DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 8, 2022

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

RE: CCN: 245252
Cycle Start Date: November 17, 2021

Dear Administrator:

On December 27, 2021, we notified you a remedy was imposed. On January 24, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 24, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 11, 2022 be discontinued as of January 24, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of December 9, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 16, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
December 9, 2021

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

RE: CCN: 245252
Cycle Start Date: November 17, 2021

Dear Administrator:

On November 17, 2021, 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" tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 February 17, 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 May 17, 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, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	C 11/17/2021

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 11/16/21 and 11/17/21, 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 H5252060C (MN78345), with no deficiency issued. As a result of the investigation a deficiency was cited at F603. The following complaints were found to be UNSUBSTANTIATED H5252061C (MN76236). 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 603 SS=D	Free from Involuntary Seclusion CFR(s): 483.12(a)(1) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 603		12/24/21

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

Electronically Signed | 12/13/2021

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F 603	Continued From page 1 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R1) reviewed was free from involuntary seclusion when staff placed R1 in the commons area, on the blueberry unit, surrounding resident with two brick ledges, a table and multiple chairs. Findings include: R1's face sheet printed 11/17/21, indicated R1 was admitted to the facility on 12/17/19. R1's diagnoses included epilepsy, profound intellectual disabilities and attention-deficit hyperactivity disorder. R1's annual Minimal Data Set (MDS) dated 10/19/21, indicated R1 required extensive assist of staff for most activities of daily living (ADLs). Further review of MDS, indicated R1 did not exhibit any behaviors such as wandering during the assessment period, and R1's behavior status and wandering is the same as R1's prior assessment dated 7/19/21. R1's care plan dated 11/20/20, identified R1 at risk for safety related to agitation, restlessness and self-propelling in wheelchair and directed	F 603	F603: Thief River Care Center will ensure that all residents are free from seclusion and restraint. R(01) is free from involuntary seclusion by having exits on each side of the pod area. She is able to wheel herself in and out of that area freely. There are no more chairs or tables in the way. The care plan was reviewed and updated. The area feels more like a home area now. A behavior plan will be implemented for R(01) for her safety. All residents have the potential for involuntary seclusion. All residents care plans have been reviewed to ensure that they are restraint free. No changes to policies, therefore, all policies regarding restraint and seclusion will be followed. DON or designee will educate staff on seclusion and restraints. They will also be re-educated on policy and procedures regarding restraint and seclusion. DON or designee will perform audits to make sure that no restraints or seclusion is in use, and that residents will be free to move about. This will be done 3 times per	

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F 603	Continued From page 2 staff to explain what is being done, provide a "busy box", slow approach, and gentle touch. Further review of care plan with a revision date of 11/17/21, directed staff to "put in center of pod for monitoring, make sure there are activities for her to interact with." However, the care plan did not direct staff to place objects surrounding R1 while in the pod to confine her to that area while displaying wandering behaviors. R1's Mood and Behavior document printed on 11/17/21, lacked evidence that R1 displayed any behaviors during the time frame of 10/1/21 through 11/17/21. R1's Elopement Risk Assessment dated 10/19/21, indicated "not at risk for elopement or wandering out of the building, moves around the pod area independently in her wheelchair, does not attempt to elope. [R1] will at times wander into other resident's room does not realize she shouldn't due to intellectual disabilities." During continuous observation on 11/17/21, at 8:35 a.m. R1 was observed sitting in her wheelchair in the commons area or "pod" and there were 8 chairs plus one table lined across one side of the pod with no spaces between objects, a brick ledge created a barrier along two sides of the pod, and three more chairs lining the exit of the pod with no space between. R1 was observed self propelling around the pod while carrying stuffed animals on her lap and other toys were observed scattered on the floor. R1 was observed attempting to move the chairs by pushing them with her hands, on two different occasions, and was unsuccessful. R1 then began to shake the chair and the legs of the chair were banging on the floor.	F 603	week for 2 weeks, 2 times per week for 2 week, and then 1 time a week for 2 weeks and monthly thereafter. DON or designee will bring audits to QAPI for further recommendations and monitoring. Completion date is 12/24/2021	

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F 603	Continued From page 3	F 603		

-at 9:22 a.m. R1 continues to remain in the enclosed area on the pod. R1 was attempting to self-propel in wheelchair between the brick ledge and the chair but was unable to fit wheelchair through. R1 then began to bang the legs of the chair on the floor. Activities assistant (AA)-A was in the kitchen area and looked over at R1.

-at 9:28 a.m. NA-A enters pod and removes R1 to bring her to her room. At approximately 9:33 a.m. NA-A returns to the pod pushing R1 in her wheelchair, places her in the middle of the chairs. However, NA-A does not place the chair to completely block off the exit to the pod. R1 was then observed self-propelling around the circle of objects while making grunting noises. R1 propelled out of the opening of chairs and onto the walkway by the nursing station. At approximately 9:36 a.m. another resident on the unit stated, "they thought they put her in there but she escaped (while shaking her head)." At approximately 9:41 a.m. AA-A pushes R1's wheelchair back into the pod and puts the chair in line with the other two chairs to close the exit of the pod. At 9:49 a.m. R1 was observed attempting to move the chairs to exit the pod but was unsuccessful. R1 was noted to be making grunting noises. During this time, NA-A was sitting at a table with other residents watched R1.

-at 10:58 a.m. R1 continues to be in the pod surrounded by objects. Surveyor attempts to visit with R1 and asked R1 if she was able to move the chairs to get out of the pod, but R1 did not respond to surveyor. At approximately 11:25 a.m. surveyor asked NA-A to assist with asking R1 to move the chair, but R1 did not respond to direction. NA-A stated R1 was content so she

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F 603	Continued From page 4	F 603		

won't move the chairs. Further, NA-A stated "we don't try other interventions" before placing R1 in the pod.

On 11/17/21, at 8:48 a.m. nursing assistant (NA)-A identified a restraint as a form of abuse and defined a restraint as "locking them [resident] in their room, keeping them from doing something" and would report the use of a restraint to the nurse manager "right away". Further, NA-A indicated R1 is unable to communicate and "likes to stroll around". NA-A indicated R1 does wander, and interventions included "we bring her back here in this area (referring to the pod) where we can see here, and we give her toys." When asked about the chairs surrounding R1, NA-A indicated staff do this "that way she can't wander out of the room or get into coffee or get into things. We do this when she gets wandering-ish. She will go into rooms and grab things off counters. They [staff] set up toys in the area and she stays there." In addition, NA-A indicated R1 would be able to move the chairs if she wanted.

On 11/17/21, at 9:27 a.m. AA-A indicated a restraint was a form of abuse and identified a restraint as "something that would make them [residents] not be able to move in ways that they can." When asked about the chairs surrounding R1 in the pod, AA-A stated "this is for her safety. If she gets out, she can get into things that she shouldn't get into. We try as good as we can, but we can't keep our eye on her all the time." AA-A was unsure how often staff place R1 in the pod surrounded by objects.

On 11/17/21, at 9:39 a.m. licensed practical nurse (LPN)-A identified a restraint as a form of abuse

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F 603	Continued From page 5	F 603		

and was "anything that a resident cannot remove, or a resident cannot get out of themselves". Further, LPN-A identified involuntary seclusion as a form of abuse and defined it as "would be where you put someone alone by themselves without them asking or wanting to be and if they can't get out themselves it would be considered seclusion." LPN-A indicated R1 does wander and will attempt to put non-edible objects into her mouth. When asked about R1 being in the pod surrounded by objects, LPN-A stated "that's an area where she is safe. We use it to keep her safe from eating stuff and getting into stuff. That intervention was in place before I started." Further, LPN-A confirmed this intervention was not in R1's care plan, however stated "I was trained to do that." LPN-A indicated R1 was kept in the pod after meals and "usually is in there for an hour or two hours. We do activities so she will come out for those and meals and toileting but other wise she is typically in there." In addition, LPN-A indicated R1 would be able to move the chairs.

On 11/17/21, at 10:03 a.m. trained medication assistant (TMA)-A indicated a restraint and involuntary seclusion would be considered abuse. TMA was unable to define involuntary seclusion but defined a restraint as "locking them [residents] in their room or if you strap them into their wheelchair or holding them down or not allowing them to move freely." TMA-A indicated R1 is non-ambulatory but self-propels in wheelchair "too much to be honest. I don't think its fair to her or us to have her here. She deserves one on one attention and we don't have time for that. She has broke things in resident rooms, and she has eaten things that are not food. I feel bad for her being here and it's

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F 603	Continued From page 6	F 603		

frustrating we can't give her the care she needs." When asked about interventions for R1's wandering behaviors, TMA-A stated "I am not sure. She has a Wanderguard on and everyone is watching her and is aware." When asked about the pod and the objects surrounding R1, TMA-A stated "not sure where it came from, who started it, or who put it like this, but I am sure it's been like this for at least a year. After breakfast they put her in there." Further, TMA-A indicated "it depends on how the chair is sitting if she can push them. Either way, even if she could or couldn't get out it is not fair for her to be in there. We use this so she doesn't wander and get into everything. I guess if it were me it would be frustrating to be locked in there. She wants to be out and about but its not safe." In addition, TMA-A stated, "I think it's a dignity issue with visitors some have stated 'oh my God she is locked in there'".

On 11/17/21, at 10:42 a.m. registered nurse (RN)-A indicated involuntary seclusion and restraints would be abuse and defined a restraint as "when they can't do what they want if you are preventing them from doing what they want to do" and involuntary seclusion as "keeping them in the room and not letting them out and shutting the door or being secluded from activities of things they want to do without their choice." RN-A indicated R1 communicates using gestures and sounds such as grunts. Further, RN-A indicated R1 wanders around the pod and into rooms and interventions include "keep her where we can keep an eye on her", followed by behavioral health, offer stuffed animal or toys of interest. When asked about R1 being place in the pod surrounded by objects, RN-A stated, "they were doing that before I got here. Her guardian and

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F 603	Continued From page 7	F 603		

social worker are aware and are ok with that. We have activities in there to do with her. We put the chairs like that to keep an eye on her. When she is really active in the morning we will put her in there so that way we know where she is. She will go into other rooms. I don't know if this intervention is in her care plan. Further, RN-A indicated R1 was able to move the "lighter" chairs.

On 11/17/21, at 11:30 a.m. director of nursing (DON) indicated "we keep her [R1] in the pod place surrounded by chairs to keep her safe. She will drink or eat anything and that has been approved by her social worker and guardian." Further, DON indicated the intervention is used when R1 is "in a wandering mood." DON indicated offering R1 snacks was an intervention for her wandering behaviors but "no other interventions that I can think of." Further, DON stated "not sure how long they keep her in there. I don't know how we determine when her wandering behavior is done." DON indicated R1 was able to move the chairs herself if she wanted to get out, but when asked what the point of the placing the chairs around R1 was if she was able to move them anyway, DON stated "the chairs prevent her from completely getting out." In addition, DON indicated the facility did not have a policy or procedure for this intervention type but stated "I know we have a restraint policy but since she can get out and has things in there, we are not considering it a restraint." DON indicated staff were expected to try interventions when R1 has wandering behaviors and document interventions tried as well as "documenting when she is needing to be in there [pod]".

On 11/17/21, at 12:19 p.m. administrator

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F 603	Continued From page 8	F 603		

indicated R1 had developmental disabilities and "her behaviors manifest through eating non-edibles and putting things in her mouth." Administrator indicated R1's interventions for behaviors included "when she is out in the pod there is an area that is predesignated for her. It is not a locked area she can get in and out of it. Everyone talks about it as her area. It's safe and has her stuff. I think that it helps people supervise her. This area has been here since I started in February. It is not classified as a restraint from my understanding is that she can get in and out of it. There has not been concern about her safety or her wishing to do something if she gave any indication of her not wanting to be in that area." In addition, administrator indicated she was not aware of the use of so many chairs, prior to this day she indicated there had only been four chairs in the pod area with space in between for R1 to fit between.

The facility policy Behavior/Mood Monitoring Policy and Behavior Interventions dated 7/10, indicated the purpose of the policy was to "develop an interdisciplinary approach to monitoring and evaluating resident behavior/mood problems to assure interventions are developed to best meet resident's needs. Using proper interventions to try decrease use of psychopharmacological medications when appropriate." Further review of policy indicated the nurse will document behavior and interventions.

The facility policy Training Employees on Maltreatment, Protecting Victims of Maltreatment, Skilled Nursing Facility Maltreatment Investigation and Reporting, and Maltreatment Reporting Guidelines direct staff to report allegations of

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 11/17/2021

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 603	Continued From page 9 maltreatment according to appropriate time frames. However, the policies lack evidence of the resident's right to be free from abuse. Further review of policies lack evidence of the definitions of restraint and involuntary seclusion and the direction for staff if they were to witness either. Facility failed to provide a restraint or involuntary seclusion policy when requested.	F 603		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 9, 2021

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

Re: Event ID: 79Y511

Dear Administrator:

The above facility survey was completed on November 17, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 11/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/16/21 and 11/17/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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

Electronically Signed | 12/13/21

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 11/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 SUBSTANTIATED: H5252060C (MN78345), with NO licensing orders issued. The following complaint was found to be UNSUBSTANTIATED: H5252061C (MN76236). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		