#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRAN PART I - TO BE COMPLETED BY THE STATE SURVE								ID: 917D Facility ID: 00761	
MEDICARE/MEDICAID PROVIDER N     (L1) 245521 2.STATE VENDOR OR MEDICAID NO.     (L2) 785540100	0.	3. NAME AND ADI (L3) CENTRAL T (L4) 406 EAST HI (L5) CLARISSA,	ODD COUNTY C IGHWAY 71, PO F	CARE CEN		5) <b>56440</b>	<ol> <li>TYPE OF ACTION</li> <li>Initial</li> <li>Termination</li> <li>Validation</li> <li>On-Site Visit</li> </ol>	DN: <u>7 (</u> L8) 2. Recertification 4. CHOW 6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE OF OWN (L9)	VERSHIP	7. PROVIDER/SUF 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L 13 PTIP	.7) 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 03/03/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2017 (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDI	ING DATE: (L35)	
11LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12.Total Facility Beds         13.Total Certified Beds         14. LTC CERTIFIED BED BREAKDOWN         18 SNF       18/19 SNF         60	60 (L18) 60 (L17) 19 SNF	B. Not in Com Requirements a ICF	nce With quirements Based On: Acceptable POC pliance with Program and/or Applied Waive IID		2. Te 3. 24 4. 7- 5. Li * Code: 15. FACILITY	echnical Personnel 4 Hour RN Day RN (Rural SNF) ife Safety Code <b>A</b> *	Following Requirements 6. Scope of S 7. Medical D 8. Patient Ro 9. Beds/Roor (L12) (L15)	Services Limit Director om Size	
	(L37)       (L38)       (L39)       (L42)       (L43)         16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):								
17. SURVEYOR SIGNATURE		Date :			18. STATE SU	JRVEY AGENCY API	PROVAL	Date:	
Brenda Fischer, U	Init Supervis	sor (	03/03/2017	(L19)	Kate Jo	hnsTon, Pro	ogram Specia	list 03/27/2017 (L20)	
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE OR	R SINGLE STAT	E AGENCY		
<ol> <li>DETERMINATION OF ELIGIBILITY</li> <li> 1. Facility is Eligible to Part</li> <li> 2. Facility is not Eligible</li> </ol>	icipate		IPLIANCE WITH CI ITS ACT:	VIL	2.		al Solvency (HCFA-2572) interest Disclosure Stmt (H		
	(L21)								
22. ORIGINAL DATE OF PARTICIPATION <b>02/01/1988</b> (L24)	23. LTC AGREEM BEGINNING (L41)		<ol> <li>LTC AGREEMEN ENDING DATE (L25)</li> </ol>		VOLUNTARY 01-Merger, Clo 02-Dissatisfact	osure ion W/ Reimbursemer	05-Fail t	(L30) <u>UNTARY</u> o Meet Health/Safety o Meet Agreement	
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L44)			oluntary Termination	<u>OTHER</u> 07-Provi 00-Activ	ider Status Change	
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS	S			
	(L28)	03001		(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION ( 02/14/2017	OF APPROVAL DAT	E	Posted 03/2	28/2017 Co.			
	(L32)	5 MI 1 11 MUL I		(L33)	DETERMIN	NATION APPRO	VAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245521 March 27, 2017

Mr. Jason Polovick, Administrator Central Todd County Care Center 406 East Highway 71, Po Box 38 Clarissa, MN 56440

Dear Mr. Polovick:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 3, 2017 the above facility is certified for or recommended for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Central Todd County Care Center March 27, 2017 Page 2

Sincerely,

ate Comston Ł

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 24, 2017

Mr. Jason Polovick, Administrator Central Todd County Care Center 406 East Highway 71, P.O. Box 38 Clarissa, MN 56440

RE: Project Number S5521026

Dear Mr. Polovick:

On January 20, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 5, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 3, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 5, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 3, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 5, 2017, effective February 3, 2017 and therefore remedies outlined in our letter to you dated January 20, 2017, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Central Todd County Care Center March 24, 2017 Page 2

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

## **POST-CERTIFICATION REVISIT REPORT**

	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
	A. Building B. Wing	Y2	3/3/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRAL TODD COUNTY CARE	CENTER	406 EAST HIGHWAY 71, PO BOX 38		
		CLARISSA, MN 56440		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE	м		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix Reg. # LSC	F0166 483.10(j)(2)-(4)		Correction Completed 02/03/2017	ID Prefix Reg. # LSC	F0242 483.10(	f)(1)-(3)	Correction Completed	ID Prefix Reg. # LSC	F0279 483.20(d);483.21(b)	)(1)	Correction Completed 01/06/2017
ID Prefix Reg. # LSC	F0282 483.21(b)(3)(ii)		Correction Completed 01/09/2017	ID Prefix Reg. # LSC	F0318 483.25(	c)(2)(3)	Correction Completed 01/09/2017	ID Prefix Reg. # LSC	F0465 483.90(i)(5)		Correction Completed 01/13/2017
ID Prefix Reg. # LSC	F0520 483.75(g)(1)(i)-(iii (h)(i)	i)(2)(i)(ii)	Correction Completed 02/03/2017	ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed
REVIEWE STATE AG REVIEWE CMS RO FOLLOWI 1/5/2017		REVIEWE (INITIALS REVIEWE (INITIALS	BF/KJ Ed by		CK FOR	SIGNATURE OF S	10 ED DEFICIENCIES			DATE 03/ DATE	03/2017

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

				AND TRANSMITTAL ID: 917D TE SURVEY AGENCY Facility ID: 0076				
MEDICARE/MEDICAID PROVIDER NO     (L1) 245521 2.STATE VENDOR OR MEDICAID NO.     (L2) 785540100 5. EFFECTIVE DATE CHANGE OF OWNI		<ol> <li>NAME AND ADI</li> <li>(L3) CENTRAL T</li> <li>(L4) 406 EAST HI</li> <li>(L5) CLARISSA, I</li> <li>7. PROVIDER/SUP</li> </ol>	ODD COUNTY C GHWAY 71, PO I MN	CARE CEN BOX 38	(L6) <b>56440</b>	4. TYPE OF ACTION:     2 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other		
(L9)		01 Hospital	05 ННА	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 01/05/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30		
11LTC PERIOD OF CERTIFICATION From (a) : To (b) : 12.Total Facility Beds	<b>60</b> (L18)	10.THE FACILITY I A. In Complian Program Rec Compliance 1. A	nce With quirements		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF)	<ul> <li>6. Scope of Services Limit</li> <li>7. Medical Director</li> <li>8. Patient Room Size</li> </ul>		
13. Total Certified Beds	<b>60</b> (L17)	-	pliance with Program and/or Applied Waive		5. Life Safety Code * Code: <b>B</b> *	9. Beds/Room (L12)		
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 60	19 SNF	ICF	IID		15. FACILITY MEETS           1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARKS	16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):							
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PROVAL Date:		
Mardelle Trettel	, HFE NE I	<u>I</u> (	02/03/2017	(L19)	Kate JohnsTon, Pr	ogram Specialist 02/13/2017 (L20)		
	PART II - TO	BE COMPLETEI	D BY HCFA RE	GIONAL	OFFICE OR SINGLE STAT	'E AGENCY		
19. DETERMINATION OF ELIGIBILITY            1. Facility is Eligible to Partice	ipate		PLIANCE WITH CI ITS ACT:	VIL	<ol> <li>Statement of Financi</li> <li>Ownership/Control I</li> <li>Both of the Above :</li> </ol>	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)		
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE OF PARTICIPATION <b>02/01/1988</b> (L24)	23. LTC AGREEMI BEGINNING (L41)		<ol> <li>LTC AGREEMEN ENDING DATE (L25)</li> </ol>		26. TERMINATION ACTION:         VOLUNTARY       00         01-Merger, Closure         02-Dissatisfaction W/ Reimbursement	05-Fail to Meet Health/Safety		
25. LTC EXTENSION DATE:	27. ALTERNATIVI A. Suspension of	of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active		
(L27)	(L27) B. Rescind Suspension Date: (L45)							
28. TERMINATION DATE:	29	. INTERMEDIARY/C			30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION C	OF APPROVAL DAT	E	Posted 02/14/2017 Co.			
	(L32)			(L33)	DETERMINATION APPRO	VAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 20, 2017

Mr. Jason Polovick, Administrator Central Todd County Care Center 406 East Highway 71, PO Box 38 Clarissa, Minnesota 56440

RE: Project Number S5521026

Dear Mr. Polovick:

On January 5, 2017, a standard 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

# <u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

### DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor St. Cloud A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: Brenda.fischer@state.mn.us Phone: (320) 223-7338 Fax: (320) 223-7348

## **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 14, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

## ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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

Central Todd County Care Center January 20, 2017 Page 4

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

#### Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

#### Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

#### Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

# 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 April 5, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

Central Todd County Care Center January 20, 2017 Page 5

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 5, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

#### INFORMAL DISPUTE RESOLUTION

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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.

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:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525 Central Todd County Care Center January 20, 2017 Page 6 Feel free to contact me if you have questions related to this eNotice.

Sincerely,

## Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

		AND HUMAN SERVICES				FORM	APPROVED
	<u>SFOR MEDICARE</u> OF DEFICIENCIES		(X2) MU	TIPI			. 0938-0391
	F CORRECTION						
		245521	B. WING			01/	05/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CENTRA	L TODD COUNTY CA	RE CENTER			106 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	FC	000			
	completed by surve Department of Hea County Care Cente compliance with the	7, a recertification survey was eyors from the Minnesota Ith (MDH). Central Todd r was found to not be in e regulations at 42 CFR Part uirements for Long Term Care					
F 166	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substat regulations has been your verification. 483.10(j)(2)-(4) RIC	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with GHT TO PROMPT EFFORTS	F 1	166			2/3/17
SS=D	(j)(2) The resident h must make prompt	has the right to and the facility efforts by the facility to resolve dent may have, in accordance					
		ust make information on how or complaint available to the					
	to ensure the prom regarding the reside paragraph. Upon re	ust establish a grievance policy pt resolution of all grievances ents' rights contained in this equest, the provider must give ance policy to the resident. The					
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						02/01/2017

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.

		AND HUMAN SERVICES				FORM	02/03/2017 APPROVED 0938-0391			
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED			
		245521	B. WING							
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
CENTRA	L TODD COUNTY CA	RE CENTER			06 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 166	postings in promine facility of the right to (meaning spoken) of grievances anonym of the grievance off can be filed, that is, address (mailing ar number; a reasonal completing the revie to obtain a written of grievance; and the independent entities be filed, that is, the Quality Improvement Agency and State L program or protecti (ii) Identifying a Grie responsible for ove receiving and trackit conclusions; leading by the facility; main information associa example, the identifi grievances submitted written grievance do coordinating with st necessary in light o (iii) As necessary, to prevent further pote right while the alleg investigated;	-	F	166						

If continuation sheet Page 2 of 45

		AND HUMAN SERVICES				FORM	02/03/2017 APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         IND PLAN OF CORRECTION       IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245521	B. WING			01/(	05/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	RE CENTER			06 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 166	reporting all alleged abuse, including inj and/or misappropria anyone furnishing s provider, to the adm as required by State (v) Ensuring that all include the date the summary statement the steps taken to in summary of the per regarding the reside as to whether the g confirmed, any corr taken by the facility and the date the wr (vi) Taking appropria accordance with State of the residents' rig or if an outside entit the State Survey Ag Organization, or loc confirms a violation rights within its area (vii) Maintaining evi result of all grievand 3 years from the iss decision. This REQUIREMEN by: Based on observat review, the facility fa cool temperatures i of 3 residents (R18	d violations involving neglect, uries of unknown source, ation of resident property, by services on behalf of the ninistrator of the provider; and	F 1	66	Residents R18, R20 and R15 have complained of cool temperatures in dining room on past occasions. Of move or rearrange the cold residen have been made, but were declined those residents like sitting by the w	the fers to ts d, as	

Facility ID: 00761

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM / //B NO.	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245521	B. WING _			01/0	05/2017
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	RE CENTER		40 C			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 166	Finding include: R20's quarterly Min 11/4/16 indicated he impaired. The MDS to express ideas ar understood. R18's significant ch indicated R18 was able to express idea himself understood R15's quarterly MD R15 was cognitively he was usually und communicating som thoughts, but was a During observation dining room on 1/3/ table along with R2 located about 4' (fe in front of a double- wide by 5' in height and sat with his bac window was an 3' w and a cold draft wa above the tables alo R18, R15 and R20 also emitted a cool	imum Data Set (MDS) dated e was moderately cognitively S also indicated R20 was able ind wants, and made himself ange MDS dated 9/23/16 cognitively intact, and was as and wants, and made S dated 10/19/16 indicated y intact. The MDS indicated erstood, had difficulty ne words and finishing able if prompted or given time. of the noon meal in the main 17 at 12: 22 p.m., R18 sat at a 0 and R15. The table was et) from a north side wall, and pane picture window, about 6' . R18, was wearing a sweater, ck to the window. Left of the vide exit metal and glass door, s felt in front of the door. Also, ong the wall, above where sat, were heat vents, which draft.	F 16	6	During the survey observations, the highest recorded outside temperatu 3 degrees F and the lowest was -21 degrees F. The lowest dining room temperature (continuously recorded during any meal services was 71.6 degrees. Upon further investigation found that during times of adequate temperature, while the HVAC was n actively heating, fresh air was being provided through the ductwork as ne for environmental engineering specifications. This fresh air was passively being heated, but could fe when exiting the HVAC system to th sitting directly under the ducts. The system programming has been upd heat the fresh air to match the ambi temperature of the room. R18, R20 R15 were interviewed and declined offer to move. All three also said the modification improved the temperatur Temperatures will be monitored dail affected resident interviews will be conducted weekly to ensure correct Dining room environmental condition resident interviews and any changes made will be reviewed in the QAU meetings. Overall Responsibility: Maintenance Supervisor	re was .9 i) i it was room ot eeded eeded eeded ose ated to ient 0 and the e ure. ly and ion. ns, s	
	stated he usually si main dining room) a down, "its damn co stated, it was "alwa and added they forg	on 1/3/17 at 12:38 p.m., R20 ts in front of the window (in the and even with the shade pulled ld, and I don't like it." R20 ys cold" in the dining room got to turn off the AC (air R20 stated staff were aware					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/03/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245521	B. WING			01/	05/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	RE CENTER			06 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 166	of his complaint of the second states of the second	the cold dining room. /4/17 at 6:53 p.m., R18 stated e dining room, he has to put . "It helps, but it's still too had been really cold this there was a south wind. R18 ioned his concern about the in the dining room, and they of 1/5/17 at 8:00 a.m., R15 om temperature seemed to omes right out of the vent. "It's " R15 stated he believed the e concern with the cold dining on 1/5/1 at 1:43 p.m., the visor (MS) stated the rooms and parts of the ked daily. The MS stated the e the main dining room were grees Fahrenheit). .m., with the MS and in veyor, the d temperature indicated the emperature was 72.0 deg F. terview, the MS stated he inistrator about placing plastic the dining area, but thought and did not implement this. r could just move the residents a there was plenty of space in the MS stated he was aware expressed discomfort from the s, but they had not done	F1	66			

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		AND HUMAN SERVICES				FORM	02/03/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED
		245521	B. WING			01/	05/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	RE CENTER			106 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 166	Continued From pa	ge 5	F1	166			
F 242 SS=D	of nursing (DON) st administrator talked "temps" (temperatu DON stated she ha complaints, but was window. The DON dietary manager as doing some other s DON acknowledged uncomfortable and something. During an interview administrator stated and change the res dining room. The a to please everyone residents who've m window, but I guess 483.10(f)(1)-(3) SEI RIGHT TO MAKE O (f)(1) The resident H schedules (includin health care and pro consistent with his o and plan of care an of this part. (f)(2) The resident H about aspects of his are significant to the (f)(3) The resident H	d about the window, and the re) in the dining room. The d not heard any specific s aware of the problem by the stated she did not know if the ked anyone about moving or eating arrangements. The d the dining room can be stated we'll have to do to f 1/5/17 at 3:20 p.m., the d we could make a change, ident order around in the administrator stated it was hard , especially when you have ade a choice to sit by the s we can make a change. LF-DETERMINATION - CHOICES has a right to choose activities, g sleeping and waking times), widers of health care services or her interests, assessments, d other applicable provisions	F2	242			1/12/17

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		AND HUMAN SERVICES			FORM	02/03/2017 APPROVED 0938-0391
STATEMENT	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245521	B. WING		01/0	05/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
CENTRA	L TODD COUNTY CA	RECENTER		406 EAST HIGHWAY 71, PO BOX CLARISSA, MN 56440	X 38	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 242	facility. This REQUIREMEI by: Based on observat review, the facility f assess and develop routine to meet the (R35) with severe of was observed to be Findings include: R35's significant ch (MDS) dated 11/16 cognitive impairme on staff for dressing identified R35 is rai During observation nursing assistant (N told NA-B, "Do you NA-A paused and t ready to go." At 7:47 a.m. (16 mi entered R35's room cares. R35's eyes respond verbally wi R35's bedding was whom was already sweater and pink p placed underneath to transfer out of th using a mechanica room for breakfast R35's Comprehens 11/17/16, identified	NT is not met as evidenced tion, interview and document ailed to comprehensively p an individualized rising needs for 1 of 1 residents cognitive impairment and who e fully dressed while in bed. nange Minimum Data Set /16, identified R35 had severe nt and was totally dependant g and bed mobility. The MDS rely or never understood. on 1/5/17, at 7:21 a.m. NA)-A was in the "B" wing and want to get [R35] up now?" hen stated, "She's [R35] all nutes later) NA-A and NA-B n to assist her with morning were closed and she did not hen spoken to by the NA staff. pulled back exposing R35 dressed in a pink adaptive air of pants with a hoyer sling of her. R35 was then assisted e bed into her wheelchair I lift, and brought to the dining	F 2	42 Reviewed all current rescannot safely or compete communicate their wiske staff. Guardians, agents representatives were con questionnaire regarding desires. Information rec update resident's plan of affected residents. A po preferences policy" was assist staff in acquiring r preferences and integrat plan of care. Staff respon interviewing and docume preferences have been en new policy and expectation resident preferences. Q Care Plans of all new res limited or inability to mak preferences known on a ensure compliance. Overall Responsibility: F Director	ently es or needs to s or resident ntacted with resident's eived was used to f care for all licy "Resident generated to esident ting them in to the onsible for enting resident educated on the ion to document AU will review sidents with a their quarterly basis to	

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		AND HUMAN SERVICES					FORM	02/03/2017 APPROVED 0938-0391
STATEMENT	EMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         PLAN OF CORRECTION       IDENTIFICATION NUMBER:				LE CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		245521	B. WING	ì		- 01/05/2017		
NAME OF	PROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
CENTRA	AL TODD COUNTY CA	RE CENTER			106 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD	BE	(X5) COMPLETION DATE
F 242	hearing. The asses labeled, "Daily Inter question asking if th conducted. This qu with a primary resp being marked, "No A further section lak completed with R35 different activities s meals, listening to r animals. The asses of R35's preferred r including getting dru until staff assisted h R35's care plan dat section of, "Daily Pr interventions which and bathing schedu identified preference bed until a later time When interviewed of stated she had was a.m. but left her in h thought it would, "B NA-A stated she was washed up or dress kept her eyes and of During interview on stated NA-A had as morning to assist R was unable to assis bed dressed. NA-E sleep in when she w awake, would then	ssment contained a section view Preference," and listed a he interview should be uestion was answered, "No" ondent for the assessment response or non-responsive." beled, "Staff assessment," was being identified to prefer such as snacks between music, and being around ssment lacked any indication morning rising routine, essed and remaining in bed her. ted 11/22/16, identified a focus references," and listed several included a preferred bedtime ule. The care plan lacked any tes to be dressed and left in e. on 1/5/17, at 7:56 a.m. NA-A shed and dressed R35 at 6:30 bed dressed because she be good to sleep in." Further, as unsure if R35 liked being sed and left in bed, and always	F	242				

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		AND HUMAN SERVICES			FORM	: 02/03/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245521	B. WING		01/	05/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	RE CENTER		406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 242	NA-A got her dress R35's medical reco any assessment to preferred rising time	ed. rd was reviewed and lacked determine what R35's e or routine was. There was	F 24	42		
	determine what R3 When interviewed of registered nurse (R and preferences we and documented in plan lacked any info there were no prefe stated R35 was una her wishes, needs of dressed at 6:30 a.m early for her." RN-A R35 choices or pref or if the family had b preferences.	facility asked R35's family to 5's preferences were. on 1/5/17, at 3:19 p.m. N)-A stated resident choices are assessed on admission the care plan adding if a care ormation on a preference, but arences identified. RN-A able to verbally communicate or preferences of getting n. which, "Seems a little bit A stated she was unaware if ferences had been identified, been asked to identify her				
	medical record and information about F dressed and left in I "Shouldn't be doing she doesn't want." spoken with other s had ever contacted input to her past pre- since R35 was unal wishes or needs an A facility policy on a	assessment of daily noices was requested, but				

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						. 0938-039	
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED	
		245521	B. WING _		01/	05/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CENTRA	L TODD COUNTY CA	ARE CENTER		406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 279	Continued From pa	age 9	F 27	79			
F 279 SS=D	483.20(d);483.21(b COMPREHENSIVE		F 27	79		1/6/17	
	assessments comp months in the resid results of the asses	nust maintain all resident bleted within the previous 15 lent's active record and use the ssments to develop, review dent's comprehensive care					
	483.21 (b) Comprehensive	e Care Plans					
	comprehensive per each resident, cons set forth at §483.10 includes measurab to meet a resident's and psychosocial n comprehensive ass	at develop and implement a rson-centered care plan for sistent with the resident rights D(c)(2) and §483.10(c)(3), that ble objectives and timeframes is medical, nursing, and mental needs that are identified in the sessment. The comprehensive scribe the following -					
	or maintain the res physical, mental, a	at are to be furnished to attain ident's highest practicable nd psychosocial well-being as 3.24, §483.25 or §483.40; and					
	under §483.24, §48 provided due to the	at would otherwise be required 33.25 or §483.40 but are not e resident's exercise of rights luding the right to refuse 83.10(c)(6).					
		l services or specialized ses the nursing facility will					

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		AND HUMAN SERVICES				FORM	02/03/2017 APPROVED 0938-0391	
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		245521	B. WING			01/0	)5/2017	
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
CENTRA	AL TODD COUNTY CA	RE CENTER	406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 279	provide as a result recommendations. findings of the PAS rationale in the resi (iv)In consultation were resident's represent (A) The resident's generation (A) The resident's generation (B) The resident's generation (B) The resident's generation future discharge. For whether the resident's generation (B) The resident's generation (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMENT by: Based on interview facility failed to dev plan which included resident behaviors/ residents (R15, R4 antidepressant. Fundevelop and identific care plan for 1 of 5 range of motion (Re Findings include: ANTIDEPRESSAN	of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative (s)- goals for admission and preference and potential for acilities must document it's desire to return to the sessed and any referrals to be and/or other appropriate pose. s in the comprehensive care e, in accordance with the orth in paragraph (c) of this NT is not met as evidenced w and document review, the elop a comprehensive care d specific interventions for mood status for 2 of 2 8) reviewed who were on an ther, the facility failed to y a restorative program on the residents (R15) who received OM) in the facility.	F 2	.79	This citation reflects two separate i in regards to care plan development those surrounding mood and behave within the care plan when residents on antidepressant medications and development of care plans with resp restorative nursing programs. Mood/Behavior Updated care plan for both resident identified in the citation (R15, R48) included mood and behavior focus. Reviewed all remaining residents of antidepressant or demonstrating me behavior issues and added mood a behavior focuses to their plan of care	t, vior were pect to ss to n an ood or and		

Facility ID: 00761

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · /	E SURVEY PLETED	
		045501	B. WING	G			
		245521	B. WING	STREET ADDRESS, CITY, STATE, ZIP CC		05/2017	
	PROVIDER OR SUPPLIER	ARE CENTER		406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 279	<ul> <li>(MDS), dated 9/12, moderate cognitive diagnosis list identi depressive disorder dated 9/13/16.</li> <li>R15's PHQ-9 (a too symptoms), dated experienced little in things, felt down, dexperienced feeling "12-14 days" durin R15's current physidentified R15 had antidepressant me once a day for dep 9/13/16.</li> <li>R15's care plan, da had impaired cogn forgetfulness and const identify R15 had hopelessness, little antidepressant. Thinterventions identified hopelessness.</li> <li>During interview or assistant (NA)-C sidepressed mood, terming interview or registered nurse (Fedictation from 9/13) Cymbalta for mode</li> </ul>	<ul> <li>diffective in the implementation of the implementation of</li></ul>	F 27	RN Care Coordinator to revie documentation regarding new mood/behavior or medication required plan of care change Restorative Nursing Reviewed and updated the re program for R15 on residents Care. Reviewed and updated resto programs and Care plans as all remaining residents. New residents will have resto programs documented on pla during normal development of Staff Education provided to lin nursing staff. Correction plan disseminated to all other dire Care plans will be reviewed ff accuracy/compliance and a of basis, and QAU will review th the Care Plan reviews and so modifications as necessary. Overall responsibility: Direct	w is to address s. estorative s Plan of rative needed on orative an of care cycles. censed n ct care staff. or quarterly he results of uggest		

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · /	TE SURVEY MPLETED	
	245521			01	/05/2017	
ROVIDER OR SUPPLIER		· [	STREET ADDRESS, CITY, STATE, ZIP COL		/00/2011	
L TODD COUNTY CA	ARE CENTER		406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	( EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETIC DATE	
down." RN-A report contain a mood for contain intervention which was missing During interview or director of nursing	ted R15's care plan should cus, address the Cymbalta, and ns for depression symptoms, n 1/5/17, at 3:11 p.m. the (DON) stated a mood focus	F 27	79			
R48 had severe co depression. R48's physician or R48 had active ord (antidepressant me time a day for majo episode, with a sta R48's PHQ-9 (a to symptoms) dated 1 experienced feeling "12-14 days" during R48 was identified Syndrome," on the R48's Psychiatric F identified R48 was psychiatric care an	ders dated 1/5/17, identified lers for, Celexa edication) 10 mg by mouth one or depressive disorder, single rt date of 9/27/16. ol used to evaluate depression 12/1/16, identified R48 g tired and having little energy, g a two week period. Further, as having, "Minor Depressive assessment. Progress Note dated 12/21/16, followed to, "establish d manage psychotropic's					
)	SUMMARY ST (EACH DEFICIENC REGULATORY OR L Continued From pa down." RN-A report contain a mood for contain intervention which was missing During interview or director of nursing along with behavio care plan. R48's quarterly ME R48 had severe co depression. R48's physician or R48 had active or (antidepressant me time a day for majo episode, with a sta R48's PHQ-9 (a to symptoms) dated to experienced feeling "12-14 days" during R48 was identified Syndrome," on the R48's Psychiatric F identified R48 was psychiatric care an [medications]." Th Celexa reduced an	DF CORRECTION       IDENTIFICATION NUMBER:         245521         PROVIDER OR SUPPLIER         L TODD COUNTY CARE CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 12 down." RN-A reported R15's care plan should contain a mood focus, address the Cymbalta, and contain interventions for depression symptoms, which was missing.         During interview on 1/5/17, at 3:11 p.m. the director of nursing (DON) stated a mood focus along with behaviors were expected to be on the care plan.         R48's quarterly MDS dated 12/1/16, identified R48 had severe cognitive impairment and	PF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDI         245521       B. WING         PROVIDER OR SUPPLIER       L         L TODD COUNTY CARE CENTER       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 12       down." RN-A reported R15's care plan should contain a mood focus, address the Cymbalta, and contain interventions for depression symptoms, which was missing.       F 2         During interview on 1/5/17, at 3:11 p.m. the director of nursing (DON) stated a mood focus along with behaviors were expected to be on the care plan.       R48's quarterly MDS dated 12/1/16, identified R48 had severe cognitive impairment and depression.         R48's physician orders dated 1/5/17, identified R48 had active orders for, Celexa (antidepressant medication) 10 mg by mouth one time a day for major depressive disorder, single episode, with a start date of 9/27/16.         R48's PHQ-9 (a tool used to evaluate depression symptoms) dated 12/1/16, identified R48 experienced feeling tired and having little energy, "12-14 days" during a two week period. Further, R48 was identified as having, "Minor Depressive Syndrome," on the assessment.         R48's Psychiatric Progress Note dated 12/21/16, identified R48 was followed to, "establish psychiatric care and manage psychotropic's [medications]." The note identified R48 had her Celexa reduced and was, "more animated and	PF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         245521       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP COL         1000000000000000000000000000000000000	FCORRECTION       IDENTIFICATION NUMBER:       A BUILDING       01         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       405 EAST HIGHWAY 71, PD BOX 38         LTODD COUNTY CARE CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE       405 EAST HIGHWAY 71, PD BOX 38         SUMMARY STATEMENT OF DEFICIENCES       ID       PROVIDERS PLAN OF CORRECTION SHOULD BE       CLARISSA, MN 56440         SUMMARY STATEMENT OF DEFICIENCES       ID       PROVIDER OF CORRECTION SHOULD BE       CLARISSA, MN 56440         Continued From page 12       F 279       Continued From page 12       CONTINUE ACCORRECTION STOLE ACTION SHOULD BE         Contain a mood focus, address the Cymbalta, and contain interventions for depression symptoms, which was missing.       F 279         During interview on 1/5/17, at 3:11 p.m. the director of nursing (DON) stated a mood focus along with behaviors were expected to be on the care plan.       F 279         P48's quarterly MDS dated 12/1/16, identified R48 had severe cognitive impairment and depression.       F 48's physician orders for, Celexa (andre orders for, Celexa (andre orders for, Celexa (andre orders) for, Celexa (andre orders) for, Gelexa (andre orders) for, Gelexa (andre orders) of depression symptoms, diated 12/1/16, identified R48 was followed by 71.6.         R48's PHQ-9 (a tool used to evaluate depression symptoms) dated 12/1/16, identified R48 was followed by, establish psychiatric care and manage psychotropic's (medications)." The note identified R48 was followed by	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/03/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245521	B. WING			01/0	05/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	RE CENTER			06 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	Continued From pa manage behaviors. R48's care plan dat impaired cognition we memory loss, howe about R48's feeling the use of an antide were no specific int to implement to hele identified symptoms During interview on stated R48 was typ however, at times we weepy. NA-A state specific intervention depressed besides offering to take her When interviewed of registered nurse (R pretty withdrawn for while taking the ord R48's care plan and antidepressant med interventions to help identified. There sh there is not. Furthe	ge 13 " ed 12/6/16, identified R48 had with short and long term ever lacked any information tired, having little energy or epressant medication. There erventions identified for staff p reduce or elevate R48's s of depression. 1/5/17, at 1:41 p.m. NA-A ically a, "Sweet lady," vould become depressed and d she was unaware of any ns to help R48 when she is just providing reassurance or to activities. on 1/5/17, at 2:16 p.m. N)-A stated R48 had been, awhile, but was doing better ered Celexa. RN-A reviewed d stated her use of dication or any specific o her depression were not ould be a mood focus and er, RN-A stated R48's history of a of psychotropic medications on her care plan.	1	279	DEFICIENCY)		
	no cognitive impair assistance with mo	S, dated 10/19/16, identified ment and needed extensive bility and transfers, and had a of the lower extremity on one					

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	1			<u>DMB NO. 0938-0391</u>	
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245521	B. WING _			01/	05/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CENTRA	L TODD COUNTY CA	RE CENTER			06 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	Continued From pa	ge 14	F 2	79			
	included goals of m for family outings, n strength, and to end tolerated or would a program included u bike), and performin	Care Program, dated 9/17/16, aintaining his ability to transfer naintain left lower extremity courage ambulation as he agree to. R15's restorative sing the NuStep (exercise ng hamstring pullbacks, hip o flexion with varying					
	10/18/16, identified impairment which c functioning. The as- leg continues to be movement." R15 wa	e Assessment, dated the same left lower extremity ontinued to affect his physical sessment indicated the "left stiff and slower with as not able to completely flex ut was on a Nursing Rehab ses.					
	R15 had an alteration Balance, Inability to Impaired LLE [left loc care plan identified however, it did not in restorative program	plan, dated 10/25/16, identified on in ADL's due to "Impaired move independently, ower extremity]." Further, the several interventions; dentify R15 was on a or at times he refused es, even though the restorative ace since 9/17/16.					
	stated care plans w quarterly with asses restorative program admission and qual plan had not been u an error." RN-C furt	1/5/17, at 1:13 p.m. RN-C rere updated on admission and ssments; however, since R15's was started in between his rterly assessments, the care updated. RN-C stated it "was ther reported R15's care plan efused the restorative program d be identified.					

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	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		DIE CONSTRUCTION (X3) DA	TE SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			MPLETED	
		245521	B. WING		/05/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	RE CENTER		406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
F 279	Continued From pa	ge 15	F 279	9		
F 282 SS=E	11/2016, identified a should be complete potential problems i are documented by the Care Plan." Fu identified problem s into the Care Plan v approaches, target assigned responsib 483.21(b)(3)(ii) SEF PERSONS/PER CA (b)(3) Comprehensi The services provid	re Planning policy dated a comprehensive assessment ed and , "All problems and identified in this assessment entering a focus statement on urther, the policy directed each should, " be incorporated which identifies goals, dates of completion, and ilities." RVICES BY QUALIFIED ARE PLAN	F 28	2	1/9/17	
	care. This REQUIREMEN by: Based on observat review, the facility fa programs were imp care plan for 4 of 5 R12) reviewed for r Findings include: R5's diagnoses, as change Minimum D 10/13/16, included Alzheimer's demention	qualified persons in ch resident's written plan of NT is not met as evidenced ion, interview and document ailed to ensure restorative lemented as directed by the residents (R5, R35, R29, and ange of motion services. identified on the significant ata Set (MDS) dated pain in left hip, anemia and tia. The MDS also indicated ive assistance for bed mobility,		Redesigned and implemented restorative nursing program for all residents, including the organization and prioritization of staffing towards execution of restorative programming activities. New programming began 1-9-2017. Direct care staff educated on new program and responsibilities. Program documentation will be reviewed/ audited on a weekly basis and corrections and adjustments to the program will be made as needed. QAU will review weekly audit/review documentation for		

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION		OMB NO. 0938-03 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		IG	· · /	PLETED	
		245521	B. WING _		01/	05/2017	
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
ENTRA	L TODD COUNTY CA	ARE CENTER		406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETI DATE	
F 282	Continued From pa	age 16	F 28	32			
		essing, and was cognitively		compliance to plan and recommodifications as necessary. Overall responsibility: Director			
	activity of daily lever related to pain, hist included the interver R5's Restorative C following directions weights on bilatera extend elbow, pund and use upper extr as needed; overhe minutes; daily walk exercise machine) During observation nursing assistant (I morning cares, and from the bed into h	ised 10/7/2016, identified an el (ADL) self-care deficit, tory of left hip fracture, and ention of a restorative program. are Program, included the s: 10 times 1-2 pound free I, upper extremities, flex and ch out and internal rotation; sit emity bike 5 minutes, with rest ad pulley with no weight 3 to 4 60 feet; and NuStep (seated, level one for 10 minutes. on 1/5/2017, at 7:13 a.m. NA)-D provided R5 with d also assisted R5 to transfer er wheelchair. There was no is provided during the provision or R5.					
	stated she did not t restorative progran	1/5/17, at 7:50 a.m. NA-D today, nor routinely, work on ns, but was sure R5 had one. were other aides who did the					
	July 2016 to Noven documentation indi were provided/refu July, 5x (times), 1x refused, 2 x unava refused; October, 6 2x refusals, 1x una documentation afte	lity Nursing Rehab sheets from nber 2016 were reviewed. The icated R5's restorative services sed or unavailable as follows: refused; August, 3x, 1x ilable; September, 5x, 1x Sx, 4x refused; November 3x, vailable; there was no er November 15th; December: and January 2017: no					

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	-	AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	тірі	LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245521	B. WING			01/(	05/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		00/2011
CENTRA	L TODD COUNTY CA	BE CENTER			06 EAST HIGHWAY 71, PO BOX 38		
				C	CLARISSA, MN 56440		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL	ID PREFIX	v	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	^	CROSS-REFERENCED TO THE APPROP		DATE
			1		DEFICIENCY)		
F 282	Continued From pa	ne 17	F 2	22			
. 202	documentation.	ge 17	12	.02			
	documentation						
		on 1/5/2017, at 2:06 p.m.					
		NA)-B stated she was one of d she "dutifully" completed					
		programs with residents.					
		out November, however,					
		available to complete the was often "pulled" from rehab					
		rk on the floor, as often as five					
		B stated R5's restorative goal					
		eek, but "it just didn't get done." no surprise there was little or					
		of the rehab program for R5					
	since the middle of						
		/5/17, at 2:58 p.m. the director					
		tated the Restorative Care					
		of R5's comprehensive care rsing's responsibility to make					
		as followed. The DON					
		restorative program was not					
	<i>j</i> 1	eted for several months, and entation that R5's program					
		Ill since mid-November. The					
	DON stated she "at	osolutely" expected R5's, and					
		e plans be followed, and the					
	restorative nursing	programs be completed.					
		ange MDS dated 11/16/16, severe cognitive impairment,					
		ent on staff for her activities of					
	daily living (ADLs),	and had impaired functional					
		OM) on both of her upper and					
	lower extremities.						
		ted 11/22/16, identified R35 ADLs and had, "Dependence					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	02/03/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245521	B. WING	i		01/	05/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	AL TODD COUNTY CA				106 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	on staff." Further, t interventions includ R35's Restorative O identified R35 had r extremity weakness goal of her program all extremities." Th labeled, "Approached Implementation of A staff to complete, "F tolerated," with a free week]." On 1/3/17, at 1:27 p with her eyes close observation on 1/4/ seated in a reclining closed. There was by staff during these During observation 7:47 a.m. nursing a assisted her with ris wheelchair. No RO upper or lower extra care. During interview on stated stated R35 v completed daily, ho "Due to not having" had not had ROM o program for over a contractures were, and R35 seemed, " cares. NA-B stated with the ROM progr	the care plan identified several ding, "Restorative Program." Care Program dated 7/1/15, right sided upper and lower s due to a stroke, and listed a n as, "Maintain current ROM to be sheet provided a space les/Recommendations for Above Goals," and directed ROM to all extremities daily as equency of "7x/wk [times per p.m. R35 was laying in bed ed. During subsequent (17, at 12:32 p.m. R32 was g wheelchair with her eyes a no observed ROM completed as times. of morning care on 1/5/17, at assistant (NA)-A and NA-B sing and seated her in her DM was completed on R35's emities during the morning n 1/5/17, at 8:45 a.m. NA-B was supposed to have ROM owever, it was not being done, full staff." NA-B stated R35 completed as directed by her		282			

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	-	AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	PLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	à	CON	<b>IPLETED</b>
		245521	B. WING			01	/05/2017
NAME OF F	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		00/2011
CENTRA	L TODD COUNTY CA	RE CENTER			406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	NC	(X5)
PRÉFIX TAG		( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLÉTION DATE
F 282	Continued From pa	ge 19	F 2	282	2		
	when it was not cor	•					
	11/2016, identified a several columns with sheet provided space	ab forms dated 9/2016 to a flowsheet which listed th 31 separate rows. This cing to record an exercise day of the month which ing entries:					
		R35 had ROM completed four eing written in 26 times on the					
	times, with a, "X" be	5 had ROM completed seven eing written in 23 times on the 35 was identified as refusing					
	times, with a, "X" be	35 had ROM completed four eing written in 12 times with e form (after 11/16/16) being					
		ner flowsheets to demonstrate a attempted or completed after					
	registered nurse (R restorative nursing contractures and sh her arms daily, "To	on 1/5/17, at 9:20 a.m. N)-B stated R35 was on a program for her arm hould have ROM completed to maintain their current range of further contractures."					
	R29 had severe co	S dated 11/11/16, identified gnitive impairment, was totally for her ADLs, and had					

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	ENTERS FOR MEDICARE & MEDICAID SERVICES			IPLE CONSTRUCTION		OMB NO. 0938-039 (X3) DATE SURVEY	
ND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDIN	NG	COMPLETED		
	245521		B. WING _		01/05/2017		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CC 406 EAST HIGHWAY 71, PO BOX 38	DE		
CENTRA	L TODD COUNTY CA	RE CENTER		CLARISSA, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 282	impaired functional both of her upper en R29's care plan dat had self care perfor contracture. The ca interventions includ Program." R29's Restorative C	range of motion (ROM) on xtremities. ed 11/21/16, identified R29 mance deficit with a left hand are plan directed staff with ing, "Restorative Rehab Care Program dated 5/18/15,	F 28	32			
	identified a goal to, extremities." The s labeled, "Approache Implementation of A staff to complete, "F	"Maintain ROM to all heet provided a space es/Recommendations for Above Goals," and directed ROM to all extremities daily as nt," with a frequency of					
	11/2016, identified a several columns wi sheet provided spa	ab forms dated 9/2016 to a flowsheet which listed th 31 separate rows. This cing to record an exercise day of the month which ing entries:					
		R29 had ROM completed eight eing written in 22 times on the					
		) had ROM completed 12 eing written in 19 times on the					
	times, with a, "X" be	29 had ROM completed five eing written in 11 times with e form (after 11/16/16) being					

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		AND HUMAN SERVICES				FORM	): 02/03/2017 / APPROVED ). 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245521		B. WING	à		01/05/2017		
NAME OF I	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
CENTRA	L TODD COUNTY CA	RECENTER			406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			NX A	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 282	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			28				
	completed since be During interview on stated a care plan are, "Getting their r	n had been attempted or eing implemented on 12/16/16. n 1/5/17, at 2:09 p.m. RN-A was used to ensure residents needs met," and staff were nent them or update the nurses						

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		AND HUMAN SERVICES				FORM	02/03/2017 APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICESSTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		245521	B. WING			01/(	05/2017	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
CENTRAL TODD COUNTY CARE CENTER			406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 282 F 318 SS=E	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR		cution	1/9/17	
	motion was maintai	ned for 5 of 5 residents (R35, R12) reviewed for range of			including the organization and prioritization of staffing towards exec of restorative programming activities			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE	0938-03 SURVEY PLETED
			A. BUILDII	NG _			
		245521	B. WING _			01/0	05/2017
AME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ENTRA	L TODD COUNTY CA	RE CENTER			96 EAST HIGHWAY 71, PO BOX 38 LARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 318	Continued From pa	age 23	F 3 <sup>.</sup>	18			
	motion services.	5			New programming began 1-9-2017		
Fic w d ra lo Fho ir Fic e g a la lr s to w	Findings include:				Direct care staff educated on new program and responsibilities. Progradocumentation will be reviewed/au		
	identified R35 had was totally dependent daily living (ADLs),	hange MDS dated 11/16/16, severe cognitive impairment, ent on staff for her activities of and had impaired functional OM) on both of her upper and			on a weekly basis and corrections a adjustments to the program will be as needed. QAU will review weekl audit/review documentation for compliance to plan and recommend modifications as necessary. Overall responsibility: Director of N	and made y d	
	had an alteration in on staff." Further,	ted 11/22/16, identified R35 ADLs and had, "Dependence the care plan identified several ling, "Restorative Program."				aronig	
	identified R35 had extremity weaknes goal of her program all extremities." Th labeled, "Approach Implementation of staff to complete, " tolerated," with a fr week]." Further, th	Care Program dated 7/1/15, right sided upper and lower s due to a stroke, and listed a n as, "Maintain current ROM to be sheet provided a space es/Recommendations for Above Goals," and directed ROM to all extremities daily as equency of "7x/wk [times per e program identified R35 had om hospice care on 11/14/16.					
	was seated in a higher room listening closed. R35 had v shoulders, elbows arms toward her up splints or braces in	on 1/4/17, at 12:32 p.m. R35 gh-back reclining wheelchair in to the radio with her eyes isible contractures of her and hands as she held her oper chest. R35 had no visible place on her arms or hands, completed by staff at this time.					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245521	B. WING		01/	05/2017
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	ARE CENTER		406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 318	bent in the arms," a upper and lower ex- suffered years prio did not use braces range of motion to During observation 7:47 a.m. nursing a assisted her with ri- wheelchair. No RC upper or lower extr care. When interviewed stated she typically "Couple times a we complete ROM or a stated she was not restorative nursing very stiff," when state other NA staff resp restorative program is short staffed, the floor, "We don't do the floor." During interview or stated she was one complete the resto NA-B stated R35 w completed daily, he "Due to not having had not had ROM of program for over a "Tighter," when state stated the staff trace ROM programs on	age 24 and had contractures in her stremities due to a stroke r. Further, RN-A stated R35 or splints, but received daily help with her contractures. of morning care on 1/5/17, at assistant (NA)-A and NA-B sing and seated her in her DM was completed on R35's emities during the morning on 1/5/17, at 7:56 a.m. NA-A helps R35 get ready a, sek," and does not ever exercises with R35. NA-A aware if R35 was on a program, but added, "She's aff are helping her dress. ed the facility had a couple onsible to complete the ns, however, when the facility ose aides are pulled to the rehab when we are short on n 1/5/17, at 8:45 a.m. NA-B e of two NA staff responsible to rative programs for residents. /as supposed to have ROM owever, it was not being done, full staff." NA-B stated R35 completed as directed by her month, and R35's seemed, ff completed cares. NA-B exed participation with the a flowsheet by signing their done, or a, "X" symbol when it	F 31	8		

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STATEMEN	OF DEFICIENCIES DF CORRECTION	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	( )	IPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED
		245521	B. WING _		01	/05/2017
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	RE CENTER		406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE
F 318	was not completed had reported these therapist (OT). R35's Nursing Reh 11/2016, identified several columns wi sheet provided spa completed on each identified the follow September 2016: Itimes, with a, "X" b remaining days. October 2016: R35 times, with a, "X" b remaining days. October 2016: R35 times, with a, "X" b remaining days. November 2016: F times, with a, "X" b the ROM once. November 2016: F times, with a, "X" b the remainder of th left blank. There were no furth any ROM had beer 11/16/16. When interviewed registered nurse (F restorative nursing contractures and s her arms daily, "To motion and preven stated the restorati complete the cares they were being pu	. Further, NA-B stated she concerns to the occupational ab forms dated 9/2016 to a flowsheet which listed th 31 separate rows. This cing to record an exercise day of the month which	F 31	8		

Facility ID: 00761

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       245521       B. WING       01/05/2017         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440       01/05/2017         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       (X5)			AND HUMAN SERVICES				FORM	02/03/2017 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       CENTRAL TODD COUNTY CARE CENTER     STREET ADDRESS, CITY, STATE, ZIP CODE       (M) ID     SUMMARY STATEMENT OF DEFICIENCIES ECONDECTIVE ADDRESS, CITY, STATE, ZIP CODE       (M) ID     SUMMARY STATEMENT OF DEFICIENCIES ECONDECTIVE ADDRESS, CITY, STATE, ZIP CODE       (M) ID     SUMMARY STATEMENT OF DEFICIENCIES ECONDECTIVE ADDRESS, CITY, STATE, ZIP CODE       (M) ID     SUMMARY STATEMENT OF DEFICIENCIES ECONDECTIVE ADDRESS, CITY, STATE, ZIP CODE       (M) ID     SUMMARY STATEMENT OF DEFICIENCIES ECONDECTIVE ADDRESS, CITY, STATE, ZIP CODE       (M) ID     SUMMARY STATEMENT OF DEFICIENCIES ECONDECTIVE ADDRESS, CITY, STATE, ZIP CODE       (M) ID     SUMMARY STATEMENT OF DEFICIENCIES ECONDECTIVE ADDRESS, CITY, STATE, ZIP CODE       (M) ID     SUMMARY STATEMENT OF DEFICIENCIES ECONDECTIVE ADDRESS, CITY, STATE, ZIP CODE       (M) ID     SUMMARY STATEMENT OF DEFICIENCIES ECONDECTIVE ADDRESS, CITY, STATE, ZIP CODE       (M) ID     SUMMARY STATEMENT OF DEFICIENCIES (CONDECTIVE ADDRESS)       (M) ID     F 318       (M) ID     F 318       (M) ID     SUMMARY STATEMENT OF DEFICIENCIES (CONDECTIVE ADDRESS)       (M) ID     SUMMARY STATEMENT OF DEFICIENCIES INFORMATION)       (M) ID     SUMMARY STATEMENT ON DEFICIENCIES INFORMATION)       (M) ID     SUMMARY STATEMENT OF DEFICIENCIES INFORMATION       (M) ID     SUMMARY STATEMENT OF DEFICIENCIES INFORMATION	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	E SURVEY
CENTRAL TODD COUNTY CARE CENTER         Description           VM. ID PREEX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREEX (EACH CORRECTIVE ACTION SHOLD BE (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         OB DEFICIENCY           F 318         Continued From page 26         F 318         F 318           During interview on 1/5/17, at 1:09 p.m. OT-A stated it had been a few years, since R35 had been last seen by OT for any therapy services, however, added she had recently requested orders for R35 to be evaluated due to nursing staff reported R35 to have, "Some tightness in her elbows and wrists."         F 318           On 1/5/17, at 1:12 p.m. OT-A completed passive range of motion (PROM) to R35's upper extremities with the surveyor present. OT-A stated R35 had poor abduction (motion of the joint away from the body) in her left shoulder adding it was, "Very, very tight." OT-A stated R35 was, "Probably missing 35 to 45 degrees of extension," in her left elbow. Further, OT-A completed PROM to R35's right side and stated R35's right shoulder was better than her left side with "About 20 degrees of abduction," and, "20 degrees of flexion (the action of bending]," however, added R35's right elbow was, "Minus 25 or 30 degrees."           When interviewed following the PROM on 1/5/17, at 1:25 p.m. OT-A stated han top personally worked with R35 prior, so she was unable to determine if a decline in R35's ROM had occurred or not. Further, OT-A stated hursing staff should be completing the ROM exercises to help increase the circulation and potentially reduce R35's pain with dressing and other			245521	B. WING _			01//	05/2017
CKINIAL TODD COUNTY CARE CENTER       CLARISSA, MN 56440         (M,I) D PREFX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH BORIDEXY MUST BE PROCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFX TAG       PROVIDENT SPLAN OF CORRECTION (EACH BORIDEXY DATE AF PROCEDIA DE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       (M, ETC) DEFICIENCY)         F 318       Continued From page 26       F 318         During interview on 1/5/17, at 1:09 p.m. OT-A stated it had been a few years, since R35 had been last seen by OT for any therapy services, however, added she had recently requested orders for R35 to be evaluated due to nursing staff reported R35 to have, "Some tightness in her elbows and wrists."       F 318         On 1/5/17, at 1:12 p.m. OT-A completed passive range of motion (PROM) to R35's upper extremities with the surveyor present. OT-A stated R35 had poor abduction (motion of the joint away from the body) in her left shoulder adding it was, "Very, very tight." OT-A stated R35 was, "Probably missing 35 to 45 degrees of extension," in her left shoulder R35's right shoulder was better than her left side with, "About 20 degrees of abduction," and, "20 degrees of flexion [the action of bending]," however, added R35's right elbow was, "Minus 25 or 30 degrees."         When interviewed following the PROM on 1/5/17, at 1:25 p.m. OT-A stated she had not personally worked with R35 prior, so she was unable to determine if a decline in R35's ROM had occurred or not. Further, OT-A stated nursing staff should be completing the ROM exercises to help increase the circulation and potentially reduce R35's pain with dressing and other	NAME OF F	PROVIDER OR SUPPLIER	•					
PHÈRIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)       PRÈFIX TAG       CEACH ODRIECTIVE ACTION SHOULD BE CROSS-REFERENCEDED TO THE APPROPRIATE DEFICIENCY)         F 318       Continued From page 26       F 318         During interview on 1/5/17, at 1:09 p.m. OT-A stated it had been a few years, since R35 had been last seen by OT for any therapy services, however, added she had recently requested orders for R35 to be evaluated due to nursing staff reported R35 to have, "Some tightness in her elbows and wrists."       F 318         On 1/5/17, at 1:12 p.m. OT-A completed passive range of motion (PROM) to R35's upper extremities with the surveyor present. OT-A stated R35 had poor abduction (motion of the joint away from the body) in her left shoulder adding it was, "Very, very tight." OT-A stated R35 was, "Probably imissing 35 to 45 degrees of extension," in her left shoulder R35's right shoulder was better than her left side with, "About 20 degrees of abduction," and, "20 degrees of flexion [the action of bending)," however, added R35's right elbow was, "Minus 25 or 30 degrees."       When interviewed following the PROM on 1/5/17, at 1:25 p.m. OT-A stated she had not personally worked with R35 prior, so she was unable to determine if a decline in R35's ROM had occurred or not. Further, OT-A stated nursing staff should be completing the ROM exercises to help increase the circulation and potentially reduce R35's pain with dressing and other	CENTRA	L TODD COUNTY CA	RE CENTER			-		
<ul> <li>During interview on 1/5/17, at 1:09 p.m. OT-A stated it had been as the wyears, since R35 had been last seen by OT for any therapy services, however, added she had recently requested orders for R35 to be evaluated due to nursing staff reported R35 to have, "Some tightness in her elbows and wrists."</li> <li>On 1/5/17, at 1:12 p.m. OT-A completed passive range of motion (PROM) to R35's upper extremities with the surveyor present. OT-A stated R35 had poor abduction (motion of the joint away from the body) in her left shoulder adding it was, "Very, very tight." OT-A stated R35 was, "Probably missing 35 to 45 degrees of extension," in her left elbow. Further, OT-A completed PROM to R35's right side and stated R35's right side and stated R35's right shoulder was better than her left side with, "About 20 degrees of abduction," and, "20 degrees of flexion [the action of bending]," however, added R35's right elbow was, "Minus 25 or 30 degrees."</li> <li>When interviewed following the PROM on 1/5/17, at 1:25 p.m. OT-A stated nursing staff should be completing the ROM exercises to help increase the circulation and potentially reduce R35's pain with dressing and other</li> </ul>	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	COMPLETION
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would be good to educate nursing staff on." R5's diagnoses, as identified on the significant change Minimum Data Set (MDS) dated		During interview on stated it had been a been last seen by C however, added sho orders for R35 to be staff reported R35 to her elbows and wris On 1/5/17, at 1:12 p range of motion (PF extremities with the stated R35 had poo joint away from the adding it was, "Very was, "Probably miss extension," in her le completed PROM to R35's right shoulde with, "About 20 deg degrees of flexion [' however, added R3 or 30 degrees." When interviewed f at 1:25 p.m. OT-A s worked with R35 pr determine if a declin occurred or not. Fu staff should be com help increase the ci reduce R35's pain v activities of daily livit would be good to ea R5's diagnoses, as	<ul> <li>a 1/5/17, at 1:09 p.m. OT-A</li> <li>a few years, since R35 had</li> <li>DT for any therapy services,</li> <li>e had recently requested</li> <li>e evaluated due to nursing</li> <li>to have, "Some tightness in sts."</li> <li>p.m. OT-A completed passive</li> <li>ROM) to R35's upper</li> <li>e surveyor present. OT-A</li> <li>or abduction (motion of the body) in her left shoulder</li> <li>y, very tight." OT-A stated R35 sing 35 to 45 degrees of</li> <li>eft elbow. Further, OT-A</li> <li>to R35's right side and stated</li> <li>er was better than her left side</li> <li>grees of abduction," and, "20</li> <li>the action of bending],"</li> <li>35's right elbow was, "Minus 25</li> </ul> following the PROM on 1/5/17, stated she had not personally rior, so she was unable to ne in R35's ROM had <ul> <li>urther, OT-A stated nursing</li> <li>npleting the ROM exercises to irculation and potentially</li> <li>with dressing and other</li> <li>ing, "That is something that ducate nursing staff on."</li> </ul>					

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		AND HUMAN SERVICES				FORM	02/03/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245521	B. WING			01/	05/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	RE CENTER			06 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 318	Alzheimer's demen R5 required extensi transferring and dre impaired. A Range of Motion dated 12/28/2016, i touching behind hei about shoulder heig extend right leg and assessment also in extending left leg, h and that impairmen extremity affected F Further, R5 was ab position with use of surface to surface t received increased depending on pain R5's Care Area Ass of daily living (ADL's dated 10/6/16, iden ADLs, and need for nursing staff. The 0 care planning to slo and to maintain cur During observation at 7:13 a.m., nursin R5's lower body wh sit up with assistand assistance to lift an the side of the bed. to hold up her arms as NA-D placed R5 shirt arm holes. R5	tia. The MDS also indicated ive assistance for bed mobility, essing, and was cognitively (ROM)/Balance Assessment, indicated R5 had difficulty r head, was able to reach to ght; was able to flex and d foot and left hand. The dicated R5 had difficulty had pain and stiffness to leg, its to upper and lower left R5's daily physical functioning. le to stand from seated a grab bar, and completed transfer independently. R5 assistance from staff		318			

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STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245521	B. WING		01/	05/2017
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	01/	00/2011
CENTRA	L TODD COUNTY CA	ARE CENTER		406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 318	from the bed into h in place, R5 graspe wheelchair next to with assistance. D slightly hunched ov NA-D assisted to s for R5 as she pivot wheelchair. No res provided during mo In an interview on a stated R5 usually no one staff for transfe also that R5's parti- pain. NA-D stated work on restorative had one. NA-D stated work on restorative had one. NA-D stated who did the rehab she has not seen F a month." R5's care plan, rev ADL self-care defice hip fracture, and im- restorative program R5's "Restorative O 11/16/15, indicated extremity strength activities of daily liv strength; maintain a maintain balance s directed the followi pound free weights extremities, flex an internal rotation; sit 5 minutes, with res with no weight 3 to	er wheelchair. With a gait belt ed the left arm rest of the the bed, and was able to stand uring the transfer, R5 was ver, but able to bear her weight. upport and maintain balance ed, then sat into her storative services were orning cares. 1/5/17, at 7:50 a.m. NA-D equired "limited" assistance of ers, and getting dressed, and cipation depended on her hip she did today, nor routinely, e programs, but was sure R5 ated there were other aides programs. NA-D also stated R5 walk with staff in "more than ised 10/7/2016, identified an sit, related to pain, history of left cluded the intervention of a n. Care Program," revised goals: maintain upper and endurance to assist with ring; maintain lower extremity ability to ambulate; and trategies. The program ng approaches: 10 times 1-2	F 3			

Facility ID: 00761

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		AND HUMAN SERVICES				FORM	02/03/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245521	B. WING _			01/	05/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	RE CENTER			6 EAST HIGHWAY 71, PO BOX 38 LARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	level one for 10 mir Nursing Rehab she	-	F 31	8			
	R5's restorative ser or unavailable as for refused; August, 3x September, 5x, 1x r refused; November unavailable; there November 15th. Th December 2016 or	vices were provided/refused ollows: July, 5x (times), 1x x, 1x refused, 2 x unavailable; refused; October, 6x, 4x r 3x, 2x refusals, 1x was no documentation after here was no documentation for January 2017.					
	nursing assistant (N the rehab aides, an restorative nursing NA-B stated that at there were no staff programs, and she assignments to wor times a week. NA- was five times a we NA-B stated it was	on 1/5/2017, at 2:06 p.m. NA)-B stated she was one of d she "dutifully" completed programs with residents. bout November, however, available to complete the was often "pulled" from rehab rk on the floor, as often as five B stated R5's restorative goal eek, but "it just didn't get done." no surprise there was little or of the rehab program fro R5 November.					
	director of nursing ( Care Program was care plan, and it was make sure the prog acknowledged R5's consistently completed also lacked docume was completed at a DON stated it was of programs, especial	/5/2017 at 2:58 p.m., the (DON) stated the Restorative part of R5's comprehensive as nursing's responsibility to gram was followed. The DON restorative program was not eted for several months, and entation that R5's program all since mid-November. The difficult to find staff to do the ly at the end of the year, and sing program struggled. The					

Facility ID: 00761

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		AND HUMAN SERVICES				FORM	02/03/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245521	B. WING			01//	05/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	RE CENTER			06 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	DON stated she "at other residents' car	ige 30 osolutely" expected R5's, and e plans be followed, and the programs be implemented.	FS	318			
	no cognitive impairr assistance with mol	S, dated 10/19/16, identified ment and needed extensive bility and transfers, and had a of the lower extremity on one					
	identified a left lowe to a previous left hip indicated the impair functioning, and R1 splints. It further inc	e Assessment, dated 7/22/16, er extremity impairment related p fracture. The assessment rment affected R15's physical 5 did not utilize any braces or dicated physical therapy ended refused to participate.					
	10/18/16, identified impairment which c functioning. The ass leg continues to be movement," and R1	e Assessment, dated the same left lower extremity continued to affect his physical sessment indicated the "left stiff and slower with 15 was not able to completely eg. It indicated R15 was on a gram for exercises.					
	included goals of m for family outings, n strength, and to end tolerated or would a program included u bike), and ROM per	Care Program, dated 9/17/16, naintaining his ability to transfer naintain left lower extremity courage ambulation as agree to. R15's restorative using the NuStep (exercise rforming hamstring pullbacks, hip flexion with varying					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	): 02/03/2017 / APPROVED ). 0938-0391
STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245521	B. WING		01	/05/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
CENTRA	L TODD COUNTY CA	RE CENTER		406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440	3	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 318	R15's current care p R15 had an alteration Balance, Inability to Impaired LLE [left loc care plan identified there was no indica program or that he Review of R15's Nu 9/2016 to 11/2016, listed several colum This sheet provided exercise completed which identified the September 2016: F seven times, with a available for exercis on the remaining da refusing once. October 2016: R15 times, with a, "X" be remaining days. R <sup>-</sup> the ROM four times November 2016: R times, with a, "X" be the remainder of the left blank. R15 was ROM twice. There were no furth any ROM had been 11/16/16. During interview on stated he did exercise	olan, dated 10/25/16, identified on in ADL's due to "Impaired move independently, ower extremity]." Further, the several interventions, but tion R15 was on a restorative refused restorative exercises. Insing Rehab forms dated identified a flowsheet which ms with 31 separate rows. I spacing to record an on each day of the month following entries: R15 had ROM completed , "X" (meaning no staff were se) being written in six times ays. R15 was identified as	F 3	18		

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/03/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245521	B. WING		01/	05/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	RE CENTER		106 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 318	Continued From pa	ge 32	F 318			
	7:11 a.m. registered assistant (NA)-F we the bathroom. With belt, R15 was able ambulated a few st NA-F proceeded to R15 was observed face and upper body, R15 extremities to assis proceeded to put of on the toilet. After of NA-F placed the wh to the toilet and, wit the assistance bar, the pants, and sat of restorative exercise observation. During interview on stated it was the firs R15 and wasn't awa During interview on stated R15 worked sometimes; however restorative program programs used to b assistants, but had During interview on stated R15 had a re the nursing assistant complete it for the I staffing. NA-B furth consistent" with doi	of morning cares on 1/5/16, at d nurse (RN)-B and nursing ere observed assisting R15 to assistance and a transfer to stand from his wheelchair, ep, and sit down on the toilet. provide R15 with washcloths. to independently wash his by NA-F assisted R15 to dress 5 was able to use his upper t with dressing. NA-F n R15's pants on while he sat completing morning cares, neelchair in the bathroom next h assistance, R15 grabbed stood while NA-F pulled up down in the wheelchair. No as were performed during the 1/5/17, at 7:34 a.m. NA-F st time she had worked with are of any restorative program. 1/5/17, at 7:49 a.m. NA-C with the physical therapist er, wasn't sure if R15 was on a a. NA-C stated the restorative be completed by a few nursing n't "seen that in a while." 1/5/17, at 11:42 a.m. NA-B setorative program; however, nts hadn't had time to ast couple of months due to er stated R15 was "pretty ng the restorative exercises. he came to the restorative				

If continuation sheet Page 33 of 45

TATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MUI 1	TIPLE CONST	TRUCTION		<u>D. 0938-039</u> ATE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		NG		· · ·	MPLETED
		245521	B. WING _			0-	1/05/2017
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP (		
CENTRA	L TODD COUNTY CA	ARE CENTER			r HIGHWAY 71, PO BOX 38 SA, MN 56440	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 318	Continued From pa	age 33	F 3	18			
		n he refused, disliked the I occasionally use ankle etches.					
	stated the facility h trained by the the p performed the rest states the restorati "pretty often," depe	n 1/5/17, at 11:58 a.m. RN-A ad two nursing assistants, ohysical therapist, who orative program. RN-A further ve program wasn't being done ending on the week, because ants were not consistently tive aides.					
	therapist (PT)-A sta on the NuStep and his legs. PT-A state combative with the admitted to the fac offered restorative refusing less to per PT-A states "he sp	n 1/5/17, at 12:22 p.m. physical ated R15 had worked with her with doing a few exercises for ed R15 had been more rapy when he was first ility, but thought he was being exercises and was currently rform exercises. In addition, oradically wheels himself down om)" to do restorative nursing.					
	was observed perf reported R15 had in no contractures. P	n on 1/5/17, at 4:01 p.m. PT-A orming ROM on R15. PT-A no decline in his ROM and had T-A reported the goal of R15's n was to prevent contractures eft hip fracture.					
	R29 had severe co dependent on staff	DS dated 11/11/16, identified ognitive impairment, was totally for her ADLs, and had I range of motion (ROM) on extremities.					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245521	B. WING		01/	05/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		03/2017
CENTRA	L TODD COUNTY CA	RE CENTER		406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 318	extremities." The s labeled, "Approach Implementation of a staff to complete, " tolerated by resider "7x/wk." R29's Nursing Reh 11/2016, identified several columns wi sheet provided spa completed on each identified the follow September 2016: It times, with a, "X" b remaining days. October 2016: R25 times, with a, "X" b remaining days. November 2016: F times, with a, "X" b the remainder of th left blank. There were no furth any ROM had been 11/16/16. R12's quarterly MD R12 had moderate extensive assistant	"Maintain ROM to all sheet provided a space es/Recommendations for Above Goals," and directed ROM to all extremities daily as ht," with a frequency of ab forms dated 9/2016 to a flowsheet which listed th 31 separate rows. This cing to record an exercise day of the month which	F 31			

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		AND HUMAN SERVICES				FORM	02/03/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATI	E SURVEY PLETED
		245521	B. WING			01/	05/2017
NAME OF	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	RE CENTER			406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318 F 465 SS=D	R12's Restorative ( identified a diagnos movement," and lis [right upper extrem The sheet provided "Approaches/Record Implementation of A staff to complete, "A of motion] R [right] instructions for staff R12's flexion and e the program identifis should be complete R12's Nursing Refa however there were demonstrate the re- attempted or completed on 12/16/16. During interview on stated the resident been completed for due to not having e been difficult with the residents should have programs completed further loss," of the A facility policy on re- implementation was provided. 483.90(h)(5)	Care Program dated 12/16/16, is of, "Joint limitation of ted a goal to, "Maintain R U/E ity] function for self feeding." a space labeled, mmendations for Above Goals," and directed AAROM [active assisted range shoulder," and listed several f to follow using weights with xtension exercises. Further, ed the restorative program ed 4 times a week. ab forms were requested, e no flowsheets to storative program had been leted sine being implemented 1/5/17, at 2:09 p.m. RN-A restorative programs had not what, "Seems like awhile," nough staff, "The staffing's hat." Further, RN-A stated twe had their restorative ed as directed to, "Prevent ir mobility. AL/SANITARY/COMFORTABL		318 465			1/13/17

Facility ID: 00761

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		E SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B	COM	PLETED
		245521	B. WING		01/0	05/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 406 EAST HIGHWAY 71, PO BOX 38		
CENTRA	L TODD COUNTY CA	RE CENTER		CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 465	The facility must pr sanitary, and comfor residents, staff and (h)(5) Establish pol applicable Federal, regulations, regardi and smoking safety, non-smoking reside This REQUIREMEN by: Based on observat review, the facility f sanitary environme and A10), reviewed potential to affect 2 utilized these room Findings include: During observation at 8:44 a.m. the priv observed stained a from an unknown s brown-colored dots lower portion of the close to the room d was also inspected brownish-colored a lower portion of the door. During an environm p.m. with the maint the presence of the A10 and A8 were residue.	ovide a safe, functional, ortable environment for the public. icies, in accordance with State, and local laws and ing smoking, smoking areas, of that also take into account ents. NT is not met as evidenced tion, interview and document ailed to provide a clean and nt in 2 of 8 resident rooms (A8 on the A wing, which had the residents who currently s. of resident rooms on 1/5/17, vacy curtain in room A10 was nd unclean. The staining, ubstance, appeared as dark, and inch-long marks, on the curtain, which was hanging oor. The curtain in Room A8 and observed unclean, with a nd faded stain, also on the gathered curtain, near the nental tour on 1/5/17, at 1:40 enance supervisor (MS) and in e surveyor, the curtains in room eviewed. The MS a curtains were unclean and in	F 46	Privacy curtains for both rooms A A 8 were replaced with clean curta other privacy curtains were examin replaced as needed. Privacy curta examination and replacement will added to monthly environmental inspection forms to ensure specific adequate attention to curtain clear Maintenance inspection results an will be reviewed with the QAU com to adjust frequency and complianc Overall Responsibility: Maintenan Supervisor	ins. All ned and ain be c and aliness. d trends amittee e.	

If continuation sheet Page 37 of 45

		AND HUMAN SERVICES				FORM	02/03/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY IPLETED
		245521	B. WING _			01/(	05/2017
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	AL TODD COUNTY CA	RE CENTER			06 EAST HIGHWAY 71, PO BOX 38 LARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465 F 520 SS=E	In an interview on 1 stated the curtains residents used the Kleenex," wipe her could be vomit. The painted, repaired ar a resident moved o there also was a me clean and repair res when housekeeping day, if they notice a they would fill out a would go in remove the dirty one would the curtain should h and stated he could "change out" the curt and stated he could "change out" the curt A facility document, Center (CTCCC) Re reviewed, and indic be checked monthly A policy regarding the resident rooms was during the survey. 483.75(g)(1)(i)-(iii)(2 COMMITTEE-MEM QUARTERLY/PLAN (g) Quality assessm (1) A facility must m	<ul> <li>/5/17, at 1:43 p.m. the MS were dirty, that one of the privacy curtain "like a mouth and added the stain e MS stated rooms were hd cleaned top to bottom when ut, but that on a monthly basis ore detailed checklist used to sident rooms. The MS stated g goes through the room every in issue, like a dirty curtain, request , and then the MS e and replace the curtain, and be washed. The MS stated have been changed sooner, d just make is a task to urtains on a monthly basis.</li> <li>, Central Todd County Care oom Inspection List, was ated privacy curtains were to y.</li> <li>he cleaning and maintaining of a requested, but not provided</li> <li>2)(i)(ii)(h)(i) QAA IBERS/MEET NS</li> <li>nent and assurance.</li> </ul>	F 4(				2/3/17

Facility ID: 00761

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		E & MEDICAID SERVICES	1			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY IPLETED
		245521	B. WING		01/	05/2017
NAME OF I	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L TODD COUNTY C			406 EAST HIGHWAY 71, PO BOX 38		
OEIIIIA				CLARISSA, MN 56440		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)		COMPLÉTIO DATE
F 520	Continued From p	age 38	F 520	)		
	(ii) The Medical D	rector or his/her designee;				
	staff, at least one	other members of the facility's of who must be the				
adn indi (g)( con (i) N coo ider ass	individual in a lead	her, a board member or other lership role; and				
	(g)(2) The quality committee must :	assessment and assurance				
	coordinate and evidentifying issues	uarterly and as needed to aluate activities such as with respect to which quality assurance activities are				
		nplement appropriate plans of lentified quality deficiencies;				
	Secretary may not records of such co such disclosure is	nformation. A State or the t require disclosure of the ommittee except in so far as related to the compliance of ith the requirements of this				
	committee to iden deficiencies will no sanctions.	d faith attempts by the tify and correct quality ot be used as a basis for ENT is not met as evidenced				
	Based on intervie facility failed to en and Assurance (Q and implemented lack of restorative consistently imple	w and document review, the sure the Quality Assessment A&A) committee developed a plan of action to address the nursing programs being mented for 5 of 5 residents 29, and R12) reviewed for range		Action plan for rehab nursing pr evaluation, organization and exe was presented to QAU team to citations, and suggest plan of co QAU approved action plan. QA review weekly audits of rehab no program documentation over the	ecution review prrection. U will ursing	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245521		۵ <u>ـــــ</u>		
	PROVIDER OR SUPPLIER	243521	-	STREET ADDRESS, CITY, STATE, ZIP CODE	01/0	05/2017
	L TODD COUNTY CA	RE CENTER		406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 520	of motion services. all 30 residents ider restorative program Findings include: R35's significant ch identified R35 had was totally depended daily living (ADLs), range of motion (Re lower extremities. R35's care plan dat had an alteration in on staff." Further, t interventions includ The Restorative Ca identified R35 was extremities daily as seven times a weel R35's Nursing Reh 11/2016, identified completed on each November 2016 R35	This had the potential to affect ntified by the facility receiving is. hange MDS dated 11/16/16, severe cognitive impairment, ent on staff for her activities of and had impaired functional OM) on both of her upper and ted 11/22/16, identified R35 ADLs and had, "Dependence he care plan identified several ing, "Restorative Program." are Program dated 7/1/15, to receive, "ROM to all tolerated," with a frequency of c. ab forms dated 9/2016 to a flowsheet to record exercise day. From September to 35 received ROM 19 times for re were no restorative forms	F 52	<ul> <li>quality assurance meetings to er compliance and integrity of the p and recommend changes if need team were educated on the citat QAU roles and expectations with to staff prioritization and program oversight.</li> <li>Overall responsibility: Director o</li> </ul>	rogram ded. QAU on and regard nming	
	(MDS) dated 10/13 and indicated R5 re	ange Minimum Data Set /16, included pain in left hip, equired extensive assistance nsferring and dressing, and paired.				

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			PI		APPROVED
		& MEDICAID SERVICES	<del></del>				0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED
		245521	B. WING			01/	05/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	RE CENTER			06 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	restorative program R5's "Restorative C 11/16/15, identified extremities exercise R5's Nursing Rehat November 2016 ide exercise program o three months. The December 2016 or R15's quarterly MD no cognitive impair assistance with mol functional limitation side. R15's Restorative C included goals of m transferring, mainta strength, and to end tolerated. R15's resusing the NuStep (e performing hamstrin and hip flexion with	Cluded the intervention of a h. Care Program," revised specific upper and lower e for R5 for strengthening. b sheets from July 2016 to entified R5 only completed the on 22 days during the past re was no documentation for January 2017. S, dated 10/19/16, identified ment and needed extensive bility and transfers, and had a of the lower extremity on one Care Program, dated 9/17/16, iaintaining his ability to a storative program included exercise bike), and ROM ng pullbacks, hip abductions, varying repetitions.	F 5	520			
	9/2016 to 11/2016, exercise 21 times ir was no documentat	ursing Rehab forms dated identified he completed his in the past three months. There tion for December 2016 and 15's rehab nursing.					
	R29 had severe co	S dated 11/11/16, identified gnitive impairment, was totally for her ADLs, and had					

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PRINTED: 02/03/2017

		AND HUMAN SERVICES				FORM	02/03/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245521	B. WING _			01/	05/2017
NAME OF F	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	RE CENTER			06 EAST HIGHWAY 71, PO BOX 38 LARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 520	both of her upper ex R29's Restorative O ROM to all extremit resident, seven day Review of R29's Nu 9/2016 to 11/2016, i completed 25 times There was no docu and January 2017 f R12's quarterly MD R12 had moderate extensive assistance impaired functional lower extremities. R12's Restorative O AAROM (active assistance shoulder using weig exercises, four time R12's Nursing Reha however there were demonstrate the rest attempted or compl on 12/16/16. During interview on stated she was not program. During interview on stated the restorative	range of motion (ROM) on xtremities. Care Program dated 5/18/15, ties daily as tolerated by vs a week. ursing Rehab forms dated identified exercises were is in the past three months. mentation for December 2016 or R29 ' s rehab nursing. S dated 9/14/16, identified cognitive impairment, required the with ADLs, and had ROM on both of his upper and Care Program dated 12/16/16, sisted range of motion) to right ghts for flexion and extension a week. ab forms were requested, on flowsheets to storative program had been leted since being implemented 1/5/17, at 7:34 a.m. NA-F aware of any restorative 1/5/17, at 7:49 a.m. NA-C ve programs used to be nursing assistants, but hadn't	F 52	20			
	"seen that in a while	ə."					

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		AND HUMAN SERVICES			FORM	02/03/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245521	B. WING		01/(	05/2017
NAME OF	PROVIDER OR SUPPLIER	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	AL TODD COUNTY CA	RECENTER		406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 520	During interview on stated the facility has responsible to comp however, when the aides are pulled to when we are short During an interview nursing assistant (N the rehab aides, an restorative nursing NA-B stated that ab staff available to co was often "pulled" f work on the floor, a Review of the facilit Todd County Care ( dated 1/2017, ident currently on active f in the facility. On 1/5/17, at 2:09 p was interviewed reg programs not being RN-A stated the ad programs were not "They know it hasn" stated she was una been brought to the addressed. The facility Quality / were reviewed and meetings were held During interview on director of nursing (	1/5/17, at 7:56 a.m. NA-A ad a couple other NA staff plete the restorative programs, facility is short staffed, those the floor, "We don't do rehab	F 520			

Facility ID: 00761

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	02/03/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245521	B. WING			01/	05/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	AL TODD COUNTY CA	RECENTER			06 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 520	restorative nursing brought to her atter staffing shortage. S aware when the fac aides working, the a completing restorat on the floor. DON s restorative nursing been an issue for a never been discuss Further, DON state discussed staffing of had taken place in a not getting complet concern. DON adde nursing would be re action would be imp During interview on administrator states shortages at the fac nursing from getting staff were designate what he had budge when the facility wa aides got pulled to administrator added concerns at QA&A, resident rehabilitation A facility Quality Ass 4/2015, identified se committee including resident outcomes imposed or determing processes within th satisfactory outcome	not getting completed was ntion based on the facility She further stated she was cility had only one or two rehab aides often got pulled from tive nursing to work as aides stated she had known getting completed as planned had a few months, but this had sed in the QA&A meetings. I the QA&A committee had concerns, but no discussion regards to restorative nursing ted, or what to do about this ed, moving forward, restorative eviewed at QA&A and a plan of plemented. 1/5/17, at 4:19 p.m. the d he was aware of staffing cility that prevented restorative g completed. He stated two red as rehab staff and that is sted for and planned for, but as short staffed, the rehab work the floor. The d, we have discussed staffing , but not specifically the	F 5	520			

Facility ID: 00761

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		AND HUMAN SERVICES				FORM	02/03/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245521	B. WING	à		01/	05/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	RE CENTER			06 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 520		age 44 hts and staff for improving esident care and/or facility	F	520			

Facility ID: 00761

	MENT OF HEALTH			7	5521025	FORM	: 01/10/2017 / APPROVED ). 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		1 · ·	LE CONSTRUCTION 8 01 - MAIN BUILDING 01	(X3) DATE S COMPL	
		245521		B, WING		01/0	5/2017
	ROVIDER OR SUPPLIER				TATE, ZIP CODE		
CENTRA	L TODD COUNTY (	CARE CENTER		STHIGHW SSA, MN 5	AY 71. PO BOX 38 6440		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN"	ſS		K 000			
	FIRE SAFETY						
	Minnesota Departm time of this survey Center 01 Main Bui with the requiremen Medicare/Medicaid 483.70(a), Life Safe edition of National	Survey was conduct nent of Public Safety Central Todd County Iding was found in c nts for participation in at 42 CFR, Subpart ety from Fire, and the Fire Protection Asso 01, Life Safety Code g Health Care.	At the Care ompliance 1 e 2012 ciation			8	
	building without a b constructed at 4 dif building was constr determined to be o 1985, an addition w on the south side a Type V(111). In 199 therapy addition wa Wing and was dete construction. In 200 west end of D Wing between E and D w are Type V(111) co apartment building which is separated north end of E wing separated from the fire barrier. The bui zones by 2 hour fire		ng was ginal as uction. In vice wing to be of ical end of A e V(111) Ided to ce and I of which ed living wing ier. The d a 2-hour 4 smoke				
	fire sprinkler system with smoke detection		m system nd spaces for		TITLE	0	(X6) DATE
LADOKAIU	INT DIRECTORS OR PROV	ADENSOFFLIER REPRES	ENTRINE 9 910	MACI ONE			

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.

	MENT OF HEALTH			1		FORM	: 01/10/2017 APPROVED ). 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA MBER:		LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE S COMPL	
		245521		B. WING			5/2017
	ROVIDER OR SUPPLIER	CARE CENTER	406 EA		TATE, ZIP CODE <b>AY 71. PO BOX 38</b> <b>6440</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI F BE PRECEDED BY FULL ENTIFYING INFORMATION	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 000		apacity of 60 beds a	nd had a	K 000	2 0		
	The requirement at MET.	42 CFR, Subpart 4	83.70(a) is				
	e		10		×	13	
							×
2							
	1						1
	-2567(02-99) Previous Ve	ersions Obsolete			917D21	If continuatio	n sheet Page 2 of



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted January 20, 2017

Mr. Jason Polovick, Administrator Central Todd County Care Center 406 East Highway 71, Po Box 38 Clarissa, MN 56440

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5521026

Dear Mr. Polovick:

The above facility was surveyed on January 3, 2017 through January 5, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number . that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested

Central Todd County Care Center January 20, 2017 Page 2 Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer at: (320) 223-7338 or email: brenda.fischer@state.mn.us.

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.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

## Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00761	B. WING		01/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	RECENTER	HIGHWAY 7 A, MN 5644	71, PO BOX 38 0		
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2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 02/01/17

Electronically Signed

If continuation sheet 1 of 41

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00761	B. WING		01/05/2017	
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2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for St enter the word "cor text. You must then State licensure pro completion date, th corrected prior to e Minnesota Departm On January 3-5, 20 Department's staff, the following correct Please indicate in y correction that you and identify the dat Minnesota Departm the State Licensing	Alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for n indicate in the electronic cess, under the heading ne date your orders will be electronically submitting to the nent of Health. 017 surveyors of this , visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, te when they will be completed nent of Health is documenting g Correction Orders using ag numbers have been				
	Nursing Homes. The assigned tag r column entitled "IE statute/rule out of c "Summary Stateme	sota state statutes/rules for number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column				
	correction order. T findings which are after the statement evidence by." Follo	To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FEDI	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. NR ON EACH PAGE.				

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		CLARISS	SA, MN 5644			
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2 000	Continued From pa	age 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 255	MN Rule 4658.007 Assurance Commit	0 Quality Assessment and ttee	2 255			1/27/17
	assessment and as of the administrator services, the medic designated by the r three other member representing discip resident care. The assurance committ respect to which quinecessary and dev appropriate plans of quality deficiencies address, at a minim	ust maintain a quality ssurance committee consisting r, the director of nursing cal director or other physician medical director, and at least ers of the nursing home's staff, lines directly involved in quality assessment and tee must identify issues with uality assurance activities are elop and implement of action to correct identified . The committee must num, incident and accident control, and medications and				
	by: Based on interview facility failed to ens and Assurance (QA and implemented a lack of restorative r consistently implen (R35, R5, R15, R25 of motion services.	ent is not met as evidenced and document review, the sure the Quality Assessment A&A) committee developed a plan of action to address the nursing programs being nented for 5 of 5 residents 9, and R12) reviewed for range This had the potential to affec ntified by the facility receiving ns.		Corrected.		
	Findings include:					

STATE FORM

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If continuation sheet 3 of 41

TATEMEN	DIT DEPARTMENT OF HE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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2 255	Continued From pa	age 3	2 255			
	identified R35 had was totally depended daily living (ADLs), range of motion (Re lower extremities.	hange MDS dated 11/16/16, severe cognitive impairment, ent on staff for her activities of and had impaired functional OM) on both of her upper and				
	had an alteration in on staff." Further, t	ted 11/22/16, identified R35 ADLs and had, "Dependence the care plan identified several ling, "Restorative Program."				
	identified R35 was	are Program dated 7/1/15, to receive, "ROM to all tolerated," with a frequency of k.	F			
	11/2016, identified completed on each November 2016 R3	ab forms dated 9/2016 to a flowsheet to record exercise day. From September to 35 received ROM 19 times for re were no restorative forms 5 or January 2017.				
	(MDS) dated 10/13 and indicated R5 re	ange Minimum Data Set /16, included pain in left hip, equired extensive assistance insferring and dressing, and paired.				
	ADL self-care defic	ised 10/7/2016, identified an it, related to pain, history of lef cluded the intervention of a n.	t			
	11/16/15, identified	Care Program," revised specific upper and lower e for R5 for strengthening.				

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2 255	Continued From pa	age 4	2 255			
	November 2016 id exercise program of three months. The	R5's Nursing Rehab sheets from July 2016 to November 2016 identified R5 only completed the exercise program on 22 days during the past three months. There was no documentation for December 2016 or January 2017.				
	no cognitive impair assistance with mo	DS, dated 10/19/16, identified ment and needed extensive obility and transfers, and had a n of the lower extremity on one				
	included goals of m transferring, mainta strength, and to en tolerated. R15's re using the NuStep ( performing hamstri	Care Program, dated 9/17/16, naintaining his ability to ain left lower extremity courage ambulation as estorative program included exercise bike), and ROM ing pullbacks, hip abductions, n varying repetitions.				
	9/2016 to 11/2016, exercise 21 times i was no documenta	ursing Rehab forms dated identified he completed his n the past three months. There tion for December 2016 and R15 ' s rehab nursing.	9			
	R29 had severe co dependent on staff	DS dated 11/11/16, identified ognitive impairment, was totally for her ADLs, and had I range of motion (ROM) on extremities.				
		Care Program dated 5/18/15, ties daily as tolerated by ys a week.				

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2 255	Continued From pa	age 5	2 255			
	9/2016 to 11/2016, completed 25 times There was no docu	ursing Rehab forms dated identified exercises were s in the past three months. Imentation for December 2016 for R29 ' s rehab nursing.				
	R12 had moderate extensive assistant	OS dated 9/14/16, identified cognitive impairment, required ce with ADLs, and had I ROM on both of his upper and				
	AAROM (active as shoulder using wei exercises, four time R12's Nursing Reh however there wer demonstrate the re	ab forms were requested,				
		n 1/5/17, at 7:34 a.m. NA-F aware of any restorative				
	stated the restorati	n 1/5/17, at 7:49 a.m. NA-C ve programs used to be v nursing assistants, but hadn't e."				
	stated the facility h responsible to com however, when the aides are pulled to when we are short During an interview	n 1/5/17, at 7:56 a.m. NA-A ad a couple other NA staff plete the restorative programs facility is short staffed, those the floor, "We don't do rehab on the floor." y on 1/5/2017, at 2:06 p.m. NA)-B stated she was one of	,			

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2 255	Continued From pa	age 6	2 255			
	restorative nursing NA-B stated that all staff available to co was often "pulled" work on the floor, a Review of the facili Todd County Care dated 1/2017, iden currently on active in the facility. On 1/5/17, at 2:09 was interviewed re programs not being RN-A stated the ac programs were not "They know it has stated she was una	nd she "dutifully" completed programs with residents. bout November, there were no omplete the programs, and she from rehab assignments to as often as five times a week. ty Restorative Program Centra Center (CTCCC) Resident List tified 30 residents were restorative nursing programs p.m. registered nurse (RN)-A garding the restorative nursing g completed in the facility. Iministration was aware the being completed adding, i't been done." Further, RN-A aware if this concern had ever e facility QA committee to be				
	were reviewed and	Assurance Signature Form(s) I identified the most recent QA d on 11/18/16, and 8/26/16.				
	director of nursing restorative nursing the restorative plar restorative nursing brought to her atter staffing shortage. aware when the far aides working, the completing restora on the floor. DON	n 1/5/17, at 4:07 p.m. the (DON) stated she was aware was not being completed per not getting completed was not getting completed was ntion based on the facility She further stated she was cility had only one or two rehab aides often got pulled from tive nursing to work as aides stated she had known getting completed as planned had				

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2 255	Continued From pa	age 7	2 255			
	Further, DON state discussed staffing of had taken place in not getting complet concern. DON addo nursing would be re- action would be imp During interview on administrator stated shortages at the fac nursing from getting staff were designat what he had budge when the facility wa aides got pulled to administrator added	n 1/5/17, at 4:19 p.m. the d he was aware of staffing cility that prevented restorative g completed. He stated two red as rehab staff and that is sted for and planned for, but as short staffed, the rehab work the floor. The d, we have discussed staffing , but not specifically the	f			
	4/2015, identified s committee including resident outcomes imposed or determ processes within th satisfactory outcom efficiency and main and, "Assessing an problems of residen	surance Plan policy, revised everal goals of the QA&A g, "Improves or maintains according to standards ined," and, "Improves he organization to promote hes for residents, improves ntains adequate cost control," ad defining needs and ints and staff for improving esident care and/or facility				
	The administrator or revise policies related		5			

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2 255	Continued From pa	age 8	2 255			
		signee could develop an ensure compliance.				
	TIME PERIOD FOI Twenty-One (21) da					
2 560	MN Rule 4658.040 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			1/6/17
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the cor assessment. The of must include the in	of plan of care. The n of care must list measurable etables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by: Based on interview facility failed to dev plan which included resident behaviors/ residents (R15, R4 antidepressant. Fur develop and identif	ent is not met as evidenced and document review, the elop a comprehensive care d specific interventions for mood status for 2 of 2 8) reviewed who were on an rther, the facility failed to y a restorative program on the residents (R15) who received OM) in the facility.		Corrected.		
	Findings include:					
	ANTIDEPRESSAN	T MEDICATION				
	(MDS), dated 9/12/	duled Minimum Data Set 16 identified R15 had impairment. R15's current				

STATE FORM

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If continuation sheet 9 of 41

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2 560	Continued From pa	age 9	2 560			
		fied a new diagnosis of "major r, single episode, unspecified,'				
	symptoms), dated experienced little ir things, felt down, d experienced feeling	ol used to evaluate depression 9/12/16, identified R15 had nterest or pleasure in doing epressed, or hopeless and g tired or having little energy, g the two week period.				
	identified R15 had antidepressant me	ician orders, dated 12/7/16, active orders for, Cymbalta (ar dication) 60 mg (milligrams) ression which was started on	ı			
	had impaired cogn forgetfulness and c not identify R15 ha hopelessness, little antidepressant. Th interventions identi	ated 10/25/16, identified R15 ition with varying confusion, dementia. The care plan did d a depressed mood, e energy or used an here were no specific fied for staff to implement to levate R15's depressed mood				
	assistant (NA)-C st	n 1/5/17, at 7:49 a.m. nursing ated R15 used to have but further states she thought r."				
	registered nurse (F dictation from 9/13 Cymbalta for mode pain. RN-A further down." RN-A repor contain a mood foo	n 1/5/17, at 11:58 a.m. RN)-A stated the physician's /16 indicated an order for erate depression and left leg stated R15 had "seemed ted R15's care plan should cus, address the Cymbalta, and ns for depression symptoms,	E			

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2 560	Continued From pa	age 10	2 560			
	which was missing					
	director of nursing	n 1/5/17, at 3:11 p.m. the (DON) stated a mood focus rs were expected to be on the				
		OS dated 12/1/16, identified ognitive impairment and				
	R48 had active ord (antidepressant me	edication) 10 mg by mouth one or depressive disorder, single				
	symptoms) dated 1 experienced feeling "12-14 days" during	ol used to evaluate depression 2/1/16, identified R48 g tired and having little energy, g a two week period. Further, as having, "Minor Depressive assessment.				
	identified R48 was psychiatric care an [medications]." Th Celexa reduced an she is more social the note included a "Staff to continue to	Progress Note dated 12/21/16, followed to, "establish d manage psychotropic's e note identified R48 had her id was, "more animated and with other residents." Further, a treatment plan which include, o use psychosocial, environmental interventions to ."				
	impaired cognition	ted 12/6/16, identified R48 hac with short and long term ever lacked any information	1			

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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2 560	Continued From pa	age 11	2 560			
	the use of an antide were no specific int to implement to hel identified symptom During interview on stated R48 was typ however, at times weepy. NA-A state specific intervention depressed besides offering to take her When interviewed of registered nurse (F pretty withdrawn for while taking the ord R48's care plan and	n 1/5/17, at 1:41 p.m. NA-A nically a, "Sweet lady," would become depressed and d she was unaware of any ns to help R48 when she is just providing reassurance or to activities. on 1/5/17, at 2:16 p.m. RN)-A stated R48 had been, r awhile, but was doing better lered Celexa. RN-A reviewed				
	identified. There sh there is not. Furthe		f			
	no cognitive impair assistance with mo	S, dated 10/19/16, identified ment and needed extensive bility and transfers, and had a of the lower extremity on one				
	included goals of m for family outings, r strength, and to en-	Care Program, dated 9/17/16, naintaining his ability to transfe naintain left lower extremity courage ambulation as he agree to. R15's restorative	r			

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2 560	Continued From pa	age 12	2 560			
	bike), and performi	using the NuStep (exercise ng hamstring pullbacks, hip o flexion with varying				
	10/18/16, identified impairment which of functioning. The as leg continues to be movement." R15 w	ce Assessment, dated I the same left lower extremity continued to affect his physical sessment indicated the "left e stiff and slower with vas not able to completely flex ut was on a Nursing Rehab ses.				
	R15 had an alterati Balance, Inability to Impaired LLE [left I care plan identified however, it did not restorative program	plan, dated 10/25/16, identified ion in ADL's due to "Impaired o move independently, ower extremity]." Further, the several interventions; identify R15 was on a n or at times he refused es, even though the restorative lace since 9/17/16.				
	stated care plans w quarterly with asse restorative program admission and qua plan had not been an error." RN-C fur	n 1/5/17, at 1:13 p.m. RN-C were updated on admission and ssments; however, since R15's n was started in between his arterly assessments, the care updated. RN-C stated it "was ther reported R15's care plan refused the restorative program Id be identified.	5			
	11/2016, identified should be complete potential problems	Assessment and are Planning policy dated a comprehensive assessment ed and , "All problems and identified in this assessment y entering a focus statement or				

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2 560	Continued From pa	age 13	2 560			
	identified problem s into the Care Plan	urther, the policy directed each should, " be incorporated which identifies goals, dates of completion, and bilities."	1			
	The director of nurs staff to develop a c interventions for all monitoring program to assure ongoing a	THOD OF CORRECTION: sing or designee could direct are plan to include appropriate identified care needs. A n could be established in order and effective care plan ponse to resident care needs.				
	TIME PERIOD FOR Twenty-One (21) da					
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			1/6/17
		omprehensive plan of care I personnel involved in the t.				
	This MN Requirem	ent is not met as evidenced				
	Based on observati review, the facility f programs were imp care plan for 4 of 5	ion, interview and document ailed to ensure restorative plemented as directed by the residents (R5, R35, R29, and range of motion services.		Corrected.		
	Findings include:					
		identified on the significant Data Set (MDS) dated				
inesota De ATE FORM	epartment of Health		6899	917D11	If continuet	ion sheet 14 c

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
			-			
		00761	B. WING		01/	05/2017
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
CENTRA	L TODD COUNTY CA	VRF CENTER	T HIGHWAY 71 SA, MN 56440	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TON SHOULD BE	(X5) COMPLET DATE
TAG			IAG	DEFICIENC		
2 565	Continued From pa	age 14	2 565			
	Alzheimer's demer R5 required extens	pain in left hip, anemia and ntia. The MDS also indicated sive assistance for bed mobility essing, and was cognitively	3			
	activity of daily lever related to pain, hist included the interver R5's Restorative C following directions weights on bilatera extend elbow, pund and use upper extr as needed; overhe minutes; daily walk	ised 10/7/2016, identified an el (ADL) self-care deficit, tory of left hip fracture, and ention of a restorative program are Program, included the s: 10 times 1-2 pound free I, upper extremities, flex and ch out and internal rotation; sit remity bike 5 minutes, with rest ad pulley with no weight 3 to 4 60 feet; and NuStep (seated, level one for 10 minutes.				
	nursing assistant (I morning cares, and from the bed into h	on 1/5/2017, at 7:13 a.m. NA)-D provided R5 with d also assisted R5 to transfer er wheelchair. There was no s provided during the provision or R5.				
	stated she did not t restorative progran	1/5/17, at 7:50 a.m. NA-D today, nor routinely, work on ns, but was sure R5 had one. were other aides who did the				
	July 2016 to Nover documentation indi were provided/refu July, 5x (times), 1x refused, 2 x unava	lity Nursing Rehab sheets from nber 2016 were reviewed. The icated R5's restorative services sed or unavailable as follows: refused; August, 3x, 1x ilable; September, 5x, 1x 5x, 4x refused; November 3x,	9			

	ta Department of He	(X1) Provider/Supplier/Clia		CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00761	B. WING		01/	05/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CENTRA	L TODD COUNTY CA		T HIGHWAY 7 <sup>.</sup>	-		
		CLARIS	SA, MN 56440		0000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ige 15	2 565			
		r November 15th; December: and January 2017: no				
	nursing assistant (Ithe rehab aides, and restorative nursing NA-B stated that all there were no staff programs, and she assignments to work times a week. NA- was five times a wee NA-B stated it was	on 1/5/2017, at 2:06 p.m. NA)-B stated she was one of id she "dutifully" completed programs with residents. bout November, however, available to complete the was often "pulled" from rehab rk on the floor, as often as five B stated R5's restorative goal eek, but "it just didn't get done. no surprise there was little or of the rehab program for R5 November.				
	of nursing (DON) s Program was part of plan, and it was nur sure the program w acknowledged R5's consistently complete also lacked docume was completed at a DON stated she "all other residents' car	1/5/17, at 2:58 p.m. the director tated the Restorative Care of R5's comprehensive care rsing's responsibility to make vas followed. The DON is restorative program was not eted for several months, and entation that R5's program all since mid-November. The bisolutely'' expected R5's, and re plans be followed, and the programs be completed.				
	identified R35 had a was totally depended daily living (ADLs),	hange MDS dated 11/16/16, severe cognitive impairment, ent on staff for her activities of and had impaired functional OM) on both of her upper and				
		ted 11/22/16, identified R35				
nesota De ATE FORM	epartment of Health		6899 Q	17D11	If continuati	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00761	B. WING		01/	05/2017
ME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ENTRA	L TODD COUNTY CA	IRE CENTER	T HIGHWAY 71 SA, MN 56440			
X4) ID REFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 16	2 565			
	on staff." Further,	n ADLs and had, "Dependence the care plan identified several ding, "Restorative Program."				
	identified R35 had extremity weaknes goal of her program all extremities." Th labeled, "Approach Implementation of staff to complete, "	Care Program dated 7/1/15, right sided upper and lower s due to a stroke, and listed a m as, "Maintain current ROM to ne sheet provided a space nes/Recommendations for Above Goals," and directed ROM to all extremities daily as requency of "7x/wk [times per				
	7:47 a.m. nursing a assisted her with ri- wheelchair. No RC	of morning care on 1/5/17, at assistant (NA)-A and NA-B sing and seated her in her DM was completed on R35's remities during the morning				
	stated stated R35 v completed daily, ho "Due to not having had not had ROM o program for over a contractures were, and R35 seemed, ' cares. NA-B stated with the ROM prog	"progressively getting worse," "Tighter," when staff completed d the staff tracked participation rams on a flowsheet by signing t was done, or a, "X" symbol				
	11/2016, identified several columns wi sheet provided spa	ab forms dated 9/2016 to a flowsheet which listed ith 31 separate rows. This acing to record an exercise a day of the month which				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00761	B. WING		01/	05/2017
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ENTRA	L TODD COUNTY CA		T HIGHWAY 71 SA, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	CTION SHOULD BE CO THE APPROPRIATE	
2 565	Continued From pa	age 17	2 565			
	identified the follow	ving entries:				
		R35 had ROM completed four eing written in 26 times on the				
	times, with a, "X" b	5 had ROM completed seven eing written in 23 times on the 35 was identified as refusing				
	times, with a, "X" b	R35 had ROM completed four eing written in 12 times with le form (after 11/16/16) being				
		her flowsheets to demonstrate n attempted or completed after				
	registered nurse (F restorative nursing contractures and s her arms daily, "To	on 1/5/17, at 9:20 a.m. RN)-B stated R35 was on a program for her arm hould have ROM completed to maintain their current range of t further contractures."				
	R29 had severe co dependent on staff	OS dated 11/11/16, identified ognitive impairment, was totally for her ADLs, and had I range of motion (ROM) on extremities.				
	had self care perfo contracture. The c	ted 11/21/16, identified R29 rmance deficit with a left hand are plan directed staff with ding, "Restorative Rehab				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00761	B. WING		01/	05/2017
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		00/2017
ENTRA	L TODD COUNTY CA	BE CENTER	T HIGHWAY 71 SA, MN 56440	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ige 18	2 565			
	identified a goal to, extremities." The s labeled, "Approach Implementation of / staff to complete, "I tolerated by resider "7x/wk." R29's Nursing Reh 11/2016, identified a several columns wi sheet provided spa completed on each identified the follow	C C				
		R29 had ROM completed eigh eing written in 22 times on the				
		eing written in 19 times on the				
	times, with a, "X" be	R29 had ROM completed five eing written in 11 times with e form (after 11/16/16) being				
		ner flowsheets to demonstrate a attempted or completed after				
	R12 had moderate extensive assistance	S dated 9/14/16, identified cognitive impairment, required ce with ADLs, and had ROM on both of his upper and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00761	B. WING		01/	05/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
ENTRA	L TODD COUNTY CA		T HIGHWAY 71 SA, MN 56440	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 19	2 565			
	lower extremities.					
	was at risk for falls	ted 12/19/16, identified R12 related to impaired mobility lirected staff to complete a, am."				
	identified a diagnos movement, and list [right upper extrem The sheet provided Approaches/Recon Implementation of staff to complete, ", of motion] R [right] instructions for staf R12's flexion and e	nmendations for Above Goals, and directed AAROM [active assisted range shoulder," and listed several if to follow using weights with extension exercises. Further, ied the restorative program				
	however none were restorative program	ab forms were requested, e provided to demonstrate the n had been attempted or eing implemented on 12/16/16.				
	stated a care plan are, "Getting their r expected to implem so interventions co Further, RN-A state their restorative pro	n 1/5/17, at 2:09 p.m. RN-A was used to ensure residents needs met," and staff were nent them or update the nurses uld be revised and addressed. ed residents should have had ograms completed as directed loss," of their mobility.				
	11/2016, identified should be complete	Assessment and are Planning policy dated a comprehensive assessment ed and , "All problems and identified in this assessment				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00761	B. WING		01/	05/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ENTRA	L TODD COUNTY CA	RE CENTER	6T HIGHWAY 7 SA, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ge 20	2 565			
	the Care Plan." Fu identified problem s into the Care Plan	entering a focus statement o urther, the policy directed each should, " be incorporated which identifies goals, dates of completion, and uilities."				
	The director of nurs a system to educat monitoring system	HOD OF CORRECTION: sing or designee could develop e staff and develop a to ensure staff are providing the written plan of care.	ρ			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one	e			
2 895	MN Rule 4658.052 Motion	5 Subp. 2.B Rehab - Range of	f 2 895			1/9/17
	that is directed town through positioning implemented and n comprehensive res of nursing services	motion. A supportive program ard prevention of deformities and range of motion must be naintained. Based on the ident assessment, the directo must coordinate the ursing care plan which				
	receives appropriat	h a limited range of motion e treatment and services to notion and to prevent further of motion.				
	by: Based on observat review, the facility f	ent is not met as evidenced on, interview and document ailed to provide restorative o ensure functional range of		Corrected.		

UMMARY STA 1 DEFICIENCY ATORY OR L at ORY ORY OR C at ORY ORY OR L at ORY ORY ORY OR L at ORY ORY ORY O	ange MDS d severe cognit and had impa OM) on both ed 11/22/16, ADLs and had	40 CL FICIENCIES CEDED BY FULI A INFORMATION 5 residents ed for range lated 11/16/ tive impairm or her activit aired functio of her uppe identified R	(R35, e of (16, nent, ties of onal er and	B. WING RESS, CITY HIGHWAY A, MN 564 PREFIX TAG	<sup>7</sup> , STATE, ZI 7 71, PO E 40	BOX 38 PROVIDEF (EACH CORF		ION SHOUL HE APPRO	ON LD BE	05/2017 (X5) COMPLETE DATE
OUNTY CA UMMARY STA 1 DEFICIENCY ATORY OR L at ORY OR L ad From pa vas maintal R29, and ervices. include: include: g (ADLs), motion (Re remities. re plan dat Iteration in	RE CENTER	40 CL FICIENCIES CEDED BY FULI A INFORMATION 5 residents ed for range lated 11/16/ tive impairm or her activit aired functio of her uppe identified R	(R35, e of (16, nent, ties of onal er and	HIGHWAY A, MN 564 ID PREFIX TAG	71, PO E 40	BOX 38 PROVIDEF (EACH CORF	RECTIVE ACTI	ION SHOUL HE APPRO	ON LD BE	(X5) COMPLETE
UMMARY STA 1 DEFICIENCY ATORY OR L at ORY ORY OR C at ORY ORY OR L at ORY ORY ORY OR L at ORY ORY ORY O	TEMENT OF DEF MUST BE PREC SC IDENTIFYING ge 21 ined for 5 of 8 R12) reviewe ange MDS d severe cognit ent on staff fo and had impa OM) on both red 11/22/16, ADLs and ha	CL FICIENCIES CEDED BY FULL A INFORMATION 5 residents ed for range lated 11/16/ tive impairm or her activit aired functio of her uppe identified R	ARISSA	A, MN 564 ID PREFIX TAG	40	PROVIDEF (EACH CORF	RECTIVE ACTI	ION SHOUL HE APPRO	D BE	COMPLETE
UMMARY STA 1 DEFICIENCY ATORY OR L at ORY ORY OR C at ORY ORY OR L at ORY ORY ORY OR L at ORY ORY ORY O	TEMENT OF DEF MUST BE PREC SC IDENTIFYING ge 21 ined for 5 of 8 R12) reviewe ange MDS d severe cognit ent on staff fo and had impa OM) on both red 11/22/16, ADLs and ha	FICIENCIES CEDED BY FULL A INFORMATION 5 residents ed for range lated 11/16/ tive impairm or her activit aired functio of her uppe identified R	(R35, e of 16, nent, ties of onal er and	ID PREFIX TAG	(	(EACH CORF	RECTIVE ACTI	ION SHOUL HE APPRO	D BE	COMPLETE
ATORY OR L d From pa ras maintai R29, and ervices. include: gnificant ch R35 had g (ADLs), motion (Re remities. re plan dat Iteration in	ge 21 ined for 5 of 8 R12) reviewe aange MDS d severe cognit ent on staff fo and had impa OM) on both ced 11/22/16, ADLs and ha	5 residents ed for range lated 11/16/ tive impairm or her activit aired functio of her uppe identified R	(R35, e of 16, nent, ties of onal er and	TAG			RENCED TO T	HE APPRO		
vas maintai R29, and ervices. include: inficant ch R35 had R35 had g (ADLs), motion (R0 remities. re plan dat Iteration in	ange MDS d severe cognit and had impa OM) on both ed 11/22/16, ADLs and had	ed for range lated 11/16/ tive impairm or her activit aired functio of her uppe identified R	of 16, nent, ties of onal er and	2 895						
R29, and ervices. include: IR35 had s IV depende IG (ADLs), motion (Re remities. re plan dat Iteration in	R12) reviewe ange MDS d severe cognit and had impa OM) on both ced 11/22/16, ADLs and ha	ed for range lated 11/16/ tive impairm or her activit aired functio of her uppe identified R	of 16, nent, ties of onal er and							
nificant ch R35 had Iy depende g (ADLs), motion (R remities. re plan dat Iteration in	severe cognit ent on staff fo and had impa OM) on both red 11/22/16, ADLs and ha	tive impairm or her activit aired function of her uppe identified R	nent, ties of onal er and							
R35 had s ly depende g (ADLs), motion (Re remities. re plan dat Iteration in	severe cognit ent on staff fo and had impa OM) on both red 11/22/16, ADLs and ha	tive impairm or her activit aired function of her uppe identified R	nent, ties of onal er and							
Iteration in	ADLs and ha		35							
	he care plan ing, "Restora	identified s	dence everal							
I R35 had i v weakness er program nities." Th 'Approach ntation of v omplete, "I ," with a fro Further, th	e program id	oper and low oke, and lis in current R ided a space endations fo ," and direct xtremities da 7x/wk [times entified R35	wer sted a COM to se or ted aily as s per 5 had							
ed in a hig I listening t R35 had vi s, elbows a ard her up	h-back reclin o the radio w sible contrac and hands as oper chest. F	hing wheelch vith her eyes tures of her s she held h R35 had no	hair in s ner visible							
toniouros	1/4/17, at 1:		indo							
	Further, the charged from ed in a hig listening t R35 had vi s, elbows a ard her up braces in	Further, the program id charged from hospice of pservation on 1/4/17, a ed in a high-back reclir listening to the radio w R35 had visible contracts s, elbows and hands as ard her upper chest. F braces in place on her terview on 1/4/17, at 1:	Further, the program identified R38 charged from hospice care on 11/1 pservation on 1/4/17, at 12:32 p.m. ed in a high-back reclining wheelc listening to the radio with her eyes R35 had visible contractures of her s, elbows and hands as she held h ard her upper chest. R35 had no braces in place on her arms or ha terview on 1/4/17, at 1:34 p.m.	" with a frequency of "7x/wk [times per Further, the program identified R35 had charged from hospice care on 11/14/16. Deservation on 1/4/17, at 12:32 p.m. R35 ed in a high-back reclining wheelchair in listening to the radio with her eyes R35 had visible contractures of her s, elbows and hands as she held her ard her upper chest. R35 had no visible braces in place on her arms or hands. terview on 1/4/17, at 1:34 p.m. d nurse (RN)-A stated R35 was, "kinda	Further, the program identified R35 had charged from hospice care on 11/14/16. Deservation on 1/4/17, at 12:32 p.m. R35 ed in a high-back reclining wheelchair in listening to the radio with her eyes R35 had visible contractures of her s, elbows and hands as she held her ard her upper chest. R35 had no visible braces in place on her arms or hands. terview on 1/4/17, at 1:34 p.m.	Further, the program identified R35 had charged from hospice care on 11/14/16. Deservation on 1/4/17, at 12:32 p.m. R35 ed in a high-back reclining wheelchair in listening to the radio with her eyes R35 had visible contractures of her s, elbows and hands as she held her ard her upper chest. R35 had no visible braces in place on her arms or hands.	Further, the program identified R35 had charged from hospice care on 11/14/16. Deservation on 1/4/17, at 12:32 p.m. R35 ed in a high-back reclining wheelchair in listening to the radio with her eyes R35 had visible contractures of her s, elbows and hands as she held her ard her upper chest. R35 had no visible braces in place on her arms or hands.	Further, the program identified R35 had charged from hospice care on 11/14/16. Deservation on 1/4/17, at 12:32 p.m. R35 ed in a high-back reclining wheelchair in listening to the radio with her eyes R35 had visible contractures of her s, elbows and hands as she held her ard her upper chest. R35 had no visible braces in place on her arms or hands. terview on 1/4/17, at 1:34 p.m.	Further, the program identified R35 had charged from hospice care on 11/14/16. Deservation on 1/4/17, at 12:32 p.m. R35 ed in a high-back reclining wheelchair in listening to the radio with her eyes R35 had visible contractures of her s, elbows and hands as she held her ard her upper chest. R35 had no visible braces in place on her arms or hands. terview on 1/4/17, at 1:34 p.m.	Further, the program identified R35 had charged from hospice care on 11/14/16. Deservation on 1/4/17, at 12:32 p.m. R35 ed in a high-back reclining wheelchair in listening to the radio with her eyes R35 had visible contractures of her s, elbows and hands as she held her ard her upper chest. R35 had no visible braces in place on her arms or hands. terview on 1/4/17, at 1:34 p.m.

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00761	B. WING		01/05/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		406 EAS	T HIGHWAY 7			
ENTRA	L TODD COUNTY CA		SA, MN 56440			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO		COMPLE DATE
				DEFICIENC	CY)	
2 895	Continued From pa	age 22	2 895			
		-				
		and had contractures in her tremities due to a stroke				
		r. Further, RN-A stated R35				
		or splints, but received daily				
		help with her contractures.				
	-					
		of morning care on 1/5/17, at				
		assistant (NA)-A and NA-B				
		sing and seated her in her				
		DM was completed on R35's				
		emities during the morning				
	care.					
	When interviewed	on 1/5/17, at 7:56 a.m. NA-A				
		helps R35 get ready a,				
		eek," and does not ever				
	complete ROM or e	exercises with R35. NA-A				
		aware if R35 was on a				
		program, but added, "She's				
		aff are helping her dress.				
		ed the facility had a couple onsible to complete the				
		ns, however, when the facility				
		se aides are pulled to the				
		rehab when we are short on				
	the floor."					
		1/5/17, at 8:45 a.m. NA-B				
		e of two NA staff responsible to				
		rative programs for residents. as supposed to have ROM				
		owever, it was not being done,				
		full staff." NA-B stated R35				
		completed as directed by her				
		month, and R35's seemed,				
		ff completed cares. NA-B				
	stated the staff trac	ked participation with the				
		a flowsheet by signing their				
		done, or a, "X" symbol when it				
	was not completed	. Further, NA-B stated she				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00761	B. WING	B. WING		01/05/2017	
AME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S				
ENTRA	L TODD COUNTY CA		Г НІ <b>GHWAY 7<sup>.</sup> 6А, MN  56440</b>	1, PO BOX 38			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
2 895	Continued From pa	age 23	2 895				
	had reported these concerns to the occupational therapist (OT).						
	11/2016, identified several columns wi sheet provided spa	ab forms dated 9/2016 to a flowsheet which listed th 31 separate rows. This cing to record an exercise day of the month which ring entries:					
		R35 had ROM completed four eing written in 26 times on the					
	times, with a, "X" b	5 had ROM completed seven eing written in 23 times on the 35 was identified as refusing					
	times, with a, "X" b	R35 had ROM completed four eing written in 12 times with e form (after 11/16/16) being					
		ner flowsheets to demonstrate a attempted or completed after					
	registered nurse (F restorative nursing contractures and sl her arms daily, "To motion and prevent	on 1/5/17, at 9:20 a.m. RN)-B stated R35 was on a program for her arm hould have ROM completed to maintain their current range of t further contractures." RN-B ve NA staff were responsible to					
	they were being pu	of each program, however, lled to the floor to work ree times a week, if not more."					
	During interview on epartment of Health	1/5/17, at 1:09 p.m. OT-A					

917D11

If continuation sheet 24 of 41

		Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			B. WING			
		00761	B. WING		01/05/2017	
AME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
ENTRA	L TODD COUNTY CA		T HIGHWAY 71 SA, MN 56440	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	age 24	2 895			
	been last seen by 0 however, added sh orders for R35 to b staff reported R35 her elbows and wri On 1/5/17, at 1:12 range of motion (P extremities with the stated R35 had poo joint away from the adding it was, "Ver was, "Probably mis extension," in her le completed PROM f R35's right shoulde with, "About 20 deg degrees of flexion	a few years, since R35 had DT for any therapy services, ie had recently requested e evaluated due to nursing to have, "Some tightness in sts." p.m. OT-A completed passive ROM) to R35's upper e surveyor present. OT-A or abduction (motion of the body) in her left shoulder y, very tight." OT-A stated R35 sing 35 to 45 degrees of eft elbow. Further, OT-A to R35's right side and stated er was better than her left side grees of abduction," and, "20 [the action of bending]," 35's right elbow was, "Minus 25				
	at 1:25 p.m. OT-A s worked with R35 p determine if a decli occurred or not. Fi staff should be con help increase the or reduce R35's pain activities of daily liv would be good to e R5's diagnoses, as change Minimum E 10/13/16, included Alzheimer's demer R5 required extense	following the PROM on 1/5/17, stated she had not personally rior, so she was unable to ine in R35's ROM had urther, OT-A stated nursing npleting the ROM exercises to irculation and potentially with dressing and other ring, "That is something that educate nursing staff on." a identified on the significant Data Set (MDS) dated pain in left hip, anemia and tia. The MDS also indicated sive assistance for bed mobility essing, and was cognitively				

917D11

If continuation sheet 25 of 41

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00761	B. WING		01/	05/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
		AND	T HIGHWAY 71	, PO BOX 38		
ENTRA	AL TODD COUNTY CA	CLARIS	SA, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	age 25	2 895	DEFICIENC	51)	
	dated 12/28/2016, touching behind he about shoulder hei extend right leg an assessment also ir extending left leg, I and that impairmer extremity affected	(ROM)/Balance Assessment, indicated R5 had difficulty in head, was able to reach to ght; was able to flex and d foot and left hand. The indicated R5 had difficulty had pain and stiffness to leg, ints to upper and lower left R5's daily physical functioning.				
	position with use of surface to surface received increased depending on pain	ble to stand from seated f a grab bar, and completed transfer independently. R5 assistance from staff and weakness. sessment (CAA) for activities				
	of daily living (ADL dated 10/6/16, ider ADLs, and need fo nursing staff. The care planning to ske	(b)/Rehabilitation Potential, ntified potential for decline in r increased assistance from CAA indicated the need for ow or minimize R5's decline, rrent level of functioning.				
	at 7:13 a.m., nursir R5's lower body wh sit up with assistan assistance to lift ar the side of the bed	of morning cares on 1/5/2017 ng assistant (NA)-D dressed nile still in bed. R5 was able to ce, and required limited nd move R5's legs to sit up at . While dressing, R5 was able				
	as NA-D placed R5 shirt arm holes. R5 dressing, and neith contracted. NA-D	s, slightly below shoulder level, 5's hands and arms through the 5 did not exhibit any pain while her hands nor arms were also assisted R5 to transfer	9			
	in place, R5 graspe wheelchair next to with assistance. D	er wheelchair. With a gait belt ed the left arm rest of the the bed, and was able to stanc uring the transfer, R5 was rer, but able to bear her weight	1			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00761	B. WING		01/	05/2017
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ENTRA	L TODD COUNTY CA		T HIGHWAY 71 SA, MN 56440	, PO BOX 38		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	ige 26	2 895			
	for R5 as she pivote	upport and maintain balance ed, then sat into her storative services were orning cares.				
	stated R5 usually re one staff for transfe also that R5's partic pain. NA-D stated work on restorative had one. NA-D sta who did the rehab p	1/5/17, at 7:50 a.m. NA-D equired "limited" assistance of ers, and getting dressed, and cipation depended on her hip she did today, nor routinely, programs, but was sure R5 ted there were other aides programs. NA-D also stated 85 walk with staff in "more than				
	ADL self-care defic	ised 10/7/2016, identified an it, related to pain, history of lef cluded the intervention of a n.	t			
	11/16/15, indicated extremity strength a activities of daily liv strength; maintain a maintain balance si directed the followin pound free weights extremities, flex and internal rotation; sit 5 minutes, with resi with no weight 3 to	d extend elbow, punch out and and use upper extremity bike t as needed; overhead pulley 4 minutes; daily walk 60 feet and NuStep (seated device)	ł			
	November 2016 we R5's restorative ser	eets from July 2016 to ere reviewed and indicated rvices were provided/refused ollows: July, 5x (times), 1x				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00761	B. WING		01/05/2017	
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, S			
ENTRA	L TODD COUNTY CA		T HIGHWAY 7 <sup>.</sup> SA, MN  56440	•		
(X4) ID			ID	PROVIDER'S PLAN OF		
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE DATE	
2 895	Continued From pa	age 27	2 895			
	September, 5x, 1x refused; November unavailable; there November 15th. Th December 2016 or During an interview nursing assistant (I the rehab aides, ar restorative nursing NA-B stated that al there were no staff programs, and she assignments to wo times a week. NA- was five times a we NA-B stated it was	y on 1/5/2017, at 2:06 p.m. NA)-B stated she was one of nd she "dutifully" completed programs with residents. bout November, however, available to complete the was often "pulled" from rehab rk on the floor, as often as five B stated R5's restorative goal eek, but "it just didn't get done." no surprise there was little or of the rehab program fro R5				
	director of nursing Care Program was care plan, and it was make sure the prog acknowledged R5's consistently completed also lacked docum was completed at a DON stated it was programs, especial the restorative nurs DON stated she "a other residents' car restorative nursing R15's quarterly MD	1/5/2017 at 2:58 p.m., the (DON) stated the Restorative a part of R5's comprehensive as nursing's responsibility to gram was followed. The DON is restorative program was not eted for several months, and entation that R5's program all since mid-November. The difficult to find staff to do the lly at the end of the year, and sing program struggled. The bsolutely" expected R5's, and re plans be followed, and the programs be implemented. DS, dated 10/19/16, identified ment and needed extensive				
		ment and needed extensive bility and transfers, and had a				

CENTRAL TODD COUNTY CARE CENTER       406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440         (X4) ID PREFIX       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL       ID PREFIX       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE       ()	STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE           406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, NN 56440         406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, NN 56440           (M) D PHERK TAG         SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COROS-REFERENCIER A DATE OF DEFICIENCIES         0 PARTIX           2 895         Continued From page 28 Unctional limitation of the lower extremity on one side.         2 895         2 895           R15's ROM/Balance Assessment, dated 7/22/16, identified a left lower extremity impairment related to a previous left hig facture. The assessment indicated the impairment affected R15's physical functioning, and R15 did not utilize any braces or splints. It further indicated physical therapy ended on 7/21/16, is R15 refused to participate.         R15's ROM/Balance Assessment, dated 10/18/16, identified the same left lower extremity impairment which continued to affect his physical functioning. The assessment indicated R15 was on a Nursing Rehab program for exercises.           R15's Restorative Care Program, dated 9/17/16, included goals of maintaining his ability to transfer for family outings, maintain left lower extremity strength, and to encourage ambulation as tolerated or would agree to. R15's restorative program included using the NuStep (exercise bike), and ROM performing hamstring pullbacks, hip abductions, and hip flexion with varying repetitions.           R15's current care plan, dated 10/25/16, identified Balance, Inability to move independently, Impaired LLE [left lower extremity]. Further, the care plan identified several interventio			00761	B. WING		01/	01/05/2017	
CMULTION COUNTY CARE CENTER       CLARISSA, MN 56440         (24) ID TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MOST BE PRECEDED BY FULL REGULTORY OR USC DEENTEYING INFORMATION)       ID PROVIDER'S PLAN OF CORRECTIVE ATORN SHOLD BE CROSS REFERENCY       0 CROSS REFERENCY         2 895       Continued From page 28       2 895         functional limitation of the lower extremity on one side.       2 895       2 895         R15's ROM/Balance Assessment, dated 7/22/16, identified a left lower extremity impairment related to a previous left hip fracture. The assessment indicated the imparment affected R15's physical functioning, and R15 did not utilize any braces or splints. It further indicated physical therapy ended on 7/21/16, as R15'refused to participate.       R15's ROM/Balance Assessment, dated 10/18/16, identified the same left lower extremity impairment which continued to affect his physical functioning. The assessment indicated R15's was on a Nursing Rehab program for exercises.         R15's Restorative Care Program, dated 91/716, included goals of maintaining his ability to transfer for family outings, maintain left lower extremity stoergith, and to encourage ambluation as tolerated or would agree to. R15's restorative program included using the NUSE(p (exercise bike), and ROM performing hamstring pullbacks, hip abductions, and hip flexion with varying repetitions.         R15's current care plan, dated 10/25/16, identified Balance, Inability to move independently. Impaired LLE [left lower extremity]. "Further, the care plan identified several interventions, but there was no indication R15 was on a restorative	NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
Image: Construction of the constrele construction of the construction of th	CENTRA	L TODD COUNTY CA						
functional limitation of the lower extremity on one side. R15's ROM/Balance Assessment, dated 7/22/16, identified a left lower extremity impairment related to a previous left hip fracture. The assessment indicated the impairment affected R15's physical functioning, and R15 did not utilize any braces or splints. It further indicated physical therapy ended on 7/21/16, as R15 refused to participate. R15's ROM/Balance Assessment, dated 10/18/16, identified the same left lower extremity impairment which continued to affect his physical functioning. The assessment indicated the "left leg continues to be stiff and slower with movement," and R15 was not able to completely flex or extend the leg. It indicated R15 was on a Nursing Rehab program, for exercises. R15's Restorative Care Program, dated 9/17/16, included goals of maintaining his ability to transfer for family outings, maintain left lower extremity strength, and to encourage ambulation as tolerated or would agree to. R15's restorative program included using the NuStep (exercise bike), and ROM performing hamstring pullbacks, hip abductions, and hip flexion with varying repetitions. R15's current care plan, dated 10/25/16, identified R15 had an alteration in ADL's due to "Impaired Balance, Inability to move independently, Impaired LLE [left lower extremity]." Further, the care plan identified several interventions, but there was no indication R15 was on a restorative	PRÉFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
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<ul> <li>identified a left lower extremity impairment related to a previous left hip fracture. The assessment indicated the impairment affected R15's physical functioning, and R15 did not utilize any braces or splints. It further indicated physical therapy ended on 7/21/16, as R15 refused to participate.</li> <li>R15's ROM/Balance Assessment, dated 10/18/16, identified the same left lower extremity impairment which continued to affect his physical functioning. The assessment indicated the "left leg continues to be stiff and slower with movement," and R15 was not able to completely flex or extend the leg. It indicated R15 was on a Nursing Rehab program for exercises.</li> <li>R15's Restorative Care Program, dated 9/17/16, included goals of maintaining his ability to transfer for family outings, maintain left lower extremity strength, and to encourage ambulation as tolerated or would agree to. R15's restorative program included using the NUStep (exercise bike), and ROM performing hamstring pullbacks, hip abductions, and hip flexion with varying repetitions.</li> <li>R15's current care plan, dated 10/25/16, identified R15 had an alteration in ADL's due to "Impaired Balance, Inability to move independently, Impaired LLE [left lower extremity]." Further, the care plan identified several interventions, but there was no indication R15 was on a restorative</li> </ul>			n of the lower extremity on one					
<ul> <li>included goals of maintaining his ability to transfer for family outings, maintain left lower extremity strength, and to encourage ambulation as tolerated or would agree to. R15's restorative program included using the NuStep (exercise bike), and ROM performing hamstring pullbacks, hip abductions, and hip flexion with varying repetitions.</li> <li>R15's current care plan, dated 10/25/16, identified R15 had an alteration in ADL's due to "Impaired Balance, Inability to move independently, Impaired LLE [left lower extremity]." Further, the care plan identified several interventions, but there was no indication R15 was on a restorative</li> </ul>		identified a left lowe to a previous left hi indicated the impai functioning, and R1 splints. It further inc on 7/21/16, as R15 R15's ROM/Balanc 10/18/16, identified impairment which of functioning. The as leg continues to be movement," and R flex or extend the left	er extremity impairment related p fracture. The assessment rment affected R15's physical 15 did not utilize any braces or dicated physical therapy ended refused to participate. The same left lower extremity continued to affect his physical sessment indicated the "left e stiff and slower with 15 was not able to completely eg. It indicated R15 was on a					
R15 had an alteration in ADL's due to "Impaired Balance, Inability to move independently, Impaired LLE [left lower extremity]." Further, the care plan identified several interventions, but there was no indication R15 was on a restorative		included goals of m for family outings, m strength, and to en tolerated or would a program included u bike), and ROM pe hip abductions, and	naintaining his ability to transfer maintain left lower extremity courage ambulation as agree to. R15's restorative using the NuStep (exercise prorming hamstring pullbacks,	r				
		R15 had an alterati Balance, Inability to Impaired LLE [left I care plan identified there was no indica	on in ADL's due to "Impaired o move independently, ower extremity]." Further, the several interventions, but ation R15 was on a restorative					
Review of R15's Nursing Rehab forms dated 9/2016 to 11/2016, identified a flowsheet which mesota Department of Health	noset- D	9/2016 to 11/2016,						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00761	B. WING		01/05/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	L TODD COUNTY CA	ADE CENTER 406 EAS	T HIGHWAY 7	1, PO BOX 38		
	L TODD COUNTY CA	CLARIS	SA, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 895	Continued From pa	age 29	2 895			
	This sheet provide	nns with 31 separate rows. d spacing to record an d on each day of the month e following entries:				
	seven times, with a available for exerci	R15 had ROM completed a, "X" (meaning no staff were se) being written in six times ays. R15 was identified as				
	times, with a, "X" b	5 had ROM completed nine eing written in 17 times on the 15 was identified as refusing s.				
	times, with a, "X" b the remainder of th	R15 had ROM completed five eing written in nine times with the form (after 11/16/16) being the identified as refusing the				
		her flowsheets to demonstrate n attempted or completed after				
	stated he did exerc	n 1/4/17, at 6:02 p.m. R15 cises "when I'm ready," further e went to exercise varied.				
	7:11 a.m. registere assistant (NA)-F w the bathroom. With belt, R15 was able ambulated a few st NA-F proceeded to	of morning cares on 1/5/16, a d nurse (RN)-B and nursing ere observed assisting R15 to assistance and a transfer to stand from his wheelchair, tep, and sit down on the toilet. provide R15 with washcloths. to independently wash his				
accete D	face and upper boo	dy. NA-F assisted R15 to dress 5 was able to use his upper	;			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00761	B. WING		01/05/2017	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE. ZIP CODE		00,2011
		406 EAS	T HIGHWAY 71			
ENIKA	L TODD COUNTY CA	CLARIS	SA, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 895	Continued From pa	age 30	2 895			
	proceeded to put o on the toilet. After o NA-F placed the w to the toilet and, wi the assistance bar, the pants, and sat	st with dressing. NA-F on R15's pants on while he sat completing morning cares, heelchair in the bathroom next th assistance, R15 grabbed , stood while NA-F pulled up down in the wheelchair. No es were performed during the				
	stated it was the fir	n 1/5/17, at 7:34 a.m. NA-F st time she had worked with vare of any restorative program				
	stated R15 worked sometimes; howev restorative program programs used to b	n 1/5/17, at 7:49 a.m. NA-C l with the physical therapist er, wasn't sure if R15 was on a n. NA-C stated the restorative be completed by a few nursing In't "seen that in a while."				
	stated R15 had a re the nursing assista complete it for the staffing. NA-B furth consistent" with do She further stated program more than	n 1/5/17, at 11:42 a.m. NA-B estorative program; however, ints hadn't had time to last couple of months due to her stated R15 was "pretty ing the restorative exercises. he came to the restorative n he refused, disliked the d occasionally use ankle etches.				
	stated the facility h trained by the the p performed the rest states the restorati "pretty often," depe	n 1/5/17, at 11:58 a.m. RN-A ad two nursing assistants, ohysical therapist, who orative program. RN-A further ve program wasn't being done ending on the week, because ints were not consistently tive aides.				

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		00761	B. WING		01/05/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
	L TODD COUNTY CA	406 EAS	T HIGHWAY 71			
ENIKA	L TODD COUNTY CA	CLARIS	SA, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 895	Continued From pa	age 31	2 895			
	therapist (PT)-A sta on the NuStep and his legs. PT-A state combative with the admitted to the fact offered restorative refusing less to per PT-A states "he spe (to the exercise roc During observation was observed perfor reported R15 had r no contractures. P	n 1/5/17, at 12:22 p.m. physical ated R15 had worked with her with doing a few exercises for ed R15 had been more rapy when he was first ility, but thought he was being exercises and was currently form exercises. In addition, oradically wheels himself dowr om)" to do restorative nursing. non 1/5/17, at 4:01 p.m. PT-A forming ROM on R15. PT-A no decline in his ROM and had T-A reported the goal of R15's in was to prevent contractures eft hip fracture.	1			
	R29 had severe co dependent on staff	OS dated 11/11/16, identified gnitive impairment, was totally for her ADLs, and had range of motion (ROM) on extremities.				
	identified a goal to, extremities." The s labeled, "Approach Implementation of staff to complete, "	Care Program dated 5/18/15, "Maintain ROM to all sheet provided a space les/Recommendations for Above Goals," and directed ROM to all extremities daily as nt," with a frequency of				
	11/2016, identified several columns wi sheet provided spa	ab forms dated 9/2016 to a flowsheet which listed ith 31 separate rows. This ucing to record an exercise a day of the month which				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED
		00761	B. WING		01/	05/2017
)F PRO	OVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
RAL T	TODD COUNTY CA	RE CENTER	T HIGHWAY 7 SA, MN 56440	1, PO BOX 38		
x	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
95 Co	Continued From pa	ge 32	2 895			
ide	identified the following entries:					
tin	September 2016: R29 had ROM completed eight times, with a, "X" being written in 22 times on the remaining days.					
tin		e had ROM completed 12 had written in 19 times on the				
tin th	mes, with a, "X" be	29 had ROM completed five eing written in 11 times with e form (after 11/16/16) being				
ar		ner flowsheets to demonstrate attempted or completed after				
R <sup>.</sup> ex im	12 had moderate xtensive assistanc	S dated 9/14/16, identified cognitive impairment, required e with ADLs, and had ROM on both of his upper and				
ide m [ri Th "A Im sta of	dentified a diagnos novement," and list right upper extremi 'he sheet provided Approaches/Recor nplementation of A taff to complete, "A f motion] R [right] s nstructions for staff	nmendations for Above Goals," and directed AAROM [active assisted range shoulder," and listed several f to follow using weights with				
Th "A In sta of ins R th sh	he sheet provided Approaches/Recorn nplementation of A taff to complete, "A f motion] R [right] f motion] R [right] f motions for staff t2's flexion and e ne program identifi	a space labeled, mmendations for Above Goals," and directed AAROM [active assisted range shoulder," and listed several				

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AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ENTRA	L TODD COUNTY CA		T HIGHWAY 71 SA, MN 56440	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 895	Continued From pa	age 33	2 895			
	however there were demonstrate the re	ab forms were requested, e no flowsheets to estorative program had been leted sine being implemented				
	stated the resident been completed for due to not having e been difficult with the residents should have	n 1/5/17, at 2:09 p.m. RN-A restorative programs had not r what, "Seems like awhile," enough staff, "The staffing's hat." Further, RN-A stated ave had their restorative ed as directed to, "Prevent ir mobility.				
		restorative nursing program s requested, but none was				
	The Director of Nur schedule an in-serv of residents receivi services for range assessment and ap intervention plan co these residents. A established in orde	THOD OF CORRECTION: rsing or designee could vice to address the importance ng appropriate treatment and of motion limitations. An opropriate treatment ould be provided by the staff fo monitoring program could be or to assure an on-going ive program for residents with				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one	9			
21685	MN Rule 4658.141 Housekeeping, Op	5 Subp. 2 Plant eration, & Maintenance	21685			2/13/17
	Subp. 2. Physical	plant. The physical plant,				

Minneso	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00761	B. WING		01/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA	RE CENTER	THIGHWAY A, MN 5644	71, PO BOX 38 0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21685	including walls, floo systems, and equip continuous state of with regard to the h well-being of the re- routine maintenance This MN Requireme by: Based on observation eview, the facility fa- sanitary environme and A10), reviewed potential to affect 2 utilized these rooms Findings include: During observation at 8:44 a.m. the priv- observed stained a from an unknown s brown-colored dots lower portion of the close to the room d was also inspected brownish-colored a lower portion of the door. During an environme p.m. with the mainten the presence of the A10 and A8 were re-	ors, ceilings, all furnishings, ment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program. ent is not met as evidenced on, interview and document ailed to provide a clean and nt in 2 of 8 resident rooms (A8 on the A wing, which had the residents who currently s. of resident rooms on 1/5/17, vacy curtain in room A10 was nd unclean. The staining, ubstance, appeared as dark, and inch-long marks, on the curtain, which was hanging oor. The curtain in Room A8 and observed unclean, with a nd faded stain, also on the gathered curtain, near the nental tour on 1/5/17, at 1:40 enance supervisor (MS) and in e surveyor, the curtains in room eviewed. The MS o curtains were unclean and in		Corrected.		
Minnesota D STATE FORI	stated the curtains	/5/17, at 1:43 p.m. the MS were dirty, that one of the	6899		If continuation	n sheet 35 of 41
	*1			917D11	uali01	1 SHEEL 3J 01 41

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00761	B. WING		01/	05/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
CENTRA	L TODD COUNTY CA	RE CENTER	T HIGHWAY 7 SA, MN 56440	1, PO BOX 38		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21685	Continued From pa	ge 35	21685			
	Kleenex," wipe her could be vomit. Th painted, repaired at a resident moved o there also was a m clean and repair res when housekeeping day, if they notice a they would fill out a would go in remove the dirty one would the curtain should h and stated he could "change out" the cu	privacy curtain "like a mouth and added the stain e MS stated rooms were nd cleaned top to bottom when ut, but that on a monthly basis ore detailed checklist used to sident rooms. The MS stated g goes through the room every n issue, like a dirty curtain, request , and then the MS e and replace the curtain, and be washed. The MS stated have been changed sooner, d just make is a task to urtains on a monthly basis. Central Todd County Care oom Inspection List, was ated privacy curtains were to y.	5			
		he cleaning and maintaining c requested, but not provided	f			
	The administrator of policy for housekee	HOD OF CORRECTION: or designee could review the pping. The administrator or form audits in resident rooms ce.				
	TIME PERIOD FOR Twenty-One (21) da					
21880	MN St. Statute 144 Residents of HC Fa	.651 Subd. 20 Patients & ac.Bill of Rights	21880			1/26/17
	Subd. 20. Grieval shall be encourage	nces. Patients and residents				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00761	B. WING		01/	05/0017
	ROVIDER OR SUPPLIER				01/	05/2017
		406 EAS	DRESS, CITY, S <sup>-</sup> <b>F HIGHWAY 7</b> 1			
ENIRA	L TODD COUNTY CA		A, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
21880	Continued From pa	age 36	21880			
	to understand and patients, residents, residents may voice changes in policies and others of their interference, coerci including threat of of grievance procedur well as addresses a Office of Health Fa nursing home omb	y or their course of treatment, exercise their rights as and citizens. Patients and e grievances and recommend and services to facility staff choice, free from restraint, ion, discrimination, or reprisal, discharge. Notice of the re of the facility or program, as and telephone numbers for the acility Complaints and the area udsman pursuant to the Older ction 307(a)(12) shall be cuous place.				
	residential program 253C.01, every nor facility employing m provides outpatient have a written inte at a minimum, sets followed; specifies limits for facility res or resident to have advocate; requires grievances; and pro an impartial decision otherwise resolved residential program 253C.01 which are treatment programs centers with section health maintenance 62D.11 is deemed	e inpatient facility, every n as defined in section nacute care facility, and every nore than two people that mental health services shall rnal grievance procedure that, forth the process to be time limits, including time ponse; provides for the patient the assistance of an a written response to written by decision by on maker if the grievance is not . Compliance by hospitals, ns as defined in section hospital-based primary s, and outpatient surgery n 144.691 and compliance by e organizations with section to be compliance with the written internal grievance				
nesota De ATE FORM	epartment of Health				lf continuati	

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
			A. BOILDING.	·		
		00761	B. WING		01/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CENTRA	L TODD COUNTY CA		HIGHWAY 7 A, MN 5644	71, PO BOX 38 0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21880	Continued From pa	ge 37	21880			
	by: Based on observati review, the facility f cool temperatures i of 3 residents (R18 complained of being Finding include: R20's quarterly Min 11/4/16 indicated he impaired. The MDS	ent is not met as evidenced on, interview and document ailed to act on concerns of n the main dining room for 3 , R20 and R15) who g cold during meal time. imum Data Set (MDS) dated e was moderately cognitively S also indicated R20 was able ad wants, and made himself		Corrected		
	indicated R18 was able to express idea himself understood R15's quarterly MD R15 was cognitively he was usually und communicating som thoughts, but was a During observation dining room on 1/3/	S dated 10/19/16 indicated y intact. The MDS indicated erstood, had difficulty ne words and finishing uble if prompted or given time. of the noon meal in the main '17 at 12: 22 p.m., R18 sat at a				
	located about 4' (fe in front of a double- wide by 5' in height and sat with his bac window was an 3' w and a cold draft wa above the tables al	0 and R15. The table was et) from a north side wall, and pane picture window, about 6' . R18, was wearing a sweater, ck to the window. Left of the <i>v</i> ide exit metal and glass door, s felt in front of the door. Also, ong the wall, above where sat, were heat vents, which				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		(X3) DATE SURVE COMPLETED		
		00761	B. WING	B. WING		01/05/2017	
	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE, ZIP CODE				
		406 EAS	T HIGHWAY 71				
CENTRA	L TODD COUNTY CA	CLARIS	SA, MN 56440				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21880	Continued From pa	age 38	21880				
	also emitted a cool	draft.					
	stated he usually s main dining room) down, "its damn co stated, it was "alwa and added they for conditioning) today	y on 1/3/17 at 12:38 p.m., R20 its in front of the window (in the and even with the shade pulled old, and I don't like it." R20 ays cold" in the dining room got to turn off the AC (air y. R20 stated staff were aware the cold dining room.	ł				
	when he goes to th on another sweate cold." R18 stated i winter, especially if stated he has men	1/4/17 at 6:53 p.m., R18 stated ne dining room, he has to put r. "It helps, but it's still too it had been really cold this there was a south wind. R18 tioned his concern about the in the dining room, and they					
	stated the dining ro always be cold, it c always cold for me	of 1/5/17 at 8:00 a.m., R15 from temperature seemed to comes right out of the vent. "It's ." R15 stated he believed the le concern with the cold dining	5				
	maintenance super temperatures in all building were chec	v on 1/5/1 at 1:43 p.m., the rvisor (MS) stated the rooms and parts of the ked daily. The MS stated the e the main dining room were grees Fahrenheit).					
	presence of the su computer-monitore main dining room t During the same in	o.m., with the MS and in rveyor, the ed temperature indicated the emperature was 72.0 deg F. Iterview, the MS stated he ninistrator about placing plastic					

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00761	B. WING		01/	05/2017
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	• • •	
ENTRA	L TODD COUNTY CA		T HIGHWAY 71 SA, MN 56440	, PO BOX 38		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21880	Continued From pa	ige 39	21880			
	on the windows by the dining area, but thought this would not work and did not implement this. The MS stated they could just move the residents from the area, since there was plenty of space in the dining room. The MS stated he was aware that residents had expressed discomfort from the cooler temperatures, but they had not done anything to alleviate this complaint. In an interview on 1/5/17 at 3:15 p.m., the director of nursing (DON) stated she and the administrator talked about the window, and the "temps" (temperature) in the dining room. The DON stated she had not heard any specific complaints, but was aware of the problem by the window. The DON stated she did not know if the dietary manager asked anyone about moving or doing some other seating arrangements. The DON acknowledged the dining room can be uncomfortable and stated we'll have to do something.					
	administrator stated and change the res dining room. The a to please everyone residents who've m	of 1/5/17 at 3:20 p.m., the d we could make a change, sident order around in the administrator stated it was hard , especially when you have ade a choice to sit by the s we can make a change.	8			
	The director of nurs the requirement to and make a good fa grievances. The di develop a monitori	THOD OF CORRECTION: sing could in-service staff on address resident concerns aith attempt to resolve the rector of nursing could ng system to ensure ongoing port the findings to the Quality tee.				
	TIME PERIOD FOR					

TATEMEN ND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				. BOILDING		
		00761	B. WING		01/	05/2017
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
ENTRA	L TODD COUNTY CA		ST HIGHWAY 71 SA, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE
21880	Continued From pa	age 40	21880	DEHOLINOT		
2.000	(21) days.		21000			
	(21) uays.					