



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 16, 2026

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

RE: CCN: 245252

Cycle Start Date: December 30, 2025

Dear Administrator:

On December 30, 2025, a survey was completed at your facility by the Minnesota Department of Health 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 immediate jeopardy (Level J).

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

### **REMOVAL OF IMMEDIATE JEOPARDY**

On December 18, 2025, the situation of immediate jeopardy to potential health and safety cited at F 689 was removed.

### **REMEDIES**

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

- **Civil money penalty, (42 CFR 488.430 through 488.444).**

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

### **NURSE AIDE TRAINING PROHIBITION**

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or

§ 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 30, 2025. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS location may notify you of their determination regarding any imposed remedies.

### **SUBSTANDARD QUALITY OF CARE (SQC)**

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

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

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, THIEF RIVER CARE CENTER is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective December 30, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

### **DEPARTMENT CONTACT**

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

**Susie Haben, Regional Operations Supervisor, Rapid Response  
Health Regulation Division  
Minnesota Department of Health  
4140 Thielman Lane  
Saint Cloud, Minnesota 56301-4557  
Email: [susie.haben@state.mn.us](mailto:susie.haben@state.mn.us)  
Office: (320) 223-7356 Mobile: (651) 230-2334**

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](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

Sincerely,



Joanne Simon, Compliance Analyst  
Minnesota Department of Health  
Health Regulation Division  
Telephone: 651-201-4161  
Email: [joanne.simon@state.mn.us](mailto:joanne.simon@state.mn.us)

cc: File

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>245252</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>12/30/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>THIEF RIVER CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2001 EASTWOOD DRIVE , THIEF RIVER FALLS, Minnesota, 56701</b>	
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F0000	INITIAL COMMENTS  On 12/29/25 through 12/30/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.  The following complaint was reviewed H52521741C (2696558) with a deficiency issued at F689 PAST NON-COMPLIANCE.  Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F0000		
F0689 SS = SQC-J	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 observation, interview and document review the facility failed to provide adequate supervision for 1 of 1 resident (R1) had a history of exit seeking behavior, communicated a desire to leave the facility and was able to elope. This resulted in an immediate jeopardy (IJ) for R1 when R1 was found outside in a wheelchair during hazardous weather conditions.  The IJ began on 12/18/25 at 10:25 a.m., a visitor	F0689	"Past Noncompliance - no plan of correction required"	

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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F0689 SS = SQC-J	<p>Continued from page 1 reported to the director of social services a resident in a wheelchair was stuck in the snow outside by the sidewalk. R1 was last seen by staff at 9:30 a.m. The weather was blizzard-like conditions, temperature approximately 0 to 5 degrees with wind from 38 to 44 miles per hour. R1 wore light weight material sweatpants, long sleeved t-shirt (waffle like material), tan colored gripper socks on his feet, with no coat/gloves/hat. The administrator and assistant director of nursing (ADON), were notified of the IJ on 12/30/25 at 5:45 p.m. The facility implemented corrective action by 12/18/25 prior to the start of the survey and therefore is issued as past non-compliance.</p> <p>Findings include:</p> <p>R1's Face Sheet dated 12/30/25, identified diagnoses paranoid personality and insomnia.</p> <p>R1's significant change Minimum Data Set (MDS) dated 12/17/25, identified he was admitted to facility on 12/9/19. R1's cognition was severely impaired without behaviors. He required partial/moderate assistance with oral hygiene, upper body dressing, roll left and right, sit to lying, sit to stand, substantial/maximal assistance with toileting hygiene, shower/bath, lower body dressing, personal hygiene, chair/bed/chair transfers, unable to walk and used a manual wheelchair for mobility. R1 was frequently incontinent of bowel and bladder. Active diagnoses identified non-traumatic brain dysfunction, diabetes mellitus (DM), osteoarthritis (a disease making bones weak and brittle), Alzheimer's Disease, and dementia. He had one fall without injury since admission. R1 received insulin injections 7 out of 7 days during the look back period, antipsychotic, antidepressant, anticoagulant, and diuretic. Wander/elopement alarm was not identified as being used.</p> <p>R1's Elopement risk assessment dated 6/25/25 at 5:39 p.m., identified he was not physically immobile. He had long/short term memory loss, disoriented times three, impaired decision-making skills, and impulsive. He had conditions in which contribute to elopement risk: Alzheimer's and dementia. He had attempted elopement in the last 90 days, looking for his car, staff was with during attempt to leave. Distracted which was successful. He verbalized seeing things (pets, people). R1 has made attempts to elope from current or previous living situations monthly with no successful attempts. Wander guard was placed on wrist and wheelchair due to</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 2 safety concerns related to Alzheimer's disease. Behaviors: Was "Santa" during Christmas, years ago.</p> <p>R1's Elopement risk assessment dated 9/24/25 at 5:06 p.m., he will have impulsive behavior (one time in the past 90 days) attempted to pull fire alarm stated, "I just want to make noise". He did not pose a risk for wandering/eloping from facility, no elopement attempts documented in the last three months. No exit seeking behavior noted. No wander guard.</p> <p>R1's medical doctor (MD) visit dated 11/20/25, identified confused, cognition poor, ambulated with walker but now stands and pivots. Confusion most likely related to intermittent worsening of dementia related to altered mental function.</p> <p>R1's Elopement risk assessment dated 12/16/25 at 10:47 p.m., identified history, cognition remained the same as 9/24/25 assessment. Summary for overall risk of elopement and interventions implemented. R1 does not pose a risk for wandering/eloping from facility, at times will have impulsive behavior such as attempting to pull fire alarm, one attempt in the past 90 days. No specific exit seeking behavior noted or documented in the last three months. No wander guard.</p> <p>R1's Elopement risk assessments dated 9/24/25 and 12/16/25 failed to identify his history of elopement, conditions which continued to contribute to his elopement risks such as Alzheimer's and dementia and failed to address winter/Christmas being an especially difficult time of year for R1.</p> <p>R1's Elopement risk assessment dated 12/18/25 at 2:12 p.m., identified changes: R1 has made attempts to elope from current living situations, weekly, and was successful. He was noted to be wandering, anxious and exit seeking behaviors in recent documentation. Could be related to the Christmas season due to history of being Santa Clause for many years and he drove a car painted like a sleigh. Additionally it was noted he had long/short term memory loss, intermittent confusion, impaired decision-making skills, and pain. R1 verbalized the desire to go home and was looking for his truck. Wander guard was placed to wheelchair due to safety concerns, Alzheimer's disease, and poor safety awareness.</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 3</p> <p>R1's care plan dated 11/21/24, indicated Focus: unable to leave facility independently initiated on 10/13/25. Directed staff to assist with dress appropriate for weather conditions, staff and family supervision for all outdoor activities, family will notify facility and sign him out when leaving facility. R1 was an elopement risk related to impaired safety awareness, dementia, and paranoid personality disorder. He had a self-care performance deficit related to Alzheimer's. Staff were directed to transfer R1 with extensive assistant of two and Sara Steady (mechanical lift) due to unaware of safety needs, occasionally exit seeks and had a history of attempts to leave the facility unattended. Staff were directed to distract R1 from wandering/exit seeking, change wander guard device per manufacturer recommendations or as needed, encourage R1 to attend activities during highest wandering times. R1's behavior will be de-escalated by 1:1, offer food or drink, distraction, provide me with a wander guard and perform checks per facility policy.</p> <p>R1's care plan dated 9/24/25, all exit seeking behavior, wandering and use of the wander guard device was removed from the care plan.</p> <p>On 12/18/25, the focus: elopement was added back into the care plan and read as; unable to leave facility independently initiated on 10/13/25. Directed staff to assist with dress appropriate for weather conditions, staff and family supervision for all outdoor activities, family will notify facility and sign him out when leaving facility. R1 was an elopement risk related to impaired safety awareness, dementia, and paranoid personality disorder. He had a self-care performance deficit related to Alzheimer's. Staff were directed to transfer R1 with extensive assistant of two and Sara Steady (mechanical lift) due to unaware of safety needs, occasionally exit seeks and had a history of attempts to leave the facility unattended. Staff were directed to distract R1 from wandering/exit seeking, change wander guard device per manufacturer recommendations or as needed, encourage R1 to attend activities during highest wandering times, noting triggers for wandering/eloping are Christmas season and little kids. R1's behavior will be de-escalated by 1:1, offer food or drink, distraction, provide me with a wander guard and perform checks per facility policy.</p> <p>Resident care sheet undated and received on 12/19/25, identified transfer assist of two via Sara Steady,</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 4 toilet every two to three hours and as needed (PRN), reposition with assist of two every two to three hours, and diabetic diet easy to chew thin.</p> <p>R1's treatment administration record (TAR) 12/1/25 through 12/17/25, identified monitoring for target behaviors: accusing people of taking my car, feeling people are stealing from me, lying to me, picking at my skin. Elopement monitoring/risk for elopement was not identified on TAR.</p> <p>R1's progress notes dated 12/6/25 through 12/23/25, identified:</p> <p>-On 12/6/25 at 9:35 p.m., R1 became agitated during supper meal. Wheeled towards another table. NA brought him back to table and sat with him and waited for supper. R1 was calm afterwards and brought back to pod.</p> <p>-On 12/16/25 at 11:38 p.m., Monthly evaluation. Mental status: disoriented, disorganized thinking, confused, severe cognitive impairment affecting all areas of judgement, and no unwanted behaviors/does not wander at night. Functional status: gait unsteady, poor balance when standing, and able to move all four extremities.</p> <p>-On 12/17/25 at 6:58 p.m., R1 asked where the exit is to find his pickup. Wandering around halls. Interventions: 1:1 with explanations of wife driving pickup home. Explained to him wife wants him to stay the night. R1 stated he did not want to stay the night. Effectiveness of interventions/follow-up: No documentation.</p> <p>-On 12/18/25 documented at 10:11 a.m., monitor bruise on right pectoral/rib 3 inches by 1 inch. Bruise is healing, purple/yellow, and resident denies pain to the area. (Nurse unavailable for interview to verify time she completed assessment).</p> <p>-On 12/18/25 at 12:51 p.m., At 10:25 a.m. R1 was found outside the facility in his wheel chair looking for his truck. He was safely redirected back into the facility without incident. Vitals taken temperature and within normal limits: 98.1 degrees Fahrenheit (F). Skin intact, cool to the touch at extremities and ears, no signs of frostbite or injury and denies pain. Warming blankets applied and placed on 1:1 visual observation. Wander guard applied and initiated hourly skin checks for 24 hours, vital signs every four hours, and head to toe assessments every shift for the next three days. R1 was oriented to place and safety needs. Elopement risk</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 5 reinforced with care team. Environment assessed and secured appropriately. R1 stable condition at this time. Provider notified at 12:00 p.m., case worker at 11:15 a.m. and DON, Administrator, assistant director of nursing (ADON) and all other appropriate parties notified per facility protocol. Continued monitoring ongoing.</p> <p>-On 12/18/25 at 1:41 p.m., 2:55 p.m., 3:26 p.m., 4:32 p.m., 6:07 p.m., 7:01 p.m., 8:23 p.m., and 10:02 p.m., Inspect skin hourly for color changes, temperature . . . R1 denies any pain, skin color/diameter/irregularity (C/D/I), no new wounds, skin color and temperature are within normal limits. No concerns. At 2:55 p.m. Temperature 97.1 degrees F.</p> <p>Facility internal incident report dated 12/18/25 at 10:25 a.m., incident description identified at 10:25 a.m. R1 was found outside the facility in his wheelchair looking for his truck. He was safely redirected back into the facility without incident. Incident was witnessed. Was not taken to hospital; warming blankets and heat applied, placed on 1:1 visual observation. Temperature 98.1 degrees Fahrenheit (F), extremities cold to the touch, no signs of frostbite or injury, able to feel everything, and denied pain. Wander guard applied, hourly skin checks initiated x24 hours, vital signs every four hours for the next three days, and head to toe assessments to be completed every shift for the next three days. All appropriate parties notified. No injuries observed. Predisposing environmental and situational factors: none checked. Predisposing Physiological factors: confused, able to answer questions appropriately, and demonstrated impaired judgement related to dementia. Redirectable with cueing.</p> <p>Facility 5-day report dated 12/23/25 at 4:18 p.m., identified on 12/17/25 at 7:00 p.m. R1 had asked staff where he could find his pickup. Staff provided 1:1, reassurance to divert behavior and no concerns noted during the night. On 12/18/25 at 10:25 a.m., a family member reported a resident was outside in a wheelchair on the sidewalk. Resident told family member he was going home. Social worker immediately went outside with administrator and asked him where he was going, and he stated I don't know. He was last observed on POD (resident rooms located along with a large open area with trees, tables, lounge, and small kitchen area) he lived on at 9:30 a.m. He had Alzheimer's disease, paranoid personality disorder, and severely impaired cognition. Wander guard had been removed on 8/31/25,</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 6 due to no exit-seeking behaviors documented in the last six months. He had a history of being the community Santa in the city, car was painted like a sleigh he drove year around. With the holiday it may be a trigger for him. Care plan was modified to prevent reoccurrence: elopement focus was added related to impaired safety awareness, dementia, and paranoid personality disorder to prevent reoccurrence. R1 triggers for exit seeking/elopeing are Christmas season/little kids. Exit seeking intervention education was provided to staff. The allegation of neglect was not verified, care plan was followed, no injuries noted, and was an isolated incident.</p> <p>According to the Weather Channel the weather the morning of 12/18/25 was blizzard-like conditions outside, 0 to 5 degrees Fahrenheit with winds from 38 to 44 miles per hour.</p> <p>Observations of R1 from 12/29/25 through 12/30/25, identified:</p> <p>-On 12/29/25 at 3:20 p.m. R1 sat in a high back wheelchair at a large round table, awake in POD where he lived. His feet were located on the floor without foot rests, tennis shoes on, fully dressed in jogging pants, t-shirt with short sleeves, and well groomed. A white wander guard bracelet was located on a bar on the back side of the wheelchair.</p> <p>-On 12/29/25 at 4:34 p.m. R1 pushed himself away from the table located in the POD area with his feet on the floor. He moved himself in wheelchair to a smaller table approximately 10 feet away.</p> <p>-On 12/30/25 at 9:02 a.m. R1 sat in high back wheelchair awake in POD area dressed in long black pants, tennis shoes, and a long-sleeved black shirt. A white wander-guard bracelet was located on a bar on the back side of the wheelchair.</p> <p>During an interview and observation on 12/29/25 at 4:25 p.m., R1 sat in a wheelchair in the lounge area at a table. He stated he liked living at the facility, was treated well and was unsure how long he had lived there. R1 stated his wife and son came to visit him but was unsure how often. R1 was not able to provide time or day. During interview a white wander guard bracelet was observed to be located on the backside of the wheelchair bar and he appeared to become anxious and restless when asked questions so interview was ended.</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 7</p> <p>During an interview on 12/30/35 at 1:07 a.m., Registered nurse (RN)-C stated R1's cognition had been declining. He was unable to self-transfer and required assist of two with the Sara Study Mechanical lift do to his poor cognition. RN-C stated she monitored R1 continuously on the evening shift, kept him within eyesight so that he did not leave the floor or find an exit door. He made her nervous with a history of attempted elopements in the past, but had not done that in a long time. The day before he eloped (12/17/25) R1 asked where his pickup was and she told him his wife had taken it home. R1 asked where an exit door was and stated he wanted to leave. RN-C kept R1 within eyesight until he was placed in bed between 7:00 p.m. and 8:00 p.m. The next day she found out he had eloped. R1 used to have a wander guard on but it was removed a couple of months ago. R1 usually stayed on the unit and should have not been allowed to leave by himself, he required supervision due to lack of cognition and poor safety awareness. If R1 saw the exit doors he would be more likely to go out. RN-C indicated she was unsure what happened that morning. The weather was cold, blowing snow, not good conditions at all. RN-C stated she should have passed the information onto the next shift so that they would have been aware to keep a closer watch on him and she failed to let them know.</p> <p>During an interview on 12/30/25 at 9:34 a.m., NA-A stated R1 had dementia, cognition/memory was not the best, and he was frequently forgetful. She used resident care sheets to identify how to care for each resident. She was unaware if he was at risk for elopement until he went out to the parking lot in a snowstorm recently. Staff were expected to check on him at least every two to three hours. NA-A stated if R1 talked about leaving and/or looking for his pickup she would have kept a closer eye on him for wandering, exit seeking, talk to him, and redirect from leaving building. He was not allowed to go outside by himself and would not have been safe out in cold weather alone.</p> <p>During an interview on 12/30/25 at 11:46 a.m., NA-C stated R1 had a poor memory, seemed lost all the time and did not really know what was going on. R1 had a history of elopement and was not safe going outside alone. Staff were expected to check on him every two to three hours, but was usually more often. On 12/18/25, she had provided cares to R1 at 7:15 a.m. and no behaviors were noted. R1 ate breakfast in the dining room and at 9:15 a.m. sat in his wheel chair in the POD</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 8 area by the nurse's station. Last time she saw him was at 9:30 a.m. where he was still sitting in his wheelchair in the POD area wearing Addidas jogging pants and a short or longed sleeved shirt (not sure), shoes and socks. When she returned from her break she became aware he had eloped outside. NA-C was unsure as to how long R1 was outside. The weather that day was a bad storm day, snowing, cold, and roads were closed. NA-C arrived at work at 6:00 a.m. and received report from the night shift. There was no mention of R1 expressing exit seeking behavior from the prior shift. If she would have been told that it would have made a difference, she would have kept a closer watch on him to keep him safe and help avoid him getting out that day.</p> <p>During an interview on 12/30/25 at 12:18 p.m., RN-B stated R1 had a short term memory loss, confused, and verbalized being frustrated and afraid when he cannot remember things. His cognition had slowly declined. R1 was able to push himself around the facility with his feet in the wheelchair, not one to go very far typically, but staff were expected to escort him to the dining room. He had poor safety awareness, cognition was not consistent verified by 12/18/25, when he eloped from the facility, and was very odd thing for him to do. RN-B had been told by staff R1 believed he was Santa Clause at one time, was more anxious around Christmas and wanted to be Santa Clause this year. RN-B added she was unsure why he was not this year during the facility's holiday events. This information was added to his care plan following the elopement due to behaviors associated with it, such as finding his truck. He was found outside in his wheel chair on 12/18/25, unsure how long he was out there, the weather was bad that day, snowing, cold, stormy weather with a wind chill. Due to his lack of memory and poor judgement he would have not been safe outside without supervision. Unknown how he got out there by himself. When R1 was brought back into the building he stated he thought he had found his truck and tried to get into it. RN-B stated she was present during the morning report given on 12/18/25, and she would have expected RN-C to have reported off to the next shift, concerns about R1 on the 12/17/25 evening shift such as R1 looking for an exit door, asking for his pickup and wanting to leave facility. The oncoming day shift could have monitored R1 closer, a management meeting would have been held right away, a plan put in place to help avoid an elopement, and a revision to his care plan.</p> <p>During a follow up interview on 12/30/25 at 2:10 p.m.,</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 9</p> <p>RN-B stated R1's target behaviors did not include elopement risk, when a resident had a behavior such as exit seeking, that would be expected to documented in the progress notes and an alert on the 24 hour report would be activated. RN-B verified she had not seen the 24 hour report and was unsure where to find it. She would have expected RN-C to have provided better documentation and include interventions and R1's response to the interventions, would have been beneficial. The incident on 12/17/25, R1 expressed exit seeking behaviors which warranted a reevaluation for elopement and he should have been reassessed to prevent the elopement.</p> <p>During an interview on 12/30/25 at 2:03 p.m., care coordinator/floor manager registered nurse (RN)-A stated she completed the resident elopement risk assessments upon admission, quarterly, and whenever there was a change in condition. The criteria used to determine if a resident was at risk for elopement would be target behaviors and the elopement assessment. She was unsure if there were different levels of risk for elopement and not every resident with a risk for elopement required a wander guard. RN-A stated she completed R1's elopement assessment on 12/16/25, for a quarterly assessment. He did not have a wander guard on at that time, was mobile, and had not made any attempts to elope. RN-A stated when a progress note was entered regarding exit seeking and elopement a 24-hour report should have popped up and she had not seen anything regarding a progress note entered 12/17/25. RN-A verified R1's care plan did not include a focus and/or intervention(s) regarding elopement/exit seeking prior to the 12/18/25 incident, most likely because he was not actively a risk, and no longer actively making attempts to elope to necessitate the wander guard. R1's cognition was severely impaired, and he remained at risk for elopement. When she resolved and removed the focus and interventions on R1's care plan on 9/24/25, she was unaware of his history and lacked knowledge training on how to assess the risk. This information should have remained on R1's care plan and would have been important for staff to be aware of his history to prevent an elopement. RN-A stated she was unaware that Christmas time would trigger R1's exit seeking behaviors and possible elopement so none of that history was included as part of the elopement assessment on 9/24/25 or 12/16/25, which was unfortunate.</p> <p>During an interview on 12/30/25 at 4:00 p.m., social service director (SS) stated on 12/18/25, between 10:00</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 10 a.m. and 10:30 a.m. a visitor informed her a resident was outside and they could not get him to come into the building. SS went outside and found R1 in a wheelchair stuck in a snowbank. He had gone off the side walk to the left of the front pillars of the building in the first handicap parking spot where there were snow drifts and could not get himself out. He was not dressed for the weather and wore light weight material sweatpants, long sleeved t-shirt (waffle like material), tan colored gripper socks on his feet, with no coat/gloves/hat. The weather was bitter cold, very windy. She had ran out there with a jacket on and was cold. R1 sat in his wheelchair faced away from the building. SS stated she was a pretty big person and it was hard for her to get him pulled out of the snow. There was an SUV parked next to where he was stuck. SS pushed R1 back into the facility and noted his left hand was blue, grabbed it, held it with both of her hands, and placed it next to her body to warm it up. R1's face and lips looked ok. R1 did not realize he was in danger. SS stated R1 used to play Santa Clause and believed this may have triggered the elopement.</p> <p>During an interview on 12/30/25 at 4:23 p.m., assistant director of nursing (ADON) stated R1 had a wander guard applied 2022 or before and was discontinued the end of August 2025. ADON verified on 12/17/25, the evening prior to his elopement R1 asked where the exit door was located, talked about looking for his pickup, and indicated he did not want to stay at the facility. ADON stated R1 was exit seeking at that time per the facility policy and she would have expected RN-C to have completed an elopement assessment right away, and place a wander guard on him to keep him safe. RN-C's documentation was not clear, lacked details such as interventions and outcome of the interventions. ADON stated she would have expected RN-C to inform the oncoming shift in the morning R1 had been exit seeking, so they could have been on alert, included him in the resident council meeting (he did not attend), kept a closer eye on him, and would have helped keep him safe and prevented the elopement. Staff statements identified R1 ate breakfast and was last seen at 9:28 a.m. inside the building. Staff were expected to check on R1 at least every two to three hours and he was usually in the POD area where he lived, supervised. ADON stated it was unknown how long he was outside, the facility did not have cameras. The weather on 12/18/25, was a bad day, stormy and cold. ADON stated she was there when he was brought back into the building and if he had been outside more than five more minutes would have had frost bite. R1's hands were cold and slightly red, no blue noted on hands. Two staff nurses assessed</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 11</p> <p>R1 and documented in his medical record. The provider was notified right away, did not want him seen/sent in, but monitored closely. Hourly checks were completed on R1 and no frost bite or injuries were identified. R1 was wearing slide on shoes, socks, nylon stretchy pants with a stripe down the side, a long-sleeved maroon colored shirt, and no hat/mittens or gloves were worn. ADON verified R1's care plan did not include an elopement focus area or interventions such as: looking for his truck, asking for the exit door, indicating he did not want to stay at facility, triggers such as Christmas and little children due to being Santa Clause in the community. ADON stated would have been important to have the elopement information in his care plan so that staff would have been aware he had displayed behaviors of elopement and would have helped prevent the elopement. The day before he went outside, another person dressed up as Santa Clause was in the building and that may have caused him to think he needed to get outside and be Santa Clause. R1 was assessed in August 2025, had not had any exit seeking behaviors in the last assessment period, and was then found no longer be at risk for elopement, wander guard was discontinued, elopement section of the care plan was resolved/removed, and should not have been. The elopement assessment process should have included the whole picture of R1's history and based on his mobility and cognition.</p> <p>Facility policy Elopement dated 5/21/25, identified definition of elopement is when a resident who is cognitively, physically, mentally, emotionally and/or chemically impaired wanders away, walks away, runs away, escapes or otherwise leaves a care center or environment, unsupervised and/or prior to their scheduled discharge. When a resident is determined at risk for determined at risk for elopement, an elopement risk assessment will be performed and a corresponding care plan developed. If a resident is suspected of leaving the building, staff will promptly report to the nurse in charge, and the Missing Resident Protocol will be initiated. If staff were unaware that the resident had exited the building and the resident was later discovered outside by the staff or a visitor, the situation would be considered an elopement and would need to be reported to the state agency. In the event of an elopement a care center wide audit will be completed including assessing residents at risk for elopement to ensure an appropriate care plan is in place, providing additional training to care center staff, as needed, to reinforce resident safety measures.</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 12</p> <p>The past noncompliance immediate jeopardy began on 12/18/25. The immediate jeopardy was removed and the deficient practice corrected by 12/18/25, after the facility implemented a systemic plan that included the following actions:</p> <ul style="list-style-type: none"> <li>-upon R1's return to facility a complete head to toe health assessment was completed</li> <li>-R1's provider was updated</li> <li>-An elopement assessment with his past and recent risk for elopement was included. A wander guard was placed on his wheelchair.</li> <li>- Reviewed and revised R1's care plan. Ensured CP included details related to his holiday challenges, how staff will communicate, behavioral tracking and interventions that will be used if R1 is exit seeking to ensure he is safe.</li> <li>- Elopement assessment practices were reviewed and revised as needed to best determine resident elopement risk. (i.e. ensure other factors such as history, mental health, seasonal challenges, med changes are considered)</li> <li>-Nursing staff completing elopement assessments were retrained on recognizing and responding to exit seeking behavior.</li> <li>-Trained all staff on R1's care plan changes and facility policy changes to include:</li> </ul> <p>Facility education document Critical Safety Alert: Elopement Prevention &amp; Emergency Protocol dated 12/18/25, identified: this training is issued following a critical safety event where a resident with Alzheimer's successfully eloped from the facility during dangerous blizzard conditions. This lapse in clinical judgement and protocol adherence placed a vulnerable life at immediate risk:</p> <ol style="list-style-type: none"> <li>1. Zero Tolerance for "Reasoning": Attempting to "reason" with a cognitively impaired resident regarding their safety is clinically insufficient and an</li> </ol>	F0689		

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F0689 SS = SQC-J	Continued from page 13 unacceptable intervention. If a resident vocalizes a desire to leave and/or displays wandering behavior, you must take immediate physical action.  2. MANDATORY Immediate Interventions: When exit-seeking behavior is identified, the following actions must be taken immediately: Elopement Assessment, interventions must be documented immediately, wander guard placement, increased Surveillance, environmental Safety.  3. Failed Communication – Endangerment: Communication breakdowns are the primary cause of elopement: Mandatory Handover- you are required to provide a detailed verbal or written report to the oncoming shift and the nurse in charge regarding any wandering or behavioral changes. Point Click Care (PCC) Entry – Documentation of elopement prevention protocols must be entered into PCC immediately and not at the end of the shift.  4. Professional & Legal Consequences: State reporting and Disciplinary Action.	F0689		

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20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>On 12/29/25 through 12/30/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure.</p> <p>The following complaints were reviewed during the survey. H52521741C (2696558).</p>	20000		

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1 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.	20000		