DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 30, 2022

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

RE: CCN: 245252
Cycle Start Date: May 4, 2022

Dear Administrator:

On June 27, 2022, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 30, 2022

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

Re: Reinspection Results
Event ID: D19Q12

Dear Administrator:

On June 27, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 4, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 12, 2022

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

RE: CCN: 245252
Cycle Start Date: May 4, 2022

Dear Administrator:

On May 4, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 4, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 4, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
May 12, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: D19Q11

Dear Administrator:

The above facility was surveyed on May 2, 2022 through May 4, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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, Compliance Analyst
Minnesota Department of Health
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 05/04/2022

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 5/2/22 through 5/4/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated, however no deficiencies were cited due to actions implemented by the facility prior to survey. H5252068C (MN81710) H5252069C (MN82259) The following complaints were found to be unsubstantiated: H5252066C (MN80774) H5252067C (MN81606) H5252070C (MN82281) H5252071C (MN83060) However, due to the investigations deficiencies were cited at F609 and F888 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		6/8/22

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

Electronically Signed | 05/17/2022

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 609	Continued From page 1 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report, no later than two hours, to the administrator and State Agency (SA), an injury of unknown origin with serious bodily injury for 1 of 3 residents (R5) reviewed for injuries of unknown source. Findings include:	F 609	For the tag;F609; A facility must report abuse immediately, or serious bodily injury of unknown source, but no later than 2 hours. If no serious bodily injury has occurred or the source is known, it can be reported within 24 hours. R(5), was hospitalized on 3/3/2022 and an xray was performed on her humerus. It	

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F 609	Continued From page 2 R5's significant change Minimum Data Set (MDS) dated 1/21/22, identified R5 had a severe cognitive impairment, was non-ambulatory, and required staff assistance activities of daily living. R5's nursing progress note dated 3/3/22, at 3:38 p.m. identified the facility was notified by the hospital R5 was admitted to the hospital and had a broken humerus. The facility report submitted to the SA on 3/7/22, identified on 3/3/22, R5 was sent to the Emergency department at the local hospital, for low blood pressure. It was there that it was found that she had an incompletely healed humerus fracture. The facility was not aware of how R5 sustained the fracture and reported the incident when R5 was returning back to the facility following hospitalization. During interview on 5/3/22, at 2:50 p.m. registered nurse (RN)-A stated on 3/3/22, the hospital nurse called to report to the facility R5 was being admitted and she had a humerus fracture. During interview on 5/3/22 3:19 PM, RN-B stated the facility should report to the SA an injury of unknown injury, especially a broken bone, immediately upon notification from the hospital. During an interview on 5/3/22, at 3:24 p.m. the administrator stated a report to the SA should have been completed on 3/3/22, when the nurse received the call from the hospital regarding R5's injury of unknown origin. The administrator was routinely notified of all falls in the facility, but could not verify if she was informed of R5's injury of	F 609	was then that staff was notified of the broken bone of unknown source. Staff did not report injury in a timely manner of 2 hours of notification of incident. This report was reported late per the guidelines set forth by the state agency. All residents have the potential to this happening to them. Skin checks and chart review were completed on all residents to ensure any injuries were identified. No further injuries of unknown source were identified Staff will be re-educated to the definition of unknown source injury must be injury that cannot be explained by resident or staff, or was not observed by any staff member, AND the injury is suspicious because of the extent or location of the injury. This will be reported to staff and what it looks like. If serious bodily injury has occurred, it will be reported within 2 hours. A facility must report an injury of unknown source without serious bodily injury no later than 24 hours The DON or designee will monitor incident reports/skin assessments and bodily injury reporting times 3x/week for two weeks, 2x/week for two weeks, and 1 x/week for two weeks and then weekly thereafter, starting 5/17/22. The monitoring results will be brought to QAPI for recommendations for ongoing monitoring. This action will be completed by June 8, 2022.	

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F 609	Continued From page 3 unknown origin prior to 3/7/22. The facility policy Maltreatment Prohibition Definitions revised 10/18/21, defined injuries of unknown source as: an injury should be classified as an "injury of unknown source" when both of the following criteria are met: 1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and 2. The injury was suspicious because of the extent of the injury or the location of the injury (for example, the injury was located in an area not generally vulnerable to trauma) or the number of injury observed at one particular point in the time or the incidence of injuries over time. The facility policy Maltreatment Reporting Guidelines revised 10/18/21, identified all staff would immediately report all allegations to their supervisor immediately. The supervisor shall immediately notify the administrator of any suspected maltreatment in order for the administrator in their administrative authority to fully assess the situation and participate in decision in reporting to officials according to the regulation. The policy further directed a report to the SA must occur immediately, but not later than 2 hours after the allegation was made, if the incident involves abuse, or neglect, exploitation or maltreatment that results in serious bodily injury including injuries of unknown source and misappropriation of resident property.	F 609		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility	F 888		6/8/22

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F 888	Continued From page 4	F 888		

must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 888	Continued From page 5 (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical	F 888		

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F 888	Continued From page 6	F 888		

exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the

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THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

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F 888	Continued From page 7 CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure all staff received the COVID-19 vaccination or were granted an religious and/or medical exemption for 2 of 8 staff members (nursing assistant (NA)-A and Housekeeper (HSK)-A) reviewed in the sample. This resulted in a 97.6% staff vaccination rate. Findings include: During entrance conference on 5/2/22, at 12:12 p.m. the admistrator stated they facility had no current resident COVID-19 cases and they had not had a COVID-19 positive resident in over four weeks. An untitled undated facility form, tracked all direct hire and contracted staff vaccination status. The form identified the employee name, hire date, birthdate, vaccine used, administration dates, and/or exemption. The form identified nursing assistant (NA)-A was hired on 12/6/16, and had received one dose of Moderna vaccine on 11/18/21, but no second dose was documented. Housekeeper (HSK)-A was hired 11/18/21, and had received one dose on 11/18/21, but no second dose was documented. During interview on 5/4/22, at 9:31 a.m. NA-A stated she received the first dose of the COVID-19 vaccine and become ill with COVID shortly after. NA-A had to have an infusion of monoclonal antibodies (a way of treating COVID-19 for people who have tested positive,	F 888	For the tag; F888; was noted that 2 staff members were outside of compliance with COVID vaccination policies. Exemptions for the 2 staff were completed on May 4th, 2022. All staff involved were re-educated on policy and vaccine requirements. All staff have the potential for this to happen. All Vaccine records were audited and compliant with mandatory COVID vaccine policy. The policy does not need to be changed. Audit of new hires will be audited by ICP or the administrator, with every new hire 3 times a week for 2 weeks, 2 times a week for 2 weeks and 1 time a week for 2 weeks. Will report further implications to the QA for recommendations for ongoing monitoring, and monitor for more occurrences. This will be completed by June 8, 2022.	

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	245252	A. BUILDING _____ B. WING _____	C 05/04/2022

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F 888	Continued From page 8	F 888		

have had mild symptoms for seven days or less, and are at high risk for developing more serious symptoms). When she returned to work, she was told the infection control nurse (IP) was tracking her status and would let her know when she was able to receive the second dose of the vaccine.

During interview with the administrator and the IP on 5/4/22, at 10:06 a.m. the IP stated they had 84 direct hire and contracted staff members. The IP stated HSK-A was hired in November and agreed to completing the vaccine series. HSK-A delayed getting vaccinated and had decided on the morning of 5/4/22, to not get vaccinated. The delay nor the decision to not complete the series was communicated to the administrator. HSK-A did not have a medical or non-medical exemption.

- IP stated NA-A received her first dose on 11/18/21. NA-A got COVID and received an infusion of monoclonal antibodies. The IP instructed NA-A to speak with her doctor and to let her know when she was able to receive her second dose. NA-A did not provide any more information to the IP. Further, NA-A had COVID on 12/6/21 and NA-A's 90 day "window" was completed on 3/6/22. This was not communicated to the administrator.

- The administrator stated she expected all staff to follow facility policy that all staff must be fully vaccinated or have a medical or non-medical exemption filed.

The Centers for Disease Control and Prevention (CDC) webpage Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United Stated

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F 888	Continued From page 9 reviewed 4/21/22, identified a contraindications and precautions to COVID-19 vaccination. However, the site did not list prior COVID-19 illness or the treatment of monoclonal antibodies as a contraindication to receiving the vaccine. The facility policy Mandatory COVID immunization dated 11/18/21, identified SFHS required all skilled nursing facility employees to receive the SARS-COV-2 (COVID 19) vaccination or obtain a documented exemption as a condition of employment. Human resources would compile and track all information related to vaccinations, including verification of vaccination status and exemption status. The vaccine would be provided upon hire. Staff not fully vaccinated would either have to have a medical or religious exemption. CDC guidance will be followed. If county transmission rate did not require testing, exempted employees will continue to test weekly.	F 888		

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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 5/2/22 through 5/4/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be substantiated; however, no licensing orders were issued: H5252068C (MN81710) H5252069C (MN82259) The following complaints were found to be unsubstantiated: H5252066C (MN80774) H5252067C (MN81606) H5252070C (MN82281) H5252071C (MN83060) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please	2 000		

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2 000	Continued From page 2 enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has	21980		6/8/22

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21980	Continued From page 3 been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the administrator and State Agency (SA), an injury of unknown origin with serious bodily injury for 1 of 3 residents (R5) reviewed for injuries of unknown source. Findings include: R5's significant change Minimum Data Set (MDS) dated 1/21/22, identified R5 had a severe cognitive impairment, was non-ambulatory, and required staff assistance activities of daily living. R5's nursing progress note dated 3/3/22, at 3:38	21980	corrected	

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21980	Continued From page 4 p.m. identified the facility was notified by the hospital R5 was admitted to the hospital and had a broken humerus. The facility report submitted to the SA on 3/7/22, identified on 3/3/22, R5 was sent to the Emergency department at the local hospital, for low blood pressure. It was there that it was found that she had an incompletely healed humerus fracture. The facility was not aware of how R5 sustained the fracture and reported the incident when R5 was returning back to the facility following hospitalization. During interview on 5/3/22, at 2:50 p.m. registered nurse (RN)-A stated on 3/3/22, the hospital nurse called to report to the facility R5 was being admitted and she had a humerus fracture. During interview on 5/3/22 3:19 PM, RN-B stated the facility should report to the SA an injury of unknown injury, especially a broken bone, immediately upon notification from the hospital. During an interview on 5/3/22, at 3:24 p.m. the administrator stated a report to the SA should have been completed on 3/3/22, when the nurse received the call from the hospital regarding R5's injury of unknown origin. The administrator was routinely notified of all falls in the facility, but could not verify if she was informed of R5's injury of unknown origin prior to 3/7/22. The facility policy Maltreatment Prohibition Definitions revised 10/18/21, defined injuries of unknown source as: an injury should be classified as an "injury of unknown source" when both of the following criteria are met: 1. The source of the injury was not observed by	21980		

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21980	Continued From page 5 any person or the source of the injury could not be explained by the resident; and 2. The injury was suspicious because of the extent of the injury or the location of the injury (for example, the injury was located in an area not generally vulnerable to trauma) or the number of injury observed at one particular point in the time or the incidence of injuries over time. The facility policy Maltreatment Reporting Guidelines revised 10/18/21, identified all staff would immediately report all allegations to their supervisor immediately. The supervisor shall immediately notify the administrator of any suspected maltreatment in order for the administrator in their administrative authority to fully assess the situation and participate in decision in reporting to officials according to the regulation. The policy further directed a report to the SA must occur immediately, but not later than 2 hours after the allegation was made, if the incident involves abuse, or neglect, exploitation or maltreatment that results in serious bodily injury including injuries of unknown source and misappropriation of resident property. SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could review and revise applicable policies and procedures pertaining to the reporting of abuse to ensure current; then inservice staff regarding the timely identification and reporting of abuse; then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21980		

Minnesota Department of Health

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Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/17/22

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21980	Continued From page 4 p.m. identified the facility was notified by the hospital R5 was admitted to the hospital and had a broken humerus. The facility report submitted to the SA on 3/7/22, identified on 3/3/22, R5 was sent to the Emergency department at the local hospital, for low blood pressure. It was there that it was found that she had an incompletely healed humerus fracture. The facility was not aware of how R5 sustained the fracture and reported the incident when R5 was returning back to the facility following hospitalization. During interview on 5/3/22, at 2:50 p.m. registered nurse (RN)-A stated on 3/3/22, the hospital nurse called to report to the facility R5 was being admitted and she had a humerus fracture. During interview on 5/3/22 3:19 PM, RN-B stated the facility should report to the SA an injury of unknown injury, especially a broken bone, immediately upon notification from the hospital. During an interview on 5/3/22, at 3:24 p.m. the administrator stated a report to the SA should have been completed on 3/3/22, when the nurse received the call from the hospital regarding R5's injury of unknown origin. The administrator was routinely notified of all falls in the facility, but could not verify if she was informed of R5's injury of unknown origin prior to 3/7/22. The facility policy Maltreatment Prohibition Definitions revised 10/18/21, defined injuries of unknown source as: an injury should be classified as an "injury of unknown source" when both of the following criteria are met: 1. The source of the injury was not observed by	21980		

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 05/04/2022

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

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21980	Continued From page 5 any person or the source of the injury could not be explained by the resident; and 2. The injury was suspicious because of the extent of the injury or the location of the injury (for example, the injury was located in an area not generally vulnerable to trauma) or the number of injury observed at one particular point in the time or the incidence of injuries over time. The facility policy Maltreatment Reporting Guidelines revised 10/18/21, identified all staff would immediately report all allegations to their supervisor immediately. The supervisor shall immediately notify the administrator of any suspected maltreatment in order for the administrator in their administrative authority to fully assess the situation and participate in decision in reporting to officials according to the regulation. The policy further directed a report to the SA must occur immediately, but not later than 2 hours after the allegation was made, if the incident involves abuse, or neglect, exploitation or maltreatment that results in serious bodily injury including injuries of unknown source and misappropriation of resident property. SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could review and revise applicable policies and procedures pertaining to the reporting of abuse to ensure current; then inservice staff regarding the timely identification and reporting of abuse; then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21980		