



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 26, 2026

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

RE: CCN: 245252
Cycle Start Date: April 1, 2026

Dear Administrator:

On May 14, 2026, the Minnesota Departments of Health and Public Safety, 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,

A handwritten signature in blue ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



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RE: CCN:245252

Cycle Start Date: April 1, 2026

Dear Administrator:

On April 1, 2026, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 July 1, 2026 (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 October 1, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

**Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division**

**445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189**

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245252		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/01/2026	
NAME OF PROVIDER OR SUPPLIER THIEF RIVER CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2001 EASTWOOD DRIVE , THIEF RIVER FALLS, Minnesota, 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
E0000	Initial Comments On 3/30/26 through 4/1/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			04/21/2026
F0000	INITIAL COMMENTS On 3/30/26 through 4/1/26, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies were cited: H52529562C (2590125), H52529583C (2801949), H52529584C (2786068) H52529585C (2694473), H52529586C (2677076), H52529587C (2638910), H52529588C (2632881) H52529589C (MN00110160) 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 substantial compliance with the regulations has been attained.			F0000			04/21/2026
F0641 SS = E	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments.			F0641			F641 Accuracy of Assessments: -failed to ensure MDS coded accurately related to antiplatelet use

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 reverse for further 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.

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

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

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F0641 SS = E	Continued from page 1 The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure medications were coded correctly on the Minimum Data Set (MDS) for 4 of 7 residents (R22, R62, R29, R46) reviewed for MDS discrepancies. Findings include: R22 R22's significant change MDS dated 3/24/26, identified R22 had a diagnosis of hyperlipidemia. The MDS identified R22 was taking an anticoagulant, antibiotic, diuretic, and hypoglycemic medications. R22's MDS did not identify they received an antiplatelet medication.	F0641	Continued from page 1 The Director of Nursing will implement corrective action for residents R22, R62, R29, and R46: The MDS Coordinator (RN) reviewed each cited resident's MDS (Significant Change or Quarterly) and corrected medication coding errors related to high-risk drug classification. The inaccurate coding of aspirin as an anticoagulant was corrected to antiplatelet, consistent with the RAI Manual, Section N0415I1. Corrected MDS assessments were signed, certified, and submitted in accordance with CMS requirements. The interdisciplinary care plans were reviewed to ensure resident care needs were accurately reflected. The DON verified corrections to ensure compliance with §483.20(g) Accuracy of Assessments. The Director of Nursing will assess residents having the potential to be affected by this practice including: · a facility-wide audit of all current residents' most recent MDS assessments (Admission, Quarterly, Annual, Significant Change). · The audit specifically reviewed Section N – Medications, focusing on: Anticoagulants Antiplatelets Antipsychotics Antidepressants · Each resident's MDS coding was cross-referenced with the MAR, Medication Review Report, and physician orders for the observation period.	05/06/2026

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F0641 SS = E	Continued from page 2 R22's March 2026, Medication Administration Record (MAR), identified R22 was receiving the following medications: Aspirin (an antiplatelet medication) 81 mg one a day for hyperlipidemia (high cholesterol or triglycerides). R22 was not receiving an anticoagulant medication during this time, as identified on the MDS. R62 R62's quarterly MDS dated 12/23/25, identified R62 had a diagnosis of hyperlipidemia. The MDS identified R62 was taking an antipsychotic, antidepressant, anticoagulant, and diuretic medications. R62's MDS did not identify they received an antiplatelet medication. R62's December 2025, MAR, identified R62 was receiving Aspirin (an antiplatelet medication) 81 mg one a day for hyperlipidemia. R62 was not receiving an anticoagulant during this time, as identified on the MDS. R29 R29's quarterly Minimum Data Set (MDS) dated 3/10/26, identified R29 had a diagnoses of a lower extremity artery aneurysm, diabetes type II, depression, hypertension and anxiety. R29 used antipsychotic, antianxiety, antidepressant, anticoagulant, opioid, hypoglycemic, and anticonvulsant medications. R29's March 2026 MAR failed to identify R29 received an anticoagulant medication during the observation period. R29's Medication Review Report dated 4/1/26, identified R29 received aspirin (an antiplatelet medication) (aspirin is used to treat mild to moderate pain, inflammation, and fever, and is frequently used at low doses to prevent heart attacks and strokes) 81 milligrams (mg) by mouth every day for prophylactic. R29 did not have a history of taking an anticoagulant. R46 R46's quarterly Minimum Data Set (MDS) dated 3/17/26, identified R46 had diagnoses that included Alzheimer's disease and diabetes type II. R46 used antipsychotic, antidepressant, anticoagulant, diuretic,			F0641	Continued from page 2 · Any discrepancies identified were corrected immediately, and revised MDS assessments were submitted as required. The MDS policy was reviewed with no revisions. The DON or designee will conduct monthly MDS accuracy audits of five (5) residents per month for three consecutive months, focusing on Section N medication coding. Audit results will be: Documented Reviewed during QAPI meetings Used to implement corrective actions if trends are identified		05/06/2026

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F0641 SS = E	Continued from page 3 and hypoglycemic medications. R46's March 2026 MAR failed to identify R46 received an anticoagulant medication during the observation period. R46's Medication Review Report dated 4/1/16, identified Aspirin EC Tablet 325 mg by mouth every day for ischemic cardiomyopathy (an issue with damaged heart muscle that can't pump blood well). R46 did not have a history of taking an anticoagulant. During an interview on 4/1/26 at 2:53 p.m., registered nurse (RN)-A stated he was the facility's MDS coordinator. RN-A had "always" coded aspirin as an anticoagulant medication and had never been told differently. During an interview on 4/1/26 at 3:57 p.m., the director of nursing (DON) stated the resident MDS assessments should be coded accurately to ensure the MDS reflected the resident's care needs. The facility policy MDS 3.0 Assessment reviewed/amended 8/20/24, identified the facility would conduct comprehensive, accurate and standardized assessments known as Minimum Data Set (MDS) for each resident, as specified in the Centers for Medicare and Medicaid and the State of Minnesota Resident Assessment Instrument (RAI) Manual. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2025, instructed to code all high-risk drug class medication according to their pharmacological classification, not how they were being used: N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g., aspirin/extended release) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days).			F0641			05/06/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document			F0677	F677 ADL Care Provided for Dependent for Residents -facility failed to provide timely assistance with checking and changing a resident reviewed for ADLs who were dependent on staff for assistance The Director of Nursing will implement corrective action for residents R10 affected by this practice by:		05/05/2026

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F0677 SS = D	Continued from page 4 review, the facility failed to follow the care plan for check and change for 1 of 2 residents (R10) observed for activities of daily living (ADLs). Findings include: R10's annual Minimum Data Set (MDS) dated 2/25/26, identified R10 had severe cognitive impairment with a diagnosis that included cerebral palsy spastic quadriplegia (the most severe form of spastic cerebral palsy, resulting from brain injury before, during, or shortly after birth). R10 was dependent on staff for all care areas. R10's Urinary Incontinence and Indwelling Catheter Care Area Assessment dated 2/25/26, identified R10 had an indwelling urinary catheter in place for chronic urinary retention secondary to cerebral palsy. R10's catheter remained patent with clear yellow urine noted. No signs of obstruction, leakage, or malfunction observed. R10's peri care provided by protocol. R10 had bowel incontinence and was checked every 2 hours and as needed. R10's care plan revised 3/20/25, identified R10 had an ADL self-care performance deficit r/t cerebral palsy (CP). The care plan directed staff to do the following: TOILET USE: R10 was not toileted due to spastic movements, and it was not safe r/t CP. R10 wore a brief medium size. R10 needed to be checked and changed when R10 was repositioned, and barrier cream was to be applied. R10 was incontinent of bowel related to CP. R10 required check and change with repositioning every 2 hours and as needed. Staff to assist with changing R10's brief and provide peri care after each incontinent episode R10 had. During a continuous observation on 4/1/26 between 7:33 a.m. to 10:06 a.m., R10 was sitting in her wheelchair in the common area. During this time, R10 attended breakfast in the dining room, attended large group activities and returned to the common area to watch television. Staff did not provide incontinence care for R10. At 4/1/26 9:58 a.m., nursing assistant (NA)-A pushed R10's wheelchair to R10's room and stated she was just waiting for NA-D to come with the full body mechanical lift to reposition R10. NA-A and NA-D transferred R10 into bed, however, R10's incontinence brief was clean and dry. During an interview on 4/1/26 at 10:15 a.m., NA-D stated she was only helping NA-A to reposition R10 and did not know the last time R10 had been toileted.	F0677	Continued from page 4 R10's care plan for ADL assistance and check-and-change was reviewed and reinforced with staff to ensure clarity that R10 requires check and change with repositioning every two (2) hours and as needed, including when seated in a wheelchair for extended periods. Staff were educated that repositioning includes transfers from wheelchair to bed and that time spent out of bed does not replace scheduled check-and-change interventions. The Director of Nursing will assess residents having the potential to be affected by this practice including: All residents who are dependent on ADL's have the potential to be affected by deficient practice. Staff education for all nursing assistants and licensed nurses on: Following individualized ADL and check-and-change care plans, providing incontinence care while residents are in wheelchairs or common areas, Importance of care sheet accessibility and accurate documentation, Reinforcement that lack of a care sheet does not delay care, and staff are expected to verify care needs via the electronic medical record or nurse if clarification is needed. ADL care expectations, including check-and-change compliance, were reinforced during shift report and huddles. The ADL policy was reviewed with no revisions. The Director of Nursing will monitor corrective actions to ensure the effectiveness of these actions including: Audits will be completed beginning the week of 4/20/26, Nurse Managers/designees will complete: Weekly audits x 4 weeks, then Monthly audits x 2 months. Audits will include: Timeliness of toileting and incontinent care, Review of CNA documentation and care sheets. Verification that care aligns with resident-specific care plans. Audit results will be brought to the QAPI committee quarterly for review and further recommendation.	05/05/2026

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F0677 SS = D	Continued from page 5 During an interview on 4/1/26 at 10:48 a.m., NA-A stated she didn't have a care sheet and was not sure how often R10 needed to be toileted. NA-A went to the nurses' desk and picked up a resident care sheet and stated R10 required toileting every two hours. NA-A stated staff were expected to write down toileting times on the care sheets, but NA-A could not find her care sheet. NA-A replaced the care sheet on the stack at the nurse's desk. NA-A stated she did not know the last time R10 had been toileted that morning because R10 had a bath and the bath aide assisted R10. During an interview on 4/1/26 at 11:14 a.m., NA-F stated R10 was the first resident to have a bath that morning and was done at approximately 6:30 a.m. During an interview on 4/1/26 at 2:29 p.m., licensed practical nurse (LPN)-A stated R10 should be provided toileting every 2 hours to prevent skin breakdown as care planned. During an interview on 4/1/26 at 2:36 p.m., registered nurse (RN)-B stated staff were expected to follow the resident care plans. R10 should be toileted every two hours as care planned to prevent skin breakdown. R10 had no ability to move on her own at all and R10 was at risk for skin breakdown due to moisture and pressure. "That's a huge concern." During an interview on 4/1/26 at 3:58 p.m., the director of nursing (DON) stated staff were expected to follow the resident care plan because the care plan reflected the resident's needs as well as the assessed needs to prevent complications. The facility policy Urinary Incontinence Program revised 4/16/15, identified each resident who is incontinent will be identified, assessed, and provided appropriate care and services to achieve or maintain their greatest level of continence. Each resident will receive the appropriate care and services to prevent incontinence related complications to the extent possible. An indwelling catheter will not be used unless there is valid medical justification for use, and if there is no indication for use, it will be discontinued as soon as clinically warranted.			F0677			05/05/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity			F0686	F686 Treatment/Svs to Prevent/Heal Pressure Ulcer -facility failed to ensure repositioning for resident with pressure ulcers The Director of Nursing will implement corrective		05/05/2026

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F0686 SS = D	Continued from page 6 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure turning and repositioning was timely for 1 of 1 resident (R10) reviewed who was at risk for the development of pressure ulcers. Findings include: R10's annual Minimum Data Set (MDS) dated 2/25/26, identified R10 had severe cognitive impairment and included a diagnosis of cerebral palsy spastic quadriplegia (the most severe form of spastic cerebral palsy, resulting from brain injury before, during, or shortly after birth). R10 was dependent on staff in all care areas. R10's Pressure Ulcer/Injury Care Area Assessment (CAA) dated 3/3/26, identified R10 was unable to reliably express needs or discomfort. Braden score indicated moderate risk for skin breakdown. R10's head of bed was typically elevated approximately 30 degrees for positioning and comfort. R10 required pressure-reducing devices for bed and chair and followed a turning/repositioning program. Foot deformity present. R10 had a history of recurrent redness under bilateral breasts and lateral trunk folds consistent with moisture/friction areas; No open areas noted at this time. Peripheral vascular disease/peripheral artery disease (poor circulation) symptoms, venous stasis signs, or neuropathy symptoms noted at this time. R10's skin remains intact. Ongoing monitoring and preventative interventions were in place to reduce risk of pressure injury and moisture associated skin disorder (MASD). R10's Comprehensive Skin Risk dated 2/24/26,	F0686	Continued from page 6 action for resident R10 affected by this practice by: The care plan was reviewed and reinforced to ensure turning and repositioning every two (2) hours, including during time spent out of bed for meals and activities. Nursing assistants assigned to R10 were re-educated individually on R10's repositioning frequency, documentation expectations, and the resident's inability to self-reposition were reinforced during shift report and huddles. The Director of Nursing will assess residents having the potential to be affected by this practice including: All residents at risk of pressure ulcers have the potential to be affected by this deficient practice. The Director of Nursing or Designee will implement measures to ensure that this practice does not recur including: Facility-wide review of all residents with turning and repositioning interventions. Residents with: Braden scores indicating moderate to high risk, Dependence for mobility, Diagnoses affecting ability to self-reposition were verified to have appropriate care plans and repositioning schedules. Any care plans found to lack clarity or consistency were updated immediately. Nursing assistants were provided updated care sheets reflecting accurate repositioning requirements for all at-risk residents. The Skin Integrity Policy was reviewed with no revisions. All staff assigned re-educated immediately on repositioning techniques, reporting changes in skin condition, offloading, and timely documentation. All licensed nurses and nursing assistants will receive education on: Importance of timely repositioning, Following individualized care plans, Documentation of repositioning times, Communication between bath aides and assigned CNAs	05/05/2026

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NAME OF PROVIDER OR SUPPLIER THIEF RIVER CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2001 EASTWOOD DRIVE , THIEF RIVER FALLS, Minnesota, 56701			
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F0686 SS = D	Continued from page 7 identified R10 was at moderate risk for pressure ulcer/injury. R10's care plan revised 3/20/26, identified R10 had a potential/actual impairment to skin integrity related to fragile skin. Staff were directed that R10 was to be turned and repositioned every two hours to help prevent skin breakdown. During a continuous observation on 4/1/26 between 7:33 a.m. to 10:06 a.m., R10 attended breakfast in the dining room, attended large group activities and returned to the common area to watch television. Staff did not reposition R10. At 4/1/26 9:58 a.m., nursing assistant (NA)-A and NA-D assisted R10 to lie down in bed using the full body mechanical lift. R10 did not have any pressure ulcers. During an interview on 4/1/26 at 10:15 a.m., NA-D stated she was only helping NA-A to reposition R10 and did not know the last time R10 had been repositioned. During an interview on 4/1/26 at 10:48 a.m., NA-A stated she didn't have a care sheet and was not sure how often R10 needed to be repositioned. NA-A went to the nurses' desk and picked up a resident care sheet and stated R10 required repositioning every two hours. NA-A stated staff were expected to write down repositioning times on the care sheets, but NA-A could not find her care sheet. NA-A placed the care sheet on the stack at the nurse's desk. NA-A stated she did not know the last time R10 had been repositioned that morning because R10 had a bath and the bath aide assisted R10. During an interview on 4/1/26 at 11:14 a.m., NA-F stated R10 was the first resident to have a bath that morning and was done at approximately 6:30 a.m. During an interview on 4/1/26 at 2:29 p.m., licensed practical nurse (LPN)-A stated R10 should be provided repositioning every two hours to prevent skin breakdown as care planned. During an interview on 4/1/26 at 2:36 p.m., registered nurse (RN)-B stated staff were expected to follow the resident care plans. R10 should be repositioned every two hours to prevent skin breakdown as care planned. R10 had no ability to move on her own at all and R10 was at risk for skin breakdown due to moisture and pressure. "That's a huge concern." During an interview on 4/1/26 at 3:58 p.m., the director of nursing (DON) stated staff were expected			F0686	Continued from page 7 The Director of Nursing or Designee will monitor corrective actions to ensure the effectiveness of these actions including: Random observational audits will be conducted to ensure: CNA repositioning documentation, Care plan consistency , Observation of repositioning practices Beginning the week of 4/20/26, Nurse Managers/designees will complete: Weekly audits x 4 weeks, then Monthly audits x 2 months until compliance is achieved. Audit results will be brought to the QAPI committee quarterly for review and further recommendation.		05/05/2026

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F0686 SS = D	Continued from page 8 to follow the resident care plan because the care plan reflected the resident's needs as well as the assessed needs to prevent complications such as pressure ulcer/injury. A turning and repositioning policy was requested but not received.			F0686			05/05/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure staff were comprehensively assessing falls and implementing appropriate interventions for 1 of 3 (R50) residents reviewed for falls. Findings include: R50's quarterly Minimum Data Set (MDS) dated 3/24/26, identified R50 was cognitively intact and was dependent on two staff for activities of daily living (ADL's) including toileting and transfers in/out of wheelchair and on/off the toilet. R50 was non-ambulatory and had contractures of both lower extremities. R50's diagnoses included cerebral palsy, epilepsy, schizophrenia and mild intellectual disability. R50's care plan dated 11/25/24, identified R50 was totally dependent on two staff and required a total mechanical lift (hoyer) for transfers to/from the bed/wheelchair/toilet. R50 was at risk for seizures related to epilepsy. Interventions included monitoring for seizure activity and staying with and ensuring the resident was safe during a seizure. R50 was at risk for falls related to impaired mobility and psychoactive medication use. Interventions included ensuring resident's call light was within. R50's fall risk assessment dated 3/10/26, identified			F0689	F689 Free of Accident Hazards/Supervision/Devices -the facility failed to ensure staff were comprehensively assessing falls and implementing appropriate interventions The Director of Nursing will implement corrective action for resident R50 affected by this practice by: R50's care plan was reviewed and revised to clearly state that R50 is not to be left unattended on the toilet with a mechanical-lift sling attached to the lift. Staff were instructed that two staff must remain present and provide direct supervision during toileting transfers using the mechanical lift. The care plan was further clarified to reflect that mechanical-lift slings will not remain attached to the lift while a resident is toileting unless the resident expresses a preference and an interdisciplinary team assessment and evaluation by therapy determines it is clinically safe to do so. All staff assigned to R50 were educated on the revised care plan and supervision expectations across all shifts. The Director of Nursing or Designee will assess residents having the potential to be affected by this practice including: The facility conducted an audit of all residents requiring mechanical lifts for transfers, including toileting, to identify residents at risk for similar occurrences. For each identified resident, licensed nursing staff completed: Review of fall risk and transfer needs Review of toileting supervision requirements Assessment of resident preference related to privacy and toileting, balanced with safety needs The Mechanical lift Policy was reviewed with no revisions Care plans were updated as indicated to reflect that		05/05/2026

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F0689 SS = D	Continued from page 9 R50 was alert and oriented, chairbound, incontinent of bowel and bladder, and was at risk for falls. The facility incident investigation report dated 7/18/25, identified R50 was being transferred from toilet to the wheelchair with the hoyer lift and staff were following the resident's care plan. The top strap on the hoyer sling on the right side came off and R50 was lowered to the floor with the hoyer. R50 reported she didn't know what happened and had not touched the strap. Immediate interventions included the hoyer strap was rehooked and R50 was lifted from the floor to her wheelchair. Staff were educated to ensure a double check was performed on all straps before lifting residents. R50 was educated on the importance of not touching the straps. The staff present at the time of incident identified the straps were hooked when R50 was lifted from the wheelchair to the toilet. The investigation failed to identify if the resident could be left unattended with the hoyer in the bathroom and if the straps were double checked prior to transferring R50 from the toilet to the wheelchair. R50's progress note dated 7/18/26 at 9:49 a.m., identified R50 had a fall in R50's bathroom on 7/18/25. the root cause analysis identified it "appears that resident had been messing with hoyer straps." The interventions identified staff were educated to ensure they double check all straps before lifting the resident. R50 was educated on the importance of not touching the straps. R50 preferred staff to stand outside of bathroom and be left alone for privacy. During observation on 3/31/26 at 9:57 a.m., NA-A and NA-B were assisting R50 onto the toilet using the hoyer lift. The NA's left the sling attached to the hoyer. NA-A secured the hoyer brakes and both NA's left R50 unattended in the bathroom. During interview on 3/30/26 at 3:51 p.m., R50 stated she fell out of the hoyer lift previously, the staff came and helped. R50 was unable to provide further details of when or how the fall happened. During interview on 3/31/26 at 10:00 a.m., NA-A stated staff usually left R50 unattended in the bathroom with the hoyer brakes locked, the lift sheet under her and fastened to the hoyer lift. During interview on 3/31/26 at 10:10 a.m., NA-B stated after R50 was transferred onto the toilet with the hoyer, staff would leave the lift sheet under the resident with the straps fastened to the lift. The hoyer locked in place in front of the resident and			F0689	Continued from page 9 mechanical lift slings will not remain attached during toileting unless the resident prefers this practice and it is determined to be safe through assessment by therapy eval. Any changes to care plan, education provided to staff. Beginning the week of 4/20/26, Nurse Managers/designees will complete: Weekly audits x 4 weeks, then Monthly audits x 2 months until compliance is achieved. Audit results will be brought to the QAPI committee quarterly for review and further recommendation		05/05/2026

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F0689 SS = D	Continued from page 10 exited the bathroom to provide privacy. During interview on 4/1/26 at 2:30 p.m., registered nurse (RN)-C stated it was a safety concern and staff were not to leave a resident unattended in the bathroom with the hoier lift sheet under them and fastened to the lift. Residents could potentially fall from the toilet and injure themselves. During interview on 4/1/26 at 4:24 p.m., the director of nursing (DON) stated staff were instructed and shown proper use of the hoier lift upon hire. The DON stated a resident should not be left unattended in the bathroom while seated on the toilet with the lift sheet under them and attached to the hoier lift. It was a safety concern because the residents could potentially use the remote control and end up dangling or falling from the lift. The facilities Mechanical Lift policy reviewed 5/28/25, identified care center staff were to use appropriate techniques and processes when utilizing mechanical lift devices to lift and move residents, to protect the safety and well-being of staff and residents, to promote quality care, and to follow applicable laws regarding use of power-driven mechanical lifts. The Volaro Series 4 Lift operator’s manual dated 3/2019, identified staff were to ensure all four loops from the sling were properly “nested” in the bottom of the hooks before lifting or transferring a patient or resident, as well as ensuring all four retainer springs were functioning correctly.			F0689			05/05/2026
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and			F0693	F693 Tube Feeding Mgmt/Restore Eating Skills -The facility failed to ensure proper positioning and management of tube feeding during turning/repositioning to prevent complications. Immediately upon identification of the deficient practice, Resident R10 was assessed by nursing staff for signs and symptoms of aspiration or other complications. No adverse outcomes were noted. The resident's care plan and care sheet were updated to clearly and explicitly state: Tube feeding must be paused by licensed nursing staff prior to any repositioning, turning, transfers, or cares that require the head of bed (HOB) to be lowered below 30 degrees. Tube feeding may only be restarted by licensed nursing staff once the HOB is elevated to at least 30–45 degrees. All nursing assistants and licensed staff caring for		05/05/2026

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F0693 SS = D	Continued from page 11 §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure staff maintained the proper positioning for gastrostomy tube care for 1 of 1 resident (R10) reviewed for tube feedings. Findings include: R10's annual Minimum Data Set (MDS) dated 2/25/26, identified R10 had severe cognitive impairment and included a diagnosis of cerebral palsy spastic quadriplegia (the most severe form of spastic cerebral palsy, resulting from brain injury before, during, or shortly after birth). R10 had an enteral feeding tube (delivers nutrition directly to the stomach or small intestine for individuals unable to take in adequate calories by mouth) and was dependent on staff for all care areas. R10's care plan revised 3/20/26, identified R10 had an ADL self-care performance deficit related to CP. Staff were directed to ensure R10's head of bed was elevated above 30 degrees when R10 was hooked up to her feeding. However, the care plan failed to identify to pause the feeding during turning and repositioning. R10's undated care sheet, directed staff that during transfers R10 needed nursing staff to stop R10's tube feeding before the transfer and restart it after transfer was complete. If nursing assistants were assisting with R10's transfer, they must notify a nurse to manage R10's feeding. During an observation on 4/1/26 at 9:58 a.m., nursing assistant (NA)-A and NA-D assisted R10 into bed using a fully body mechanical lift and performed turning and repositioning for R10. When R10 initially laid down, R10's head of bed was flat, and NA-A raised the bed to approximately 20 degrees. NA-A and NA-D rolled R10 left and right while R10's feeding continued running. A bright pink sign hung on the wall at the head of R10's bed stating "Reminder: have nurses pause feeding when lying lower than 30 degrees during repositioning, transfers, or cares. Restart by nurse when above 30 degrees." At 10:05 a.m., NA-A raised R10's head of			F0693	Continued from page 11 R10 received immediate re-education on the resident-specific tube feeding interventions and expectations. The Director of Nursing will assess residents having the potential to be affected by this practice including: No other enteral feeding residents. To prevent recurrence, the facility implemented the following systemic changes: The Enteral Feeding Tube Usage policy was reviewed with no revisions. Staff Education: All licensed nurses and nursing assistants received re-education on: Aspiration risk associated with improper tube feeding positioning Required staff communication and role responsibility Resident-specific enteral feeding precautions Education was documented and reinforced through competencies. Care Plan Standardization: The facility revised care planning guidelines to require clear, observable, and measurable instructions outlining: When feedings must be stopped Who is responsible for stopping and restarting feedings Required positioning before and after feeding Visual Cues Reinforced: Resident-specific signage remains posted and staff were re-educated that signage does not replace required nursing notification and action.		05/05/2026

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F0693 SS = D	Continued from page 12 bed to 45 degrees. During an interview on 4/1/26 at 10:08 a.m., NA-A stated the nurses using came and took care of R10's feeding and "stuff". However, neither NA-A or NA-D had asked the nurse to come and pause R10's feeding before laying R10 down. NA-A stated R10 was lying flat but NA-A had raised the head of the bed but could not say if it was greater than 30 degrees. NA-A then stated she did not know if the feeding needed to be paused if it was a "split second thing. I'll have to get that clarified." During an interview on 4/1/26 at 10:15 a.m., NA-D stated she was only helping NA-A to lay R10 down and didn't think of the feeding "at all." NA-D stated they should have asked the nurse to pause R10's feeding because R10 could have vomited. During an interview on 4/1/26 at 2:29 p.m., licensed practical nurse (LPN)-A stated whenever the aides were going to lie R10 down they were supposed to ask a nurse to come and pause the feeding, then when they're done, they're supposed to call the nurse to turn it back on. "That is supposed to happen every time." During an interview on 4/1/26 at 2:36 p.m., registered nurse (RN)-B stated the nursing assistants were expected to ask nursing to pause R10's feeding before transfers and to restart once the transfers/cares were done. This was required every time to prevent complications such as vomiting and aspiration. During an interview on 4/1/26 at 3:58 p.m., the director of nursing (DON) stated R10 had been assessed for possible aspiration but lung sounds were clear and R10 had no signs or symptoms of distress. The DON stated staff were expected to follow R10's care plan and request to have R10's feeding paused prior to transfers because the care plan reflected the R10's needs as well as the assessed needs to prevent complications. The DON stated R10 had been assessed for possible aspiration but lung sounds were clear and R10 had no signs or symptoms of distress. The facility policy Enteral Feeding Tube Usage revised 4/1/19, identified the facility provided enteral feeding tube care and services. However, the policy failed to direct staff how to care for the feeding during turning and repositioning. Nursing Skills textbook ISBN-13: 9781734914122 (ebook) dated 2021, identified the head of the bed	F0693	Continued from page 12 The Director of Nursing (DON) or designee will oversee compliance through the following monitoring process: Weekly audits for four (4) weeks, then Monthly audits for 2 months, including: Direct observation of tube feeding care during repositioning and transfers Review of care plans and care sheets for accuracy Interviews with staff regarding tube feeding precautions Audit results will be reviewed at QAPI meetings, and corrective action will be implemented promptly if noncompliance is identified.	05/05/2026	

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F0693 SS = D	Continued from page 13 (HOB) should be elevated to a 30 to 45-degree angle (semi-Fowler's position) during enteral feeding and for at least 30–60 minutes afterward to prevent aspiration. This positioning is crucial for all patients receiving tube feeds to reduce the risk of formula entering the lungs.			F0693			05/05/2026

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/31/2026. At the time of this survey, Thief River Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR			K0000			05/05/2026

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. The Thief River Care Center is a 1-story building with no basement that was built in 2011 and was determined to be of Type II(000) construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is monitored for automatic fire department notification. The facility is protected throughout by a complete fire sprinkler system. The facility also has smoke detection throughout the corridors and spaces open to the corridors. The facility has a capacity of 75 beds and had a census of 74 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:		K0000				
K0271 SS = F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7		K0271	Sidewalks will be inspected on a monthly basis by the Environmental Services (EVS) department to identify any hazardous tripping conditions, including uneven surfaces. Inspection documentation will be maintained and presented at quarterly Quality Assurance and Performance Improvement (QAPI) meetings for administrative review. Seasonal conditions, particularly the freeze-thaw cycle in the spring, may result in shifting or heaving of sidewalk sections near building stoops. During routine inspections, any areas that do not return to an acceptable level condition following ground thaw will be addressed in a timely manner. Corrective actions may		05/05/2026	

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K0271 SS = F	Continued from page 2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed provide approved discharge walking surfaces as identified per NFPA 101 (2012 edition), Life Safety Code, section 19.2, 7.1.6. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 03/31/2026 at the following times,, it was revealed by observation that the following exterior exit door thresholds to slab as-well-as slab-to-slab height transition greater than ½ inch, presenting a trip and fall hazard. 1) at 11:51am, uneven walk way outside Blueberry wing exit door by room 168 2) at 11:54am, uneven walk way outside Blueberry wing exit door, by room 161 3) at 12:09pm, uneven walk way outside Evergreen wing exit door, off dining room An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0271	Continued from page 2 include concrete grinding, mud jacking, or full replacement of the affected sidewalk sections, as appropriate.		
K0324 SS = D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per			K0324	Wheel chocks will be installed on each applicable piece of equipment by May 10, 2026. Thereafter, the Dietary Manager will conduct weekly inspections to ensure all wheeled equipment underneath the kitchen hood is in its proper place and is properly secured with the tether. Documentation of these inspections will be submitted to the Environmental Services (EVS) department monthly and presented at quarterly Quality Assurance and Performance Improvement (QAPI) meetings for administrative review and oversight.		05/10/2026

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K0324 SS = D	Continued from page 3 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to install the kitchen hood extinguishing system in accordance with NFPA 101 (2012 edition), The Life Safety Code, section 19.3.2.5, 19.3.2.5.1, 19.3.2.5.2*, 9.2.5, NFPA 96 (2011 edition) Ventilation Control and Fire Protection of Commercial Cooking Operations, section 12.1.2.3 and 12.1.2.3.1. These deficient findings could an isolated impact on the residents within the facility. The findings include: On 03/31/2026 at 12:24pm, it was revealed that the wheeled, gas-fired stove and griddle located on the cooking line in the kitchen was not provided with an approved method of attachment and/or an alignment mark to ensure the appliances was returned to an approved design location after it had been moved for maintenance and cleaning. Both the attachment device and alignment mark are required for each gas operated and deep fat fryer cooking device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0324				
K0353 SS = D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source		K0353	K0353: 1.) The Laundry Department will implement a standardized checklist to conduct weekly inspections ensuring proper 18-inch clearances from sprinkler heads and ceilings. To ensure future compliance, all laundry staff have scheduled training regarding these specific requirements, which will be completed by May 1, 2026. Completed checklists will be submitted to the Environmental Services (EVS) department monthly, and documentation will be reviewed and presented at quarterly Quality Assurance and Performance Improvement (QAPI) meetings for final administrative oversight. 2.) The facility immediately inspected the automatic sprinkler system and verified current operational status to ensure no immediate life safety hazards exist. All residents are protected by a comprehensive audit of the fire protection system and the integration of NFPA 25 ITM requirements into a digital preventative		05/01/2026	

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K0353 SS = D	Continued from page 4 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: 1) Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could an isolated impact on the residents within the facility. 2) Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: (1) On 03/31/2026 at 12:17pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in Evergreen Clean Storage Room Findings include: (2) On 03/31/2026 at 11:10am, it was revealed by a review of available documentation the facility failed to include proper dates on the quarter sprinkler system testing documents. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0353	Continued from page 4 maintenance schedule with automated alerts. The Maintenance Director and staff were re-educated on NFPA 101 and 25 documentation standards, specifically regarding water-based fire protection system inspections. Monthly audits of fire safety records will be reported to the QAPI Committee for six months to ensure 100% ongoing compliance.		
K0712 SS = F	Fire Drills CFR(s): NFPA 101 Fire Drills			K0712	K0712, Part 1: A preplanned annual fire drill matrix will be developed and provided to the Administrator to ensure that drills are consistently conducted across all three shifts. The matrix will identify scheduled dates and times and will include a "completion" column to facilitate final administrative sign-off upon the		05/05/2026

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K0712 SS = F	Continued from page 5 Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 03/31/2026 at 11:01am, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: second shift 03/10/2026 at 3:50pm, 09/30/2026 at 3:22pm, and 12/31/2026 at 3:35pm. 2. On 03/31/2026 at 11:01am, it was revealed by a review of available documentation that fire drills were not completed: first shift missing second quarter (April - June) and second shift, second quarter (April - June) drills completely. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0712	Continued from page 5 conclusion of each drill. In the absence of maintenance staff, Administration will ensure that fire drills are conducted in accordance with the established matrix to maintain continuous compliance. K0712, Part 2: A comprehensive, calendar-year fire drill matrix has been established to ensure drills are conducted on staggered dates throughout each month. Drill times will be scheduled approximately 90 minutes to 2 hours apart to promote variability and simulate realistic conditions. The Environmental Services (EVS) department will be responsible for ensuring all fire drills are conducted in accordance with the matrix. All documentation will be reviewed and presented at quarterly Quality Assurance and Performance Improvement (QAPI) meetings for final administrative oversight		
K0741 SS = D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.			K0741	The Environmental Services (EVS) department will conduct weekly inspections of the designated smoking area to ensure compliance with proper cigarette disposal practices. If cigarettes are found to be disposed of improperly and not placed in the designated receptacle, notification will be provided to leadership staff, and additional staff education will be conducted regarding proper disposal procedures. Inspection results and any corrective actions will be documented and presented at quarterly Quality Assurance and Performance Improvement (QAPI) meetings for final administrative review.		05/05/2026

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K0741 SS = D	Continued from page 6 (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to implement a staff smoking policy per NFPA 101 (2012 edition), Life Safety Code section 19.7.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 03/31/2026, 12:28pm, it was revealed by observation that the smoking was occurring outside of back entrance from the mechanical room as evident by discarded cigarette butts on ground and not in proper receptacles. All discarded smoking debris must be placed in proper fire safe containers. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0741		
K0761 SS = D Bldg. 02	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.	K0761	The door inspection form has been revised to include all 13 required inspection points, correcting the previous version which contained only 12 points. Moving forward, all applicable doors will be inspected in accordance with the updated form to ensure compliance with all 13 inspection criteria.	04/23/2026

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K0761 SS = D Bldg. 02	Continued from page 7 Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/31/2026 at 11:25am, it was revealed by review of available documentation the required annual door inspection documentation the facility failed to provide a document showing all 13 points of the required door inspection was completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0761			