



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 27, 2026

Administrator
CENTRAL TODD COUNTY CARE CENTER
406 EAST HIGHWAY 71
PO BOX 38
CLARISSA, MN 56440

RE: CCN:245521

Cycle Start Date: March 18, 2026

Dear Administrator:

On March 18, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

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

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

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

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

DEPARTMENT CONTACT

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

Stacy Line, BSN, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: stacy.line@state.mn.us

Office: 218-332-5159

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 June 18, 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 September 18, 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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245521	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER CENTRAL TODD COUNTY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 406 EAST HIGHWAY 71 PO BOX 38, CLARISSA, Minnesota, 56440	
(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 3/16/26 to 3/18/26 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		03/30/2026
F0000	INITIAL COMMENTS On 3/16/26 to 3/18/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint were reviewed: H55217320C (iQIES # 2581014). NO deficiencies were cited. The following complaint was reviewed: H55215540C (iQIES #2734215). An incidental finding was discovered and cited at (F558). 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		03/30/2026
F0558	Reasonable Accommodations Needs/Preferences	F0558	Staff education provided on the need for residents to	04/24/2026

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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<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245521</p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING</p>	<p>(X3) DATE SURVEY COMPLETED 03/18/2026</p>	
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<p>F0558 SS = D</p>	<p>Continued from page 1</p> <p>CFR(s): 483.10(e)(3)</p> <p>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to ensure a resident's call light was accessible for 1 of 1 residents (R15) reviewed for call light accessibility.</p> <p>Findings include:</p> <p>R15's quarterly Minimum Data Set (MDS) dated 1/27/25, identified R15 had severely impaired cognition and had a diagnosis that included Alzheimer's disease (disease that cause dementia), non-Alzheimer's dementia. R15 needed maximal assistance with toileting and touching assistance with transfers.</p> <p>R15's care plan revised on 1/15/26, identified R15 was at risk for falls, and staff were to reinforce the need to call for assistance.</p> <p>R15's fall safety assessment dated 1/13/26, identified R15 of having a moderate risk for falls.</p> <p>During an observation on 3/17/26 at 1:03 p.m., R15 was lying in bed; the call light was not accessible. The call light was clipped to the call light wire that was coming out from the wall. The call light was approximately two feet above the bed and a foot away from the end of the bed, above a small dresser.</p> <p>During an interview/ observation on 3/17/26 at 1:47 p.m., nursing assistant (NA)-A and NA-B, verified R15 was able to use the call light and should have access to the call light when in room. NA-A looked at R15's call light placement and verified R15's call light was not within reach and moved the call light into R15's reach.</p> <p>During an interview on 3/17/26 at 4:12 p.m., director</p>	<p>F0558</p>	<p>Continued from page 1 have access to call lights. Audits to be conducted on R15 and building wide. Results of the audits/ trending will be reviewed at the next QA meeting and depending on the results may modify audit schedule/frequency as needed. DON responsible.</p>	

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F0558 SS = D	Continued from page 2 of nursing (DON) indicated R15's fall interventions were appropriate and R15 was able to use the call light. DON's expectations was for staff to follow care plan interventions and to ensure R15's call light was in reach at all times to prevent falls. Facility policy titled Call Light Response dated 7/25, lack information regarding placing call light where accessible to resident.	F0558		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be	F0880	EBP placed on both residents identified as requiring precautions. Review of entire census concluded all required precautions were in place. Staff education on EBP policy and clarifications. Daily IDT review of new potential wounds/scenarios that could require EBP will be conducted to ensure timely initiation of appropriate precautions. Additional precautions placed will be documented in the residents EHR. QA will review outcomes and determine efficacy of correction and continued monitoring. DON responsible.	04/24/2026

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F0880 SS = D	<p>Continued from page 3 followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens.</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented in accordance with Centers for Disease Control (CDC) guidelines for 1 of 2 (R19) residents who were reviewed for enhanced barrier precautions.</p> <p>Findings include: Review of Centers for Disease Control and Prevention (CDC) guidance dated 4/1/24, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier</p>	F0880		

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F0880 SS = D	Continued from page 4 Precautions included: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. R19's quarterly Minimum Set Data dated 1/27/26, identified R19 had severely impaired cognition and had a diagnosis which included Parkinson's disease (neurological disorder), non-Alzheimer's dementia. R19 was dependent on staff for dressing, toileting, and transfers. R19 had an unstageable pressure ulcer that was present on entry and received pressure ulcer care. R19's signed electronic medication administration record (EMAR) directed staff to change Allevyn (dressing) to buttocks measure and update skin sheet on bath days start date 1/22/26 and discontinued 3/17/26. EMAR identified dressing change was completed on 3/5/26 and 3/12/26. R19's EMAR directed staff to change to Mepilex (dressing) buttocks, measure, and update skin sheet on bath days. EMAR identified the task was completed on 3/18/26. R19's altered skin integrity sheet dated 3/12/26, identified R19 had an open area on left buttocks measuring 4 centimeters (cm) x 4.5 cm. The wound bed is shallow and consists of 10% slough (tissue in the wound bed appearing white or yellow, resulting from wound healing) and 90% granular tissue (pink or red tissue, signifying a sign of wound healing). Edges were irregular and lightly macerated (soft tissue). Blanchable erythema (tissue surrounding a wound). No drainage noted at the time of the dressing change. Skin prep was applied around the wound, and Mepilex applied over the wound. R19's altered skin integrity sheet dated 3/5/26, identified R19 had two small scab areas and one small open area. R19's altered skin integrity sheet dated 2/26/25, identified R19 wound measures 3.5 cm x 7 cm with small shallow areas are bleeding. Erythema (redness of skin) to periwound (tissue surrounding a wound) was blanchable. Large Mepilex placed over coccyx. R19's care plan revised on 10/24/25, identified R19 had alteration in skin integrity related to pressure injury on the left buttocks. The care plan lacked EBP. During an observation/interview on 3/17/26 at 10:04 a.m., there were no signs on R19's door indicating R19 was on EBP or any gowns available for staff to use. Nursing assistant (NA)-C, NA-D, and registered nurse (RN)-A sanitized hands and went into R19 's room. RN-A indicated R19 needed to have a wound dressing changed. NA-C and NA-D assisted R19 into a mechanical standing lift. RN-A brought skin protective wipes, wound wash, gauze, and dressing into the room. RN-A indicated a measuring device was not brought into the room as the wound was measured on Thursdays. RN-A indicated R19 had	F0880		

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F0880 SS = D	Continued from page 5 a pressure wound to the left upper buttocks. RN-A applied gloves and removed the old dressing and indicated there was a small amount of squamous (clear serous fluid) drainage. The wound was shallow, with 75% maturation (newly formed tissue) and 25% of red granulation (pink tissue forms during wound healing) tissue. Wound wash and gauze were used for debridement (removal of dead or damaged tissue) of the wound. RN-A removed gloves, sanitized hands, and applied new gloves. RN-A indicated the wound was approximately 4 cm x 6 cm. RN-A applied skin prep wipe around the wound to help protect the skin, then applied a new dressing. RN-A indicated the wound had been healing and was almost healed two weeks prior, but the wound has since reopened. During an interview on 3/17/26 at 12:34 p.m., RN-A indicated EBP was to be used on residents who had chronic wounds. RN-A indicated R19 was not on EBP, as R19's wound was not chronic, as it had healed in the past. RN-A indicated R19's wound had been open for approximately two weeks. During an interview on 3/17/26 at 1:13 p.m., registered nurse care coordinator (RNCC)-A indicated R19 had an open wound measuring 4 cm x 4.5 cm on 3/12/26. RNCC indicated EBP would be started on a resident who had chronic wounds. RNCC verified R19 had a chronic wound and should have been placed on EBP. During an interview on 3/18/26 at 10:21 a.m., director of nursing (DON) indicated EBP was to be used on residents with wounds. DON verified R19 should have been on EBP related to having a wound. DON's expectation would be for EBP to be used per policy to keep residents and staff safe from the spread of multidrug-resistant organisms (MDROs). During an interview on 3/18/26 at 1:56 p.m., infection preventionist (IP)-A verified R19 should have been on enhanced barrier precautions for an open wound. IP indicated EBP was important for the prevention of MDROs. Review of policy titled enhanced barrier precautions for multidrug-resistant organisms (MDROs) dated 4/25, identified Central Todd County Care Center would utilize enhanced barrier precautions for residents with chronic wounds, and not those with only shorter-lasting wounds such as breaks in the skin or skin tears covered with a Band-Aid or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Enhanced barrier precautions require the use of a gown and gloves during high-contact care activities, including dressing, grooming, bathing/showering, transferring, toileting, dressing changes, wound care, and changing linens. Review of policy titled wound care dated 1/26 identified EBP should be utilized for residents with chronic wounds.	F0880		

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NAME OF PROVIDER OR SUPPLIER CENTRAL TODD COUNTY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 406 EAST HIGHWAY 71 PO BOX 38, CLARISSA, Minnesota, 56440	
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K0000 Bldg. 01	<p>INITIAL COMMENTS</p> <p>Fire Safety</p> <p>An annual Life Safety Code survey was conducted on 03/17/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Central Todd County Care Center was found 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.</p> <p>Central Todd County Care Center is a 1-story building without a basement. The building was constructed at 4 different times. The original building was constructed in 1976 and was determined to be of Type V(111) construction. In 1985, an addition was added to the service wing on the south side and was determined to be of Type V(111). In 1992 an activities/ physical therapy addition was added to the east end of A Wing and was determined to be of Type V(111) construction. In 2002 additions were added to west end of D Wing, to the main entrance and between E and D wings dining room, all of which are Type V(111) construction. An assisted living apartment building is attached to the B wing which is separated by a 2-hour fire barrier. The north end of E wing are apartments and separated from the nursing home with a 2-hour fire barrier. The building is divided into 4 smoke zones by 2 hour fire barriers.</p> <p>The building is fully fire sprinkler protected 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.</p> <p>The facility has a capacity of 45 beds and had a census of 40 at the time of the survey.</p> <p>The requirements at 42 CFR, Subpart 483.70(a) are MET.</p>	K0000		

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.

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June 9, 2026

Administrator
CENTRAL TODD COUNTY CARE CENTER
406 EAST HIGHWAY 71
PO BOX 38
CLARISSA, MN 56440

RE: CCN: 245521

Cycle Start Date: March 18, 2026

Dear Administrator:

On April 27, 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.

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

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