

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

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Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                           |                                                                                             |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245052                                                       | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY<br>COMPLETED<br><br>10/21/2011 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Moorhead Restorative Care Center                                                               |                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2810 Second Avenue North<br>Moorhead, MN 56560 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                           |                                                                                             |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |                                                                                             |                                                 |
| Level of Harm - Unknown<br><br>Residents Affected - Unknown                                                                        | No health deficiencies found                                                                                              |                                                                                             |                                                 |

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE