileting, restorative program, transferring and repositioning, body mechanics and exercise positioning, infection control and safety measures, skin and wound care, heat and cold application, twenty-nine Educare online training courses, communication and documentation, use of mechanical lift, transfer belts, call system, mandatory nursing meetings, severe weather procedure, location of emergency books, RACE fire procedures, resident and employee incident reporting, family/resident concerns, missing resident procedures, Heimlich maneuver, emergency procedures and promoting resident independence

NA-A's employee file identified the following:

-NA-A was hired on 10/26/20.

-NA-A's facility computerized training transcript indicated NA-A had received 4.25 hours of online training in Health Insurance Portability and Accountability Act (HIPAA), Infection Prevention and Control-N95 Respirator, Coronavirus COVID-19, Abuse Prevention and Resident Rights and Bathing Without a Battle. NA-A's transcript lacked training on resident mobility, behavioral health, cultural competency, dementia care, dining, emergency preparedness, hospice care, diets, resident activities of daily living (ADL)

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	245252	A. BUILDING _____ B. WING _____	C 12/31/2020

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) COMPLETION DATE
F 728	Continued From page 8	F 728		

training and communication and conflict resolution.

- NA-A's file lacked the required NA Floor Orientation Checklist to indicate each nursing skill had been explained to NA-A and NA-A had been observed by another staff to verify competency of the nursing skills. NA-A's Initial Hiring/Training Record was empty with no completion dates entered.

On 12/30/20, the Minnesota Nursing Assistant Registry identified NA-A was not registered by the State Agency (SA).

NA-B's employee file identified the following:

- NA-B was hired on 10/27/20.

- NA-B's facility computerized training transcript indicated NA-B had received 5.5 hours of online training in HIPAA, Infection Prevention and Control-personal protective equipment (PPE), Infection Prevention and Control-SNF, Infection Prevention and Control-N95, Coronavirus COVID-19, and Abuse Prevention and Resident Rights. NA-B's transcript lacked training on resident mobility, behavioral health, cultural competency, dementia care, dining, emergency preparedness, hospice care, diets, resident activities of daily living (ADL) training and communication and conflict resolution.

- NA-B's employee file lacked the required NA Floor Orientation Checklist to indicate each nursing skill had been explained to NA-B and NA-B had been observed by another staff to verify competency of the nursing skills. NA-B's Initial Hiring/Training Record was empty with no

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F 728	Continued From page 9	F 728		

completion dates entered.

On 12/30/20, the Minnesota Nursing Assistant registry identified NA-B was not registered by the SA.

On 12/30/20, at 2:36 p.m. RN-A stated the facility wanted her to do the training with the new NA's and she was suppose to do six hours of training with them. RN-A was not completing the training as they were always scheduled on the medication cart and had no time allotted to do the required training for the NA's.

During interview on 12/31/20, at 10:11 a.m. the director of nursing (DON) stated the nursing assistants were trained online through the Educare system and then they received orientation on the floor with a seasoned NA. The facility did have a NA training course that was 75 hours, which included 16 hours of clinical and 12 hours of lab time but the training course stopped several months ago due to lack of licensed staff to teach it. Return demonstrations and competencies were on the NA Floor Orientation Checklist and verified by a nursing assistant. The DON indicated all newly hired NA's should have a completed form in their employee files shortly after hire. The facility was relying on the Educare online training due to time constraints of the licensed staff. The DON stated there was no registered nurses involvement with the training of new NA's because all the registered nurses were needed on the floor for resident care. There was certain training that had to be done before the NA's could perform resident cares but the DON indicated she was not sure exactly what was required and would have to check with human resources (HR)-A for that information. HR-A and

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F 728	Continued From page 10 the DON were responsible for checking on the completion of training for the NA's. All the nursing assistants had the potential to care for all the residents residing in the facility. The DON stated she would check for the NA-B and NA-s completed competency check lists. On 12/30/20, at 10:45 a.m. HR-A stated the NA's needed to have their HIPPA, Abuse and Resident Rights, COVID-19, and Infection Control for SNF's training completed before they could work on the floor providing resident care. HR-A did not identify how the facility would ensure untrained staff were competent to care for the residents residing in the facility. NA-A and NA-B's completed NA Floor Orientation Checklist were never provided.	F 728		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 11, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: CTCS11

Dear Administrator:

The above facility was surveyed on December 30, 2020 through December 31, 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:

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

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 12/30/20 and 12/31/20, an abbreviated survey was conducted to determine compliance for state licensure. The following correction orders are 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: H5252044C (MN68513) Correction order(s) issued at: MN Rule 144.651 Subd. 5 1805 & 4658.0105 0300 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. State licensing orders are delineated on 2567, under the Minnesota Department of Health licensing order statute(s) 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 on the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting your plan of correction to the Minnesota Department of Health. 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 found 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	2 000		

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2 000	Continued From page 2 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.	2 000		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 4 nursing assistants (NA-A, NA-B) reviewed were deemed competent to complete cares for residents. This had the potential to affect all 45 residents residing in the facility. Findings include: The COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers dated 12/1/20, identified the Center for Medicare and Medicaid Services (CMS) waived the requirement that a skilled nursing facility "may not employ anyone for longer than four months unless they met training	2 300	Corected	2/3/21

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2 300	Continued From page 3 and certification requirements to assist in potential staffing shortages seen with the COVID-19 pandemic. However, to ensure the health and safety of nursing home residents, CMS did not waive the requirement which requires facilities to not use any individual working as a nurse aide for more than four months, unless that individual is competent to provide nursing and nursing related services. CMS continues to require facilities to ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments and described in the plan of care." A Common Entry Point intake form submitted to the state agency (SA) on 12/26/20, at 7:13 a.m. indicated the facility had allowed student nursing assistants that were not trained to complete resident direct resident care. The facility provided an undated Nursing Assistant Job description. The job description identified nursing assistants education and experience requirements for the facility as one of the following: the NA was on the MN State Registry in good standing or the ability and plan to complete nursing assistant course work and/or complete skills and written competency testing in accordance with regulations and care center policy. In addition, the facility provided a blank NA Floor Orientation Checklist, to evaluate each person's nursing skills. The skills on the form were to be dated and initialed by the orientating person to indicate the skills had been explained and had been observed by another staff to verify competency. The form did not identify a registered nurse (RN) would verify the skills were	2 300		

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2 300	Continued From page 4 completed successfully. The form listed skills under resident care expectations, personal hygiene and grooming skills, elimination skills, nutrition and fluids, bed making and bathing, measurements and vital signs, feeding, diet cards, toileting, restorative program, transferring and repositioning, body mechanics and exercise positioning, infection control and safety measures, skin and wound care, heat and cold application, twenty-nine Educare online training courses, communication and documentation, use of mechanical lift, transfer belts, call system, mandatory nursing meetings, severe weather procedure, location of emergency books, RACE fire procedures, resident and employee incident reporting, family/resident concerns, missing resident procedures, Heimlich maneuver, emergency procedures and promoting resident independence NA-A's employee file identified the following: -NA-A was hired on 10/26/20. -NA-A's facility computerized training transcript indicated NA-A had received 4.25 hours of online training in Health Insurance Portability and Accountability Act (HIPAA), Infection Prevention and Control-N95 Respirator, Coronavirus COVID-19, Abuse Prevention and Resident Rights and Bathing Without a Battle. NA-A's transcript lacked training on resident mobility, behavioral health, cultural competency, dementia care, dining, emergency preparedness, hospice care, diets, resident activities of daily living (ADL) training and communication and conflict resolution. - NA-A's file lacked the required NA Floor Orientation Checklist to indicate each nursing skill	2 300		

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2 300	Continued From page 5 had been explained to NA-A and NA-A had been observed by another staff to verify competency of the nursing skills. NA-A's Initial Hiring/Training Record was empty with no completion dates entered. On 12/30/20, the Minnesota Nursing Assistant Registry identified NA-A was not registered by the State Agency (SA). NA-B's employee file identified the following: - NA-B was hired on 10/27/20. - NA-B's facility computerized training transcript indicated NA-B had received 5.5 hours of online training in HIPAA, Infection Prevention and Control-personal protective equipment (PPE), Infection Prevention and Control-SNF, Infection Prevention and Control-N95, Coronavirus COVID-19, and Abuse Prevention and Resident Rights. NA-B's transcript lacked training on resident mobility, behavioral health, cultural competency, dementia care, dining, emergency preparedness, hospice care, diets, resident activities of daily living (ADL) training and communication and conflict resolution. - NA-B's employee file lacked the required NA Floor Orientation Checklist to indicate each nursing skill had been explained to NA-B and NA-B had been observed by another staff to verify competency of the nursing skills. NA-B's Initial Hiring/Training Record was empty with no completion dates entered. On 12/30/20, the Minnesota Nursing Assistant registry identified NA-B was not registered by the SA.	2 300		

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2 300	Continued From page 6 On 12/30/20, at 2:36 p.m. RN-A stated the facility wanted her to do the training with the new NA's and she was suppose to do six hours of training with them. RN-A was not completing the training as they were always scheduled on the medication cart and had no time allotted to do the required training for the NA's. During interview on 12/31/20, at 10:11 a.m. the director of nursing (DON) stated the nursing assistants were trained online through the Educare system and then they received orientation on the floor with a seasoned NA. The facility did have a NA training course that was 75 hours, which included 16 hours of clinical and 12 hours of lab time but the training course stopped several months ago due to lack of licensed staff to teach it. Return demonstrations and competencies were on the NA Floor Orientation Checklist and verified by a nursing assistant. The DON indicated all newly hired NA's should have a completed form in their employee files shortly after hire. The facility was relying on the Educare online training due to time constraints of the licensed staff. The DON stated there was no registered nurses involvement with the training of new NA's because all the registered nurses were needed on the floor for resident care. There was certain training that had to be done before the NA's could perform resident cares but the DON indicated she was not sure exactly what was required and would have to check with human resources (HR)-A for that information. HR-A and the DON were responsible for checking on the completion of training for the NA's. All the nursing assistants had the potential to care for all the residents residing in the facility. The DON stated she would check for the NA-B and NA-s completed competency check lists.	2 300		

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2 300	Continued From page 7 On 12/30/20, at 10:45 a.m. HR-A stated the NA's needed to have their HIPPA, Abuse and Resident Rights, COVID-19, and Infection Control for SNF's training completed before they could work on the floor providing resident care. HR-A did not identify how the facility would ensure untrained staff were competent to care for the residents residing in the facility. NA-A and NA-B's completed NA Floor Orientation Checklist were never provided. SUGGESTED METHOD OF CORRECTION: The DON or designee could ensure competancy training to nursing assistants was completed and verified by a registered nurse prior to providing cares to residents. The facility could review and revise or implement new policies / procedures on training required for nursing staff. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 300		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide a dignified bathing	21805	Corrected	2/3/21

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21805	Continued From page 8	21805		

experience for 1 of 3 residents (R1) reviewed with cognitive impairment and were dependent on staff for bathing assistance.

Findings include:

R1's quarterly Minimum Data Set (MDS) dated 10/7/20, identified R1 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADL)'s, including bathing. Diagnoses included dementia, cerebral infarction (a brain lesion in which cluster of brain cells die when they do not get enough blood) and chronic pain.

R1's care plan revised 11/30/20, indicated R1 required assistance with all bathing and could be non compliant at times. The care plan directed staff to take time when giving baths to avoid agitation, move slowly, avoid getting water into her face, and indicated R1 startled easily which would increase agitation. The care plan identified R1 experienced agitation and restlessness and directed staff to explain all cares prior to starting and during cares, maintain consistent routine, be positive in approach to resident, and engage in activity.

A Common Entry Point intake form submitted to the state agency (SA) on 12/26/20, at 7:13 a.m. indicated nursing assistants (NA)-A and NA-B were behaving in an unprofessional manner while assisting R1 with her weekly tub bath.

On 12/30/20, at 11:22 a.m. NA-C stated NA-A and NA-B were assisting R1 with her weekly bath and the aides were "kind of goofing off" while assisting R1. NA-C indicated they were making hair styles on R1 with the shampoo and laughing and joking around.

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 12/31/2020

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
21805	Continued From page 9 During telephone interview on 12/30/20, at 12:41 p.m. NA-A stated she and NA-B had assisted R1 with her weekly bath on 12/21/20. R1 did not like baths and began hollering while washing her hair. NA-A stated they were careful not to spray any water in her face and NA-B was talking with R1 in soothing tones to try to keep R1 calm. NA-A indicated the bath took about 45 minutes and R1 acted her usual self. During telephone interview on 12/30/20, at 12:51 p.m. NA-B stated she assisted NA-A to give R1 a tub bath on 12/21/20. NA-B indicated R1 did not like baths, so they tried to make the bath fun. NA-B indicated they talked and had a little fun. R1 liked to mimic staff, so they had a couple of laughs when R1 mimicked them. R1 was fussy and yelled during the bath but seemed to like it when they shampooed her hair. Further they had a "little fun with the shampoo", making different hair styles with it. R1 did not seem to mind it, but wanted to get out of the tub as the bath went on. They just kept reassuring her they would finish soon. Although R1 did not like baths and hollered and yelled during her baths, R1 reacted in her usual manner with the bath and did not appear upset once the bath was completed. During interview on 12/30/20, at 2:36 p.m. registered nurse (RN)-A stated she received a verbal report from NA-C that NA-A and NA-B were goofing around while assisting R1 with her weekly bath. RN-A spoke with NA-A and NA-B immediately and educated them on appropriate behavior around residents. The nursing assistants immediately stopped their behavior and proceeded with the bath without further incident. RN-A stated the two nursing assistants were fairly new and lacked training.	21805		

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21805	Continued From page 10 When interviewed on 12/30/20, at 3:35 p.m. the director of nursing (DON) stated she had heard there were a couple nursing assistants assisting a resident with a bath and they were shampooing R1's hair up and being silly. The DON indicated the charge nurse immediately intervened and instructed the nursing assistants on proper resident care. The DON stated she did not feel the incident needed to be reported to the state agency (SA) as NA-A and NA-B did not act in a cruel or mean manner and were not berating or mistreating R1; however, the behavior was not appropriate and RN-A corrected their behavior. Further, facility wide education had not been provided to ensure all staff were providing dignified care to residents. The facility policy Maltreatment Prohibition Policy, reviewed 2/19/18, identified all staff are expected to be in control of their own behavior, are to behave professionally and should appropriately understand how to work with the nursing home population. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure resident(s) dignity are maintained. Audits could be completed, and results of these audits are reviewed by the quality assessment and performance improvement (QAPI) committee could ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21805		

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21805	Continued From page 11 (21) days.	21805		