DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: Q179

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00761

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245521**

2.STATE VENDOR OR MEDICAID NO.
(L2) **785540100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRAL TODD COUNTY CARE CENTER**
(L4) **406 EAST HIGHWAY 71, PO BOX 38**
(L5) **CLARISSA, MN** (L6) **56440**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/11/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Brenda Fischer, Unit Supervisor 09/11/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 01/07/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 01/11/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/02/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

CMS Certification Number (CCN): 245521
January 7, 2016

Mr. Jason Polovick, Administrator
Central Todd County Care Center
406 East Highway 71, Po Box 38
Clarissa, Minnesota 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 September 1, 2015 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.

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

MDH
Minnesota
Department
of Health

Electronically delivered
January 7, 2016

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

RE: Project Number S5521024

Dear Mr. Polovick:

On August 3, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 16, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 11, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 4, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 16, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 1, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 16, 2015, effective September 1, 2015, and therefore remedies outlined in our letter to you dated August 3, 2015, 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.

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245521	A. Building B. Wing	9/11/2015

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0309 Reg. # 483.25 LSC	08/21/2015	ID Prefix F0356 Reg. # 483.30(e) LSC	08/21/2015	ID Prefix F0441 Reg. # 483.65 LSC	08/21/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By BF/KJ	Date: 01/07/2016	Signature of Surveyor: 10562	Date: 09/11/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 7/16/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245521	01 - MAIN BUILDING 01	9/4/2015

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0046	08/21/2015	ID Prefix Reg. # NFPA 101 LSC K0054	09/01/2015	ID Prefix Reg. # NFPA 101 LSC K0056	09/01/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By TL/KJ	Date: 01/07/2016	Signature of Surveyor: 27200	Date: 09/04/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 7/14/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: Q179

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00761

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245521**

2.STATE VENDOR OR MEDICAID NO.
(L2) **785540100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRAL TODD COUNTY CARE CENTER**
(L4) **406 EAST HIGHWAY 71, PO BOX 38**
(L5) **CLARISSA, MN** (L6) **56440**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/16/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Austin Frey, HFE NE II — 08/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 08/31/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/02/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 3, 2015

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

RE: Project Number S5521024

Dear Mr. Polovick:

On July 16, 2015, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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:

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

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

Remedies - 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;

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

Informal Dispute Resolution - 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
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Brenda.Fischer@state.mn.us
Telephone: (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 August 25, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 25, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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

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 October 16, 2015 (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.

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 January 16, 2016 (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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING _____ B. WING _____	07/16/2015

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the change in behavior for 1 of 1 cognitively impaired residents (R27) who was involved in a sexual relationship with another resident (R45). Furthermore, the facility failed to ensure proper leg support was provided for 1 of 3 residents (R42) reviewed for positioning and whose legs were not supported in her wheelchair.	F 309	Failure to comprehensively assess change in behavior: -R27's care plan was changed to reflect MD statement regarding mental capacity and decision making capability. MD determined that resident no longer had the ability to make significant decisions (i.e. engaging in a sexual relationship). -Interventions added to R27's care plan to	8/21/15

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

Electronically Signed | 08/12/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING _____ B. WING _____	07/16/2015

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

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F 309	Continued From page 1 Findings include: CHANGE IN BEHAVIOR R27's quarterly Minimum Data Set (MDS), dated 3/27/15, identified R27 was independent with transfers and ambulation, had Alzheimer's disease (progressive disease that destroys memory and other mental function), and severe cognitive impairment. R27's annual MDS, dated 9/29/14, indicated that this resident was able to express preferences, and displayed no behaviors. R27's mental status was determined to be moderate cognitively impaired. Review of R27's progress notes, dated 1/31/15 to 6/7/15, identified new escalating sexual behaviors were occurring with resident R45. Review of R45's admission MDS, dated 1/15/15 and subsequent 4/14/15 quarterly MDS, both indicated R45 was cognitively intact. During the month of January 2015, the facility documented the following behavior in the progress notes: 1/31/15: R27 made comments about her sexual readiness. A review of R27's quarterly MDS dated 12/29/14, indicated R27 had severe cognitive impairment, with no behaviors observed, and no acute onset of mental status change. This was a change from the previous MDS of 9/29/14 when she had been identified as moderately cognitively impaired. During the month of February 2015, the facility had documented the following behaviors in the progress notes: 2/15/15: a NA (nursing assistant) requested that	F 309	reflect restrictions on sexual relationship(s) due to physician determination. -chart review of all other residents was performed to assess potential for impaired residents indicating or demonstrating interest in pursuing a sexual relationship(s). -All residents will be monitored changes in cognition/pursuit of sexual relationship(s) via IDT team review of current charting/verbal report on a daily basis. -Policy "Resident Relations" was initiated for staff to follow in the event that resident's desire to pursue a sexual relationship. -Staff education provided on new policy, and R27's care plan changes/interventions Failure to ensure proper leg support -R42 received foot rests on wheelchair -R42's care plan was revised to reflect her leg elevation habit during locomotion -All other residents were assessed for proper leg position and care planning reflects refusal of recommended leg support. -Foot pedals for all resident assigned wheelchairs have been made available for resident/staff usage. -Ongoing monitoring of leg position/foot support will be performed via IDT team review of current charting/verbal reporting as well as formal review on MDS schedule. -Policy "Wheelchair foot pedals/rests Policy" was initiated and staff were educated.	

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F 309	Continued From page 2 the licensed social worker come to a resident's (R45) room. R27 was there and would not leave making sexually explicit comments to resident (R45). Staff asked R27 to leave the room, which R27 eventually did, however, R27 later returned. R45 informed the staff that R27's comments make him uncomfortable. 2/17/15: "[R27] Made the following comments to NA 'I have a boyfriend..." 2/21/15: R27 attempted to enter R45 room during evening cares stating that she had a book for R45. Staff was able to verbally redirect R27. During the month of March 2015, the facility documented the following behaviors in the progress notes: 3/7/15: Resident walked up to NA and a female resident (unknown)...and [exposed herself] and CNA [certified nursing assistant]." 3/8/15: Resident was seen by NA, as she passed by a R45's room, and exposed herself. 3/8/15: R27 was overheard while helping another resident through the closed shared bathroom door, involved in a sexual interaction with R45. Administrator and DON were made aware of the incident. R27's Social Service Assessment dated 3/27/15, indicated the family and facility had noted resident making socially inappropriate comments. The assessment indicated R27's Alzheimer's disease was progressing, and she was displaying behaviors she never had before. Further, the assessment identified, "...due to current state of cognition and resident's lack of ability to comprehend complex things, [family member] [FM]-A does the majority of the decision making for the best interest of the resident's care and safety." The assessment did not identify any	F 309	-Fall/Safety assessment modified to reflect/review foot/feet support while in wheelchair, if applicable and is performed per MDS schedule/sig changes - DON responsible for correction.	

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F 309	Continued From page 3	F 309		

potential rationale for the sudden increase in sexual behaviors, nor whether R27 had the mental capacity to make a decision to engage in a sexual relationship with another resident (R45) despite her cognitive impairment.

During the month of April 2015, the facility documented the following behaviors in the progress notes:
4/8/15: R27 was observed by a NA during an interaction with R45.
4/10/15: R27 was observed in R45's room exposed.
4/22/15: R27 was very aggressively tugging and pulling on a nurse's arm and pulling writer closer to her continuously saying, 'I like you, don't you like me?'
4/22/15: R27 was observed involved in an interaction with R45. Staff documentation following the encounter indicated they had ensured both residents "were safe."

R27's medical record included a Physician Call Fax dated 4/23/15, that identified, "Resident [R27] has been sexually aggressive with staff and residents and behavior is increasingly disturbing. Is there any medication that can decrease sexual behavior?" The physician had responded with an order for, "Celexa [an anti-depressant] 10 mg [milligrams] i [one] PO [by mouth] daily", with a diagnosis of, "Dementia [with] behavioral disturbance." The note did not identify any assessment of R27's change and increase in sexual behavior, nor was there a documented assessment of R27's mental capacity to make decisions about a sexual relationship.

Progress notes of 4/27/15, identified a late entry on this date that R27 had fallen off R45's bed,

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F 309	Continued From page 4	F 309		

resulting in no injury. The note also referenced the initiation of medication 4/23/15, due to R27's increased sexual displays towards R45 and staff.

In further review of R27's progress notes, a note dated 4/24/15, indicated the facility's licensed social worker (LSW) had contacted R27's family (FM-A) in regards to the new medication ordered due to aggressive sexual behaviors. The documentation indicated staff had noticed an increase in her grabbing out at the male nurses, making more sexually inappropriate comments to staff and making more of these comments in public areas. The LSW also informed FM-A, that R27 had been engaging in a sexual relationship for quite a while with a male resident that continued to progress. The documentation indicated FM-A had asked the LSW if the facility could restrict these visits, and the LSW had responded that R27's rights would then be restricted, and that FM-A should talk with R27's physician. There was still no indication the facility had assessed the resident's increase in behaviors, nor had they assessed R27's mental capacity to determine whether she could consent to a sexual relationship.

A progress note documented by LSW on 4/28/15, indicated the LSW had received a phone call from FM-A. The note indicated FM-A had scheduled a doctor's (medical doctor) appointment with R27's primary physician for 5/5/15. The note further indicated FM-A wanted information for obtaining guardianship and/or conservatorship of R27, and documented FM-A's concern that R27 would have never been engaged in this type of behavior previously. A note later that day, indicated that the LSW had provided FM-A's requested information and

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F 309	Continued From page 5	F 309		

discussed the upcoming 5/5/15 doctor's appointment, as well as talking about getting some neuropsych testing done to see where the resident was with her mental competency and capacity.

Progress notes from 5/7/15 documented a conversation between LSW and FM-A in regards to R27's medical appointment on 5/5/15. The notes indicated FM-A had stated the appointment went well and that FM-A would possibly be pursuing guardianship. FM-A had stated that MD-A had informed him these behaviors would most likely resurface.

R27's care plan last reviewed 6/16/15, identified R27 as having, "Impaired cognitive function r/t [related to] Alzheimer's Disease AEB [as evidenced by] BIMS score, confusion (initiated on 10/31/13)." The facility identified an intervention to "communicate regarding resident's capability and needs, allow her to make decisions as she is able regarding tasks of daily living and activities." The facility identified that R27 had behaviors (initiated on 10/31/13) which was revised on 3/8/15 and 4/41/15 to include "Alteration in behavior r/t Alzheimer's AEB (as evidenced by) ....."Resident desires sexual activity AEB history of seeking out male residents, allowing male resident in room." The care plan did not identify a rationale for R27's behaviors, nor any facility assessment to determine whether R27 had the mental capacity to make a decision to engage in a sexual relationship despite being identified as having severe cognitive impairment and confusion.

During interview on 7/14/15, at 3:50 p.m. licensed social worker LSW-A stated that R27's behaviors were felt by both FM-A and MD-A to be "not her

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F 309	Continued From page 6	F 309		

[R27] nature", and that the behaviors were thought to have been more cognitive loss and illness based. However, LSW-A said the facility had wanted to honor R27's rights, so they'd consulted with the regional Ombudsman (an official appointed as an advocate for a resident and their rights) in an attempt to "make the best decision" for R27. R27's record was reviewed and lacked any documentation indicating what had been decided between the Ombudsman and facility. LSW-A stated that FM-A expressed concerns regarding R27's ability to make the decision to engage in a sexual relationship, and verified FM-A had been encouraged by the facility to consult with R27's physician, and to obtain a neurology consultation. However, no neurological consultation had been completed for R27 to date. Further, LSW-A stated she was not aware if R27's physician had ever been included or consulted in determining if R27 had the mental capacity to make a decision to engage in a sexual relationship other than when staff had requested the medication intervention 4/23/15 related to R27's hyper-sexuality.

R27's physician's progress note from MD-A dated 5/5/15 identified, "She has definitely had a reduction in behaviors. Part of it is her [FM-A] addressing her aggressive sexual behaviors and creating boundaries for her in addition to the medication." This progress note from MD-A also documented the following: "They [the facility] are a little concerned though; they say she seems a little bit more distant and withdrawn; her son has not witnessed this."

In a telephone interview on 7/15/15, at 10:30 a.m. MD-A stated she had met with R27 in the clinic back in May 2015 with FM-A for a re-check after

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F 309	Continued From page 7	F 309		

having starting Celexa for dementia with sexual behaviors. MD-A stated that even with R27's Alzheimer's dementia, the resident had the mental capacity to make decisions and comprehend the consequences back when the relationship had started to progress, however MD-A stated currently, the resident (R27) no longer has that ability. Further, MD-A stated the facility had never consulted with her regarding cognitive assessment of R27's mental capacity or her ability to make decisions at the time when her sexual behaviors had been progressing.

During interview on 7/16/15, at 11:00 a.m. with the facility administrator, LSW-A and director of nursing (DON), the surveyor informed the facility of the conversation with MD-A, in regards to the lack of assessment regarding R27's mental capacity to take part in a sexual relationship. The facility was unaware MD-A felt R27 currently lacked capacity to make a decision in regards to a sexual relationship. LSW-A stated the facility lacked documentation that R27 had been assessed earlier in the year when the behaviors began, nor had she been reassessed since a recent hospitalization which had resulted in further mental status change.

Although the facility had identified R27 as being cognitively impaired and demonstrating increased sexual behaviors, which was new for R27, the facility had not completed a comprehensive assessment of the behaviors to determine why there was a change. In addition, there was no indication the facility had completed an assessment to determine whether R27 had the mental capacity to make a decision to be in a consenting sexual relationship, nor had they consulted with a medical professional who would

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F 309	Continued From page 8 be capable of assisting the facility in making a determination of mental capacity. POSITIONING: R42's quarterly Minimum Data Set (MDS) dated 5/8/15, identified R42 had severe cognitive impairment, required extensive assistance for activities of daily living (ADLs), and used a wheelchair for her mobility. During observation on 7/13/15, at 6:59 p.m. R42 was seated in her room watching television (TV). She was seated in a standard sized wheelchair, however only had one foot pedal in place on the right side causing her left foot to dangle un-supported. R42's foot did not touch the floor. R42 stated she did not know where her other foot pedal was, "What foot pedals?" On 7/14/15, at 8:20 a.m. R42 was seated in her wheelchair at a table in the dining room eating breakfast. R42 continued to have one right foot pedal only, her left foot was dangling un-supported. R42's left foot was approximately 4 to 5 inches from the floor. On 7/15/15, at 7:31 a.m. R42 was seated in her wheelchair in the hair salon underneath a hair dryer. R42 had no foot pedals on the chair, causing both of her feet to dangling un-supported approximately 4-5 inches from the floor. During interview on 7/15/15, at 8:52 a.m. nursing assistant (NA)-B stated R42 used to have two foot pedals, but was not sure where the other pedal was anymore. She (R42) has not had any supportive devices under her legs or feet for "a long time." Further, NA-B stated she looked through R42's room and was unable to find the other wheelchair pedal (left side) for R42's wheelchair.	F 309		

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F 309	Continued From page 9 When interviewed on 7/15/15, at 12:26 p.m. licensed practical nurse (LPN)-A observed R42 seated in her wheelchair with her left foot un-supported. LPN-A stated she seldom had seen R42 use both foot pedals on her wheelchair. Further, LPN-A stated R42 had "4 to 6 inches" of space from her feet to the floor, and added foot pedals (when used) should be at a comfortable position for the resident and "not too long or too short." R42 was observed seated in her wheelchair with her left foot un-supported with physical therapist (PT)-A on 7/15/15, at 12:51 p.m. PT-A stated R42 likes to be mobile in her chair, but "probably needs two foot rests." The occupational therapist (OT) had last seen her (R42) in March 2015, and no recommendations or discussion of wheelchair positioning had been made at that time. PT-A stated the residents (R42's) legs were at risk for stiffness, pain, and contracture if left un-supported. Nursing staff should have consulted with the OT for R42 positioning concerns and to, "Try to get an order to do some positioning." A facility wheelchair positioning policy was requested, but none was provided.	F 309		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 356		8/21/15

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F 356	Continued From page 10 resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to post the required information for nursing hours in a timely manner on a daily basis. This had the potential to affect all 56 residents residing in the facility, staff, and visitors who wished to review the information. Findings include: During the initial tour of the facility on 7/13/15, at 1:29 p.m. the facility staff postings dated 7/10/15, 7/11/15, and 7/12/15, were posted on a bulletin board near the facility entrance. The documents	F 356	Staffing to be posted per requirement. Education provided to staff responsible for positing. Policy updated for change in practice/responsibility. Monitoring will be conducted to ensure timely posting- Schedule of monitoring will be as follows: Daily for 1 week, twice weekly for two weeks, and weekly until the next QAU meeting. Results will be reviewed at QAU and further monitoring will be scheduled if needed. Administrator responsible for correction/compliance	

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F 356	Continued From page 11 displayed the facility name, census, staff type, number of staff, shift time, number of staff members, and total hours worked. However, there was no posted information visible regarding the staffing for the current day, 7/13/15. During interview on 7/14/15, at 9:26 a.m. the facility receptionist (FR) stated she was the person responsible for posting the staff schedule but "forgot to hang the posting up yesterday before I left." When interviewed on 7/15/14, at 12:30 p.m. the administrator stated the lack of posting on 7/13/15 was "an oversite", and added it would be fixed "going forward." A facility Staff Posting of Hours policy dated 10/15/07, identified, "It is the procedure of Central Todd County to post nursing staff hours in accordance with Federal law. Each morning the Health Unit Coordinator (HUC) will post the nursing staff hours as worked. Should a change occur in the AM or PM staffing prior to the HUC leaves work. The HUC will make adjustments. On weekends available staff will make adjustments before leaving. "	F 356		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		8/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 12 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to develop an infection control program to include the trending and analysis of collected infection data to reduce the risk of transmission to other residents in the facility. This had potential to affect all 56 residents whom resided in the facility.	F 441	-"Infection Control Program Protocol" policy was revised to include more specific and directed analysis -"Infection/Antibiotic Monthly Tracking Record" was revised to add demographic information and signs/symptoms start and end date. -Infections Monitored on facility map	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING _____ B. WING _____	07/16/2015

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

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F 441	Continued From page 13 Findings include: A facility Infection/Antibiotic Monthly Tracking Record dated June 2015, identified the following infections: 1 prophylaxis, 1 surgical site, 6 UTI (urinary tract infection), 1 incision, 1 Bells Palsy (paralysis of the facial nerve), and 2 skin. The report identified each specific resident, the organism identified, the antibiotic it was treated with, and the antibiotic start and stop dates. The record did not identify what signs or symptoms each resident had, when the signs or symptoms of infection started or ended, what room each resident resided in, or any analysis of the collected data to determine if potentially infectious disease was spreading in the facility or if education to the staff was deemed necessary. A facility Monthly Infection Tracking sheet dated June 2015, identified a map of the facility, and a legend of colors representing the following type of infections: UTI, C. Diff (clostridium difficle, a bacteria which can caused inflammation of the colon), MDRO (multi-drug resistant organism), pneumonia, influenza, bronchitis, cold s/sx (signs and symptoms). The map had 5 separate rooms colored identifying those residents as have a UTI. The map did not identify which resident(s) had the surgical infection, incisional infection, of skin infections as identified by the Infection/Antibiotic Monthly Tracking Record. A facility Infection/Antibiotic Monthly Tracking Record dated May 2015, identified the following infections: 1 prophylaxis, 1 conjunctivitis, 2 UTI, 1 incision, 1 otitis media (middle ear infection), 1 suprapubic site, 1 cellulitis, and 3 pneumonia. In addition, the identified organism responsible for the case of conjunctivitis was identified as being caused by methicillin-resistant staphylococcus	F 441	revised to include more infections, as well as the infection tracking record -Infection control audit template was revised to include additional infection types. -Audit results, monthly tracking maps/logs will be reviewed at monthly Saftey meeting as well as quarterly QA meeting. -Alternate RN designated and trained as backup in the event of Infection Control Nurse attrition. DON responsible for correction of citation.	

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F 441	Continued From page 14 aureus (MRSA, a bacteria resistant to several antibiotics). The record did not identify what signs or symptoms each resident had, when the signs or symptoms of infection started or ended, what room each resident resided in, or any analysis of the collected data to determine if potentially infectious disease was spreading in the facility or if education to the staff was deemed necessary. A facility Monthly Infection Tracking sheet dated May 2015, identified a map of the facility, and a legend of colors representing the following type of infections: UTI, C. Diff, MDRO, pneumonia, influenza, bronchitis, cold s/sx. The map had 6 separate rooms colored identifying the following infections: 2 UTI, 3 pneumonia, and 1 MDRO. The map did not identify which resident(s) had the incisional infection, the otitis media infection, the suprapubic site infection, or the cellulitis infection as identified by the Infection/Antibiotic Monthly Tracking Record. A facility Infection/Antibiotic Monthly Tracking Record dated April 2015, identified the following infections: 1 prophylaxis, 1 conjunctivitis, 4 UTI, 1 otitis media, 1 herpes zoster (shingles), 1 rash/skin, and 1 pneumonia. In addition, the identified organism responsible for the case of pneumonia was identified as being caused by methicillin-resistant staphylococcus aureus (MRSA, a bacteria resistant to several antibiotics). The record did not identify what signs or symptoms each resident had, when the signs or symptoms of infection started or ended, what room each resident resided in, or any analysis of the collected data to determine if potentially infectious disease was spreading in the facility or if education to the staff was deemed necessary. A facility Monthly Infection Tracking sheet dated April 2015, identified a map of the	F 441		

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F 441	Continued From page 15	F 441		

facility, and a legend of colors representing the following type of infections: UTI, C. Diff, MDRO, pneumonia, influenza, bronchitis, cold s/sx. The map had 6 separate rooms colored identifying the following infections: 5 UTI, and 1 pneumonia. The map did not identify which resident(s) had the herpes zoster infection, otitis media infection, rash/skin infection, or the MRSA pneumonia as identified by the Infection/Antibiotic Monthly Tracking Record.

When interviewed about the infection control program on 7/16/15, at 9:51 a.m. registered nurse (RN)-A stated she was responsible for the program. The infection data is gathered from review of a 24 hour report, along with nurses who "let me know" about new signs and symptoms of potential infections and/or antibiotics being started. The program uses an on-going surveillance, and the identified data (Infection/Antibiotic Monthly Tracking Records) is all she used adding, "this is the data." The analysis of the data is completed by herself on an "on-going" basis, and if concerns were noted with potential trends of infections, RN-A stated she would go out and perform some audits and make sure good hand hygiene was being followed. Further, RN-A stated her analysis, and completed audits and education completed with past identified trends had not been documented, "I didn't write anything down for that."

During a subsequent interview on 7/16/15, at 10:57 a.m. RN-A stated the data was reviewed at the facility's Quality Assurance (QA) meeting, but no analysis of it is completed or action plans created to reduce the risk of infection transmission in the facility. Further, residents who develop signs and symptoms of infection are

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F 441	Continued From page 16 tracked on a different "symptom tracker" form, but one for 2015 was not available as no residents had developed signs and symptoms of infection needing to be placed on the form. A facility Infection Control Program Protocol policy dated 5/2015, identified, "The purpose of the infection control program is to closely monitor, track, trend, and investigate infections within CTCCC [the facility], and educate staff on infection control and prevention." Further, the policy identified how the infection control program data was collected, but lacked any guidance or procedure for how to complete the analysis of the data, or develop action plans to reduce the spread of infection in the facility.	F 441		

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	245521	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/14/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Central Todd County Care Center 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or Or by email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/12/2015

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.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Central Todd County Care Center is a 1-story building without a basement. The building was constructed at 4 different times. The original building was constructed in 1976 and was determined to be of Type V(111) construction. In 1985, an addition was added to the service wing on the south side and was determined to be of Type V(111). In 1992 an activities/ physical therapy addition was added to the east end of A Wing and was determined to be of Type V(111) construction. In 2002 additions were added to west end of D Wing, to the main entrance and between E and D wings dining room, all of which are Type V(111) construction. An assisted living apartment building is attached to the B wing which is separated by a 2-hour fire barrier. The north end of E wing are apartments and separated from the nursing home with a 2-hour fire barrier. The building is divided into 4 smoke zones by 2 hour fire barriers.	K 000		

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	245521	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/14/2015**

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K 000	Continued From page 2 The building is protected by a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The 2002/ 2003 addition has smoke detection in the sleeping rooms, with automatic fire detection installed in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 60 beds and had a census of 56 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9.3, and 19.2.9.1. This deficient practice could 10 of 60 residents, staff and visitors in the event of an emergency evacuation during a power outage.	K 046	Annual testing of the Emergency lighting indicated will be scheduled as part of the routine maintenance/inspection that satisfies 7.9.19.2.9.1 Maintenance Supervisor will be responsible for performing and documenting outcome of the emergency lighting testing.	8/21/15

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	245521	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/14/2015**

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K 046	Continued From page 3 Findings include: On facility tour between 8:30 AM to 12:30 PM on 07/14/2015, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Supervisor (CB) revealed the that the facility failed to conduct the required annual 90 minute testing of the battery backup emergency lights. This deficient practices was confirmed by the Maintenance Supervisor (CB).	K 046		
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that automatic smoke detectors have not been installed in all spaces open to the corridors in accordance with NFPA 72 " The National Fire Alarm Code" 1999 Edition section 2-1.3.3 and the Minnesota State Fire Code (2007) section 907.2.6.3. Lack of complete automatic smoke detector coverage may cause a delay in fire alarm activation negatively impact 10 of 60 residents, staff and visitors. Findings include:	K 054	Smoke detector(s) will be installed in the living room (onsite known as TV room) indicated. Once installed, this smoke detector will be maintained as per current policy and schedule. Scheduling of installation, and oversight of maintenance is the responsibility of the Maintenance Supervisor.	9/1/15

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K 054	Continued From page 4 On facility tour between 8:30 AM to 12:30 PM on 07/14/2015, observations revealed that the living room located next to the main nurses station is open to the corridor and is not protected with a smoke detector. This deficient practices was confirmed by the Maintenance Supervisor (CB).	K 054		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that	K 056	Sprinklers have been schedule to be replaced with sprinkler head appropriate for their position. Maintenance supervisor is responsible for scheduling and oversight of documentation for replacement sprinkler heads.	9/1/15

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K 056	Continued From page 5 would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 8:30 AM to 12:30 PM on 07/14/2015, observations have revealed that there are 3 side wall sprinkler heads that were installed outside of the kitchens freezer are upright sidewall sprinkler heads that have been installed as if they are a pendant style sprinkler. The current installation of the heads will not provide complete coverage for the affected area. This deficient practices was confirmed by the Maintenance Supervisor (CB).	K 056		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 3, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5521024

Dear Mr. Polovick:

The above facility was surveyed on July 13, 2015 through July 16, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted 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 only a suggestion 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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 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:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Brenda.Fischer@state.mn.us
Telephone: (320) 223-7338 Fax: (320) 223-7348

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.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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	00761	A. BUILDING: _____ B. WING _____	07/16/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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	00761	A. BUILDING: _____ B. WING _____	07/16/2015

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On July 13-16, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 830	Continued From page 2	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the change in behavior for 1 of 1 cognitively impaired residents (R27) who was involved in a sexual relationship with another resident (R45). Furthermore, the facility failed to ensure proper leg support was provided for 1 of 3 residents (R42) reviewed for positioning and whose legs were not supported in her wheelchair. Findings include: CHANGE OF BEHAVIOR R27's quarterly Minimum Data Set (MDS), dated 3/27/15, identified R27 was independent with transfers and ambulation, had Alzheimer's disease (progressive disease that destroys memory and other mental function), and severe cognitive impairment.	2 830	Corrected	8/21/15

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2 830	Continued From page 3 R27's annual MDS, dated 9/29/14, indicated that this resident was able to express preferences, and displayed no behaviors. However, the MDS prompted the facility to determine if a "brief interview for mental status be conducted?" The facility identified this as "no, resident is rarely/never understood." The MDS process directed the facility staff to skip assessment of mental status. R27's mental status was determined to be moderate cognitively impaired. Review of R27's progress notes, dated 1/31/15 to 6/7/15, identified new escalating sexual behaviors were occurring with resident R45. Review of R45's admission MDS, dated 1/15/15 and subsequent 4/14/15 quarterly MDS, both indicated R45 was cognitively intact. During the month of January 2015, the facility documented the following behavior in the progress notes: 1/31/15: R27 made comments about her sexual readiness. A review of R27's quarterly MDS dated 12/29/14, indicated R27 had severe cognitive impairment, with no behaviors observed, and no acute onset of mental status change. This was a change from the previous MDS of 9/29/14 when she had been identified as moderately cognitively impaired. During the month of February 2015, the facility had documented the following behaviors in the progress notes: 2/15/15: a NA (nursing assistant) requested that the licensed social worker come to a resident's (R45) room. R27 was there and would not leave making sexually explicit comments to resident (R45). Staff asked R27 to leave the room, which R27 eventually did, however, R27 later returned. R45 informed the staff that R27's comments	2 830		

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2 830	Continued From page 4	2 830		

make him uncomfortable.
2/17/15: "[R27] Made the following comments to NA 'I have a boyfriend..."
2/21/15: R27 attempted to enter R45 room during evening cares stating that she had a book for R45. Staff was able to verbally redirect R27.

During the month of March 2015, the facility documented the following behaviors in the progress notes:
3/7/15: Resident walked up to NA and a female resident (unknown)...and [exposed herself] and CNA [certified nursing assistant]."
3/8/15: Resident was seen by NA, as she passed by a R45's room, and exposed herself.
3/8/15: R27 was overheard while helping another resident through the closed shared bathroom door, involved in a sexual interaction with R45. Administrator and DON were made aware of the incident.

R27's Social Service Assessment dated 3/27/15, indicated the family and facility had noted resident making socially inappropriate comments. The assessment indicated R27's Alzheimer's disease was progressing, and she was displaying behaviors she never had before. Further, the assessment identified, "...due to current state of cognition and resident's lack of ability to comprehend complex things, [family member] [FM]-A does the majority of the decision making for the best interest of the resident's care and safety." The assessment did not identify any potential rationale for the sudden increase in sexual behaviors, nor whether R27 had the mental capacity to make a decision to engage in a sexual relationship with another resident (R45) despite her cognitive impairment.

During the month of April 2015, the facility

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2 830	Continued From page 5	2 830		

documented the following behaviors in the progress notes:
4/8/15: R27 was observed by a NA during an interaction with R45.
4/10/15: R27 was observed in R45's room exposed.
4/22/15: R27 was very aggressively tugging and pulling on a nurse's arm and pulling writer closer to her continuously saying, 'I like you, don't you like me?'
4/22/15: R27 was observed involved in an interaction with R45. Staff documentation following the encounter indicated they had ensured both residents "were safe."

R27's medical record included a Physician Call Fax dated 4/23/15, that identified, "Resident [R27] has been sexually aggressive with staff and residents and behavior is increasingly disturbing. Is there any medication that can decrease sexual behavior?" The physician had responded with an order for, "Celexa [an anti-depressant] 10 mg [milligrams] i [one] PO [by mouth] daily", with a diagnosis of, "Dementia [with] behavioral disturbance." The note did not identify any assessment of R27's change and increase in sexual behavior, nor was there a documented assessment of R27's mental capacity to make decisions about a sexual relationship.

Progress notes of 4/27/15, identified a late entry on this date that R27 had fallen off R45's bed, resulting in no injury. The note also referenced the initiation of medication 4/23/15, due to R27's increased sexual displays towards R45 and staff.

In further review of R27's progress notes, a note dated 4/24/15, indicated the facility's licensed social worker (LSW) had contacted R27's family (FM-A) in regards to the new medication ordered

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2 830	Continued From page 6 due to aggressive sexual behaviors. The documentation indicated staff had noticed an increase in her grabbing out at the male nurses, making more sexually inappropriate comments to staff and making more of these comments in public areas. The LSW also informed FM-A, that R27 had been engaging in a sexual relationship for quite a while with a male resident that continued to progress. The documentation indicated FM-A had asked the LSW if the facility could restrict these visits, and the LSW had responded that R27's rights would then be restricted, and that FM-A should talk with R27's physician. There was still no indication the facility had assessed the resident's increase in behaviors, nor had they assessed R27's mental capacity to determine whether she could consent to a sexual relationship. A progress note documented by LSW on 4/28/15, indicated the LSW had received a phone call from FM-A. The note indicated FM-A had scheduled a doctor's (medical doctor) appointment with R27's primary physician for 5/5/15. The note further indicated FM-A wanted information for obtaining guardianship and/or conservatorship of R27, and documented FM-A's concern that R27 would have never been engaged in this type of behavior previously. A note later that day, indicated that the LSW had provided FM-A's requested information and discussed the upcoming 5/5/15 doctor's appointment, as well as talking about getting some neuropsych testing done to see where the resident was with her mental competency and capacity. Progress notes from 5/7/15 documented a conversation between LSW and FM-A in regards to R27's medical appointment on 5/5/15. The	2 830		

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2 830	Continued From page 7	2 830		

notes indicated FM-A had stated the appointment went well and that FM-A would possibly be pursuing guardianship. FM-A had stated that MD-A had informed him these behaviors would most likely resurface.

R27's care plan last reviewed 6/16/15, identified R27 as having, "Impaired cognitive function r/t [related to] Alzheimer's Disease AEB [as evidenced by] BIMS score, confusion (initiated on 10/31/13)." The facility identified an intervention to "communicate regarding resident's capability and needs, allow her to make decisions as she is able regarding tasks of daily living and activities." The facility identified that R27 had behaviors (initiated on 10/31/13) which was revised on 3/8/15 and 4/41/15 to include "Alteration in behavior r/t Alzheimer's AEB (as evidenced by) ....."Resident desires sexual activity AEB history of seeking out male residents, allowing male resident in room." The care plan did not identify a rationale for R27's behaviors, nor any facility assessment to determine whether R27 had the mental capacity to make a decision to engage in a sexual relationship despite being identified as having severe cognitive impairment and confusion.

During interview on 7/14/15, at 3:50 p.m. licensed social worker LSW-A stated that R27's behaviors were felt by both FM-A and MD-A to be "not her [R27] nature", and that the behaviors were thought to have been more cognitive loss and illness based. However, LSW-A said the facility had wanted to honor R27's rights, so they'd consulted with the regional Ombudsman (an official appointed as an advocate for a resident and their rights) in an attempt to "make the best decision" for R27. R27's record was reviewed and lacked any documentation indicating what had been decided between the Ombudsman and

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2 830	Continued From page 8	2 830		

facility. LSW-A stated that FM-A expressed concerns regarding R27's ability to make the decision to engage in a sexual relationship, and verified FM-A had been encouraged by the facility to consult with R27's physician, and to obtain a neurology consultation. However, no neurological consultation had been completed for R27 to date. Further, LSW-A stated she was not aware if R27's physician had ever been included or consulted in determining if R27 had the mental capacity to make a decision to engage in a sexual relationship other than when staff had requested the medication intervention 4/23/15 related to R27's hyper-sexuality.

R27's physician's progress note from MD-A dated 5/5/15 identified, "She has definitely had a reduction in behaviors. Part of it is her [FM-A] addressing her aggressive sexual behaviors and creating boundaries for her in addition to the medication." This progress note from MD-A also documented the following: "They [the facility] are a little concerned though; they say she seems a little bit more distant and withdrawn; her son has not witnessed this."

In a telephone interview on 7/15/15, at 10:30 a.m. MD-A stated she had met with R27 in the clinic back in May 2015 with FM-A for a re-check after having starting Celexa for dementia with sexual behaviors. MD-A stated that even with R27's Alzheimer's dementia, the resident had the mental capacity to make decisions and comprehend the consequences back when the relationship had started to progress, however MD-A stated currently, the resident (R27) no longer has that ability. Further, MD-A stated the facility had never consulted with her regarding cognitive assessment of R27's mental capacity or her ability to make decisions at the time when her

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2 830	Continued From page 9 sexual behaviors had been progressing. During interview on 7/16/15, at 11:00 a.m. with the facility administrator, LSW-A and director of nursing (DON), the surveyor informed the facility of the conversation with MD-A, in regards to the lack of assessment regarding R27's mental capacity to take part in a sexual relationship. The facility was unaware MD-A felt R27 currently lacked capacity to make a decision in regards to a sexual relationship. LSW-A stated the facility lacked documentation that R27 had been assessed earlier in the year when the behaviors began, nor had she been reassessed since a recent hospitalization which had resulted in further mental status change. Although the facility had identified R27 as being cognitively impaired and demonstrating increased sexual behaviors, which was new for R27, the facility had not completed a comprehensive assessment of the behaviors to determine why there was a change. In addition, there was no indication the facility had completed an assessment to determine whether R27 had the mental capacity to make a decision to be in a consenting sexual relationship, nor had they consulted with a medical professional who would be capable of assisting the facility in making a determination of mental capacity. R42's quarterly Minimum Data Set (MDS) dated 5/8/15, identified R42 had severe cognitive impairment, required extensive assistance for activities of daily living (ADLs), and used a wheelchair for her mobility. During observation on 7/13/15, at 6:59 p.m. R42 was seated in her room watching television (TV).	2 830		

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2 830	Continued From page 10 She was seated in a standard sized wheelchair, however only had one foot pedal in place on the right side causing her left foot to dangle un-supported. R42's foot did not touch the floor. R42 stated she did not know where her other foot pedal was, "What foot pedals?" On 7/14/15, at 8:20 a.m. R42 was seated in her wheelchair at a table in the dining room eating breakfast. R42 continued to have one right foot pedal only, her left foot was dangling un-supported. R42's left foot was approximately 4 to 5 inches from the floor. On 7/15/15, at 7:31 a.m. R42 was seated in her wheelchair in the hair salon underneath a hair dryer. R42 had no foot pedals on the chair, causing both of her feet to dangling un-supported approximately 4-5 inches from the floor. During interview on 7/15/15, at 8:52 a.m. nursing assistant (NA)-B stated R42 used to have two foot pedals, but was not sure where the other pedal was anymore. She (R42) has not had any supportive devices under her legs or feet for "a long time." Further, NA-B stated she looked through R42's room and was unable to find the other wheelchair pedal (left side) for R42's wheelchair. When interviewed on 7/15/15, at 12:26 p.m. licensed practical nurse (LPN)-A observed R42 seated in her wheelchair with her left foot un-supported. LPN-A stated she seldom had seen R42 use both foot pedals on her wheelchair. Further, LPN-A stated R42 had "4 to 6 inches" of space from her feet to the floor, and added foot pedals (when used) should be at a comfortable position for the resident and "not too long or too short." R42 was observed seated in her wheelchair with her left foot un-supported with physical therapist	2 830		

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2 830	Continued From page 11 (PT)-A on 7/15/15, at 12:51 p.m. PT-A stated R42 likes to be mobile in her chair, but "probably needs two foot rests." The occupational therapist (OT) had last seen her (R42) in March 2015, and no recommendations or discussion of wheelchair positioning had been made at that time. PT-A stated the residents (R42's) legs were at risk for stiffness, pain, and contracture if left un-supported. Nursing staff should have consulted with the OT for R42 positioning concerns and to, "Try to get an order to do some positioning." A facility wheelchair positioning policy was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director or nursing or designee could inservice staff regarding the identification and correction of residents found to not be using foot pedals, then audit to ensure compliance. The social services director or designee (s)could review and revise policies and procedures related to assessment of behaviors and mental capacity for individual residents who are involved in a personal relationship. The social services director or designee could develop a system to educate staff and complete a monitoring system to ensure residents behavioral assessments are accurate and up to date. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 830		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection	21390		8/21/15

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21390	Continued From page 12 control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review te facility failed to develop an infection control program to include the trending and analysis of collected infection data to reduce the risk of transmission to other residents in the facility. This had potential to affect all 56 residents whom resided in the facility. Findings include:	21390	Corrected	

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21390	Continued From page 13 A facility Infection/Antibiotic Monthly Tracking Record dated June 2015, identified the following infections: 1 prophylaxis, 1 surgical site, 6 UTI (urinary tract infection), 1 incision, 1 Bells Palsy (paralysis of the facial nerve), and 2 skin. The report identified each specific resident, the organism identified, the antibiotic it was treated with, and the antibiotic start and stop dates. The record did not identify what signs or symptoms each resident had, when the signs or symptoms of infection started or ended, what room each resident resided in, or any analysis of the collected data to determine if potentially infectious disease was spreading in the facility or if education to the staff was deemed necessary. A facility Monthly Infection Tracking sheet dated June 2015, identified a map of the facility, and a legend of colors representing the following type of infections: UTI, C. Diff (clostridium difficle, a bacteria which can caused inflammation of the colon), MDRO (multi-drug resistant organism), pneumonia, influenza, bronchitis, cold s/sx (signs and symptoms). The map had 5 separate rooms colored identifying those residents as have a UTI. The map did not identify which resident(s) had the surgical infection, incisional infection, of skin infections as identified by the Infection/Antibiotic Monthly Tracking Record. A facility Infection/Antibiotic Monthly Tracking Record dated May 2015, identified the following infections: 1 prophylaxis, 1 conjunctivitis, 2 UTI, 1 incision, 1 otitis media (middle ear infection), 1 suprapubic site, 1 cellulitis, and 3 pneumonia. In addition, the identified organism responsible for the case of conjunctivitis was identified as being caused by methicillin-resistant staphylococcus aureus (MRSA, a bacteria resistant to several antibiotics). The record did not identify what	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00761	A. BUILDING: _____ B. WING _____	07/16/2015

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21390	Continued From page 14 signs or symptoms each resident had, when the signs or symptoms of infection started or ended, what room each resident resided in, or any analysis of the collected data to determine if potentially infectious disease was spreading in the facility or if education to the staff was deemed necessary. A facility Monthly Infection Tracking sheet dated May 2015, identified a map of the facility, and a legend of colors representing the following type of infections: UTI, C. Diff, MDRO, pneumonia, influenza, bronchitis, cold s/sx. The map had 6 separate rooms colored identifying the following infections: 2 UTI, 3 pneumonia, and 1 MDRO. The map did not identify which resident(s) had the incisional infection, the otitis media infection, the suprapubic site infection, or the cellulitis infection as identified by the Infection/Antibiotic Monthly Tracking Record. A facility Infection/Antibiotic Monthly Tracking Record dated April 2015, identified the following infections: 1 prophylaxis, 1 conjunctivitis, 4 UTI, 1 otitis media, 1 herpes zoster (shingles), 1 rash/skin, and 1 pneumonia. In addition, the identified organism responsible for the case of pneumonia was identified as being caused by methicillin-resistant staphylococcus aureus (MRSA, a bacteria resistant to several antibiotics). The record did not identify what signs or symptoms each resident had, when the signs or symptoms of infection started or ended, what room each resident resided in, or any analysis of the collected data to determine if potentially infectious disease was spreading in the facility or if education to the staff was deemed necessary. A facility Monthly Infection Tracking sheet dated April 2015, identified a map of the facility, and a legend of colors representing the following type of infections: UTI, C. Diff, MDRO, pneumonia, influenza, bronchitis, cold s/sx. The	21390		

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21390	Continued From page 15 map had 6 separate rooms colored identifying the following infections: 5 UTI, and 1 pneumonia. The map did not identify which resident(s) had the herpes zoster infection, otitis media infection, rash/skin infection, or the MRSA pneumonia as identified by the Infection/Antibiotic Monthly Tracking Record. When interviewed about the infection control program on 7/16/15, at 9:51 a.m. registered nurse (RN)-A stated she was responsible for the program. The infection data is gathered from review of a 24 hour report, along with nurses who "let me know" about new signs and symptoms of potential infections and/or antibiotics being started. The program uses an on-going surveillance, and the identified data (Infection/Antibiotic Monthly Tracking Records) is all she used adding, "this is the data." The analysis of the data is completed by herself on an "on-going" basis, and if concerns were noted with potential trends of infections, RN-A stated she would go out and perform some audits and make sure good hand hygiene was being followed. Further, RN-A stated her analysis, and completed audits and education completed with past identified trends had not been documented, "I didn't write anything down for that." During a subsequent interview on 7/16/15, at 10:57 a.m. RN-A stated the data was reviewed at the facility's Quality Assurance (QA) meeting, but no analysis of it is completed or action plans created to reduce the risk of infection transmission in the facility. Further, residents who develop signs and symptoms of infection are tracked on a different "symptom tracker" form, but one for 2015 was not available as no residents had developed signs and symptoms of infection needing to be placed on the form.	21390		

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21390	Continued From page 16 A facility Infection Control Program Protocol policy dated 5/2015, identified, "The purpose of the infection control program is to closely monitor, track, trend, and investigate infections within CTCCC [the facility], and educate staff on infection control and prevention." Further, the policy identified how the infection control program data was collected, but lacked any guidance or procedure for how to complete the analysis of the data, or develop action plans to reduce the spread of infection in the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review their infection control program to ensure policies and procedures are established to include the analysis of collected data, inservice staff regarding policy and procedure, and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On July 13-16, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 830	Continued From page 2	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the change in behavior for 1 of 1 cognitively impaired residents (R27) who was involved in a sexual relationship with another resident (R45). Furthermore, the facility failed to ensure proper leg support was provided for 1 of 3 residents (R42) reviewed for positioning and whose legs were not supported in her wheelchair. Findings include: CHANGE OF BEHAVIOR R27's quarterly Minimum Data Set (MDS), dated 3/27/15, identified R27 was independent with transfers and ambulation, had Alzheimer's disease (progressive disease that destroys memory and other mental function), and severe cognitive impairment.	2 830	Corrected	8/21/15

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2 830	Continued From page 3 R27's annual MDS, dated 9/29/14, indicated that this resident was able to express preferences, and displayed no behaviors. However, the MDS prompted the facility to determine if a "brief interview for mental status be conducted?" The facility identified this as "no, resident is rarely/never understood." The MDS process directed the facility staff to skip assessment of mental status. R27's mental status was determined to be moderate cognitively impaired. Review of R27's progress notes, dated 1/31/15 to 6/7/15, identified new escalating sexual behaviors were occurring with resident R45. Review of R45's admission MDS, dated 1/15/15 and subsequent 4/14/15 quarterly MDS, both indicated R45 was cognitively intact. During the month of January 2015, the facility documented the following behavior in the progress notes: 1/31/15: R27 made comments about her sexual readiness. A review of R27's quarterly MDS dated 12/29/14, indicated R27 had severe cognitive impairment, with no behaviors observed, and no acute onset of mental status change. This was a change from the previous MDS of 9/29/14 when she had been identified as moderately cognitively impaired. During the month of February 2015, the facility had documented the following behaviors in the progress notes: 2/15/15: a NA (nursing assistant) requested that the licensed social worker come to a resident's (R45) room. R27 was there and would not leave making sexually explicit comments to resident (R45). Staff asked R27 to leave the room, which R27 eventually did, however, R27 later returned. R45 informed the staff that R27's comments	2 830		

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2 830	Continued From page 4	2 830		

make him uncomfortable.
2/17/15: "[R27] Made the following comments to NA 'I have a boyfriend..."
2/21/15: R27 attempted to enter R45 room during evening cares stating that she had a book for R45. Staff was able to verbally redirect R27.

During the month of March 2015, the facility documented the following behaviors in the progress notes:
3/7/15: Resident walked up to NA and a female resident (unknown)...and [exposed herself] and CNA [certified nursing assistant]."
3/8/15: Resident was seen by NA, as she passed by a R45's room, and exposed herself.
3/8/15: R27 was overheard while helping another resident through the closed shared bathroom door, involved in a sexual interaction with R45. Administrator and DON were made aware of the incident.

R27's Social Service Assessment dated 3/27/15, indicated the family and facility had noted resident making socially inappropriate comments. The assessment indicated R27's Alzheimer's disease was progressing, and she was displaying behaviors she never had before. Further, the assessment identified, "...due to current state of cognition and resident's lack of ability to comprehend complex things, [family member] [FM]-A does the majority of the decision making for the best interest of the resident's care and safety." The assessment did not identify any potential rationale for the sudden increase in sexual behaviors, nor whether R27 had the mental capacity to make a decision to engage in a sexual relationship with another resident (R45) despite her cognitive impairment.

During the month of April 2015, the facility

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2 830	Continued From page 5	2 830		

documented the following behaviors in the progress notes:
4/8/15: R27 was observed by a NA during an interaction with R45.
4/10/15: R27 was observed in R45's room exposed.
4/22/15: R27 was very aggressively tugging and pulling on a nurse's arm and pulling writer closer to her continuously saying, 'I like you, don't you like me?'
4/22/15: R27 was observed involved in an interaction with R45. Staff documentation following the encounter indicated they had ensured both residents "were safe."

R27's medical record included a Physician Call Fax dated 4/23/15, that identified, "Resident [R27] has been sexually aggressive with staff and residents and behavior is increasingly disturbing. Is there any medication that can decrease sexual behavior?" The physician had responded with an order for, "Celexa [an anti-depressant] 10 mg [milligrams] i [one] PO [by mouth] daily", with a diagnosis of, "Dementia [with] behavioral disturbance." The note did not identify any assessment of R27's change and increase in sexual behavior, nor was there a documented assessment of R27's mental capacity to make decisions about a sexual relationship.

Progress notes of 4/27/15, identified a late entry on this date that R27 had fallen off R45's bed, resulting in no injury. The note also referenced the initiation of medication 4/23/15, due to R27's increased sexual displays towards R45 and staff.

In further review of R27's progress notes, a note dated 4/24/15, indicated the facility's licensed social worker (LSW) had contacted R27's family (FM-A) in regards to the new medication ordered

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2 830	Continued From page 6 due to aggressive sexual behaviors. The documentation indicated staff had noticed an increase in her grabbing out at the male nurses, making more sexually inappropriate comments to staff and making more of these comments in public areas. The LSW also informed FM-A, that R27 had been engaging in a sexual relationship for quite a while with a male resident that continued to progress. The documentation indicated FM-A had asked the LSW if the facility could restrict these visits, and the LSW had responded that R27's rights would then be restricted, and that FM-A should talk with R27's physician. There was still no indication the facility had assessed the resident's increase in behaviors, nor had they assessed R27's mental capacity to determine whether she could consent to a sexual relationship. A progress note documented by LSW on 4/28/15, indicated the LSW had received a phone call from FM-A. The note indicated FM-A had scheduled a doctor's (medical doctor) appointment with R27's primary physician for 5/5/15. The note further indicated FM-A wanted information for obtaining guardianship and/or conservatorship of R27, and documented FM-A's concern that R27 would have never been engaged in this type of behavior previously. A note later that day, indicated that the LSW had provided FM-A's requested information and discussed the upcoming 5/5/15 doctor's appointment, as well as talking about getting some neuropsych testing done to see where the resident was with her mental competency and capacity. Progress notes from 5/7/15 documented a conversation between LSW and FM-A in regards to R27's medical appointment on 5/5/15. The	2 830		

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2 830	Continued From page 7	2 830		

notes indicated FM-A had stated the appointment went well and that FM-A would possibly be pursuing guardianship. FM-A had stated that MD-A had informed him these behaviors would most likely resurface.

R27's care plan last reviewed 6/16/15, identified R27 as having, "Impaired cognitive function r/t [related to] Alzheimer's Disease AEB [as evidenced by] BIMS score, confusion (initiated on 10/31/13)." The facility identified an intervention to "communicate regarding resident's capability and needs, allow her to make decisions as she is able regarding tasks of daily living and activities." The facility identified that R27 had behaviors (initiated on 10/31/13) which was revised on 3/8/15 and 4/41/15 to include "Alteration in behavior r/t Alzheimer's AEB (as evidenced by) ....."Resident desires sexual activity AEB history of seeking out male residents, allowing male resident in room." The care plan did not identify a rationale for R27's behaviors, nor any facility assessment to determine whether R27 had the mental capacity to make a decision to engage in a sexual relationship despite being identified as having severe cognitive impairment and confusion.

During interview on 7/14/15, at 3:50 p.m. licensed social worker LSW-A stated that R27's behaviors were felt by both FM-A and MD-A to be "not her [R27] nature", and that the behaviors were thought to have been more cognitive loss and illness based. However, LSW-A said the facility had wanted to honor R27's rights, so they'd consulted with the regional Ombudsman (an official appointed as an advocate for a resident and their rights) in an attempt to "make the best decision" for R27. R27's record was reviewed and lacked any documentation indicating what had been decided between the Ombudsman and

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2 830	Continued From page 8	2 830		

facility. LSW-A stated that FM-A expressed concerns regarding R27's ability to make the decision to engage in a sexual relationship, and verified FM-A had been encouraged by the facility to consult with R27's physician, and to obtain a neurology consultation. However, no neurological consultation had been completed for R27 to date. Further, LSW-A stated she was not aware if R27's physician had ever been included or consulted in determining if R27 had the mental capacity to make a decision to engage in a sexual relationship other than when staff had requested the medication intervention 4/23/15 related to R27's hyper-sexuality.

R27's physician's progress note from MD-A dated 5/5/15 identified, "She has definitely had a reduction in behaviors. Part of it is her [FM-A] addressing her aggressive sexual behaviors and creating boundaries for her in addition to the medication." This progress note from MD-A also documented the following: "They [the facility] are a little concerned though; they say she seems a little bit more distant and withdrawn; her son has not witnessed this."

In a telephone interview on 7/15/15, at 10:30 a.m. MD-A stated she had met with R27 in the clinic back in May 2015 with FM-A for a re-check after having starting Celexa for dementia with sexual behaviors. MD-A stated that even with R27's Alzheimer's dementia, the resident had the mental capacity to make decisions and comprehend the consequences back when the relationship had started to progress, however MD-A stated currently, the resident (R27) no longer has that ability. Further, MD-A stated the facility had never consulted with her regarding cognitive assessment of R27's mental capacity or her ability to make decisions at the time when her

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2 830	Continued From page 9 sexual behaviors had been progressing. During interview on 7/16/15, at 11:00 a.m. with the facility administrator, LSW-A and director of nursing (DON), the surveyor informed the facility of the conversation with MD-A, in regards to the lack of assessment regarding R27's mental capacity to take part in a sexual relationship. The facility was unaware MD-A felt R27 currently lacked capacity to make a decision in regards to a sexual relationship. LSW-A stated the facility lacked documentation that R27 had been assessed earlier in the year when the behaviors began, nor had she been reassessed since a recent hospitalization which had resulted in further mental status change. Although the facility had identified R27 as being cognitively impaired and demonstrating increased sexual behaviors, which was new for R27, the facility had not completed a comprehensive assessment of the behaviors to determine why there was a change. In addition, there was no indication the facility had completed an assessment to determine whether R27 had the mental capacity to make a decision to be in a consenting sexual relationship, nor had they consulted with a medical professional who would be capable of assisting the facility in making a determination of mental capacity. R42's quarterly Minimum Data Set (MDS) dated 5/8/15, identified R42 had severe cognitive impairment, required extensive assistance for activities of daily living (ADLs), and used a wheelchair for her mobility. During observation on 7/13/15, at 6:59 p.m. R42 was seated in her room watching television (TV).	2 830		

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	00761	A. BUILDING: _____ B. WING _____	07/16/2015

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2 830	Continued From page 10 She was seated in a standard sized wheelchair, however only had one foot pedal in place on the right side causing her left foot to dangle un-supported. R42's foot did not touch the floor. R42 stated she did not know where her other foot pedal was, "What foot pedals?" On 7/14/15, at 8:20 a.m. R42 was seated in her wheelchair at a table in the dining room eating breakfast. R42 continued to have one right foot pedal only, her left foot was dangling un-supported. R42's left foot was approximately 4 to 5 inches from the floor. On 7/15/15, at 7:31 a.m. R42 was seated in her wheelchair in the hair salon underneath a hair dryer. R42 had no foot pedals on the chair, causing both of her feet to dangling un-supported approximately 4-5 inches from the floor. During interview on 7/15/15, at 8:52 a.m. nursing assistant (NA)-B stated R42 used to have two foot pedals, but was not sure where the other pedal was anymore. She (R42) has not had any supportive devices under her legs or feet for "a long time." Further, NA-B stated she looked through R42's room and was unable to find the other wheelchair pedal (left side) for R42's wheelchair. When interviewed on 7/15/15, at 12:26 p.m. licensed practical nurse (LPN)-A observed R42 seated in her wheelchair with her left foot un-supported. LPN-A stated she seldom had seen R42 use both foot pedals on her wheelchair. Further, LPN-A stated R42 had "4 to 6 inches" of space from her feet to the floor, and added foot pedals (when used) should be at a comfortable position for the resident and "not too long or too short." R42 was observed seated in her wheelchair with her left foot un-supported with physical therapist	2 830		

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2 830	Continued From page 11 (PT)-A on 7/15/15, at 12:51 p.m. PT-A stated R42 likes to be mobile in her chair, but "probably needs two foot rests." The occupational therapist (OT) had last seen her (R42) in March 2015, and no recommendations or discussion of wheelchair positioning had been made at that time. PT-A stated the residents (R42's) legs were at risk for stiffness, pain, and contracture if left un-supported. Nursing staff should have consulted with the OT for R42 positioning concerns and to, "Try to get an order to do some positioning." A facility wheelchair positioning policy was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director or nursing or designee could inservice staff regarding the identification and correction of residents found to not be using foot pedals, then audit to ensure compliance. The social services director or designee (s)could review and revise policies and procedures related to assessment of behaviors and mental capacity for individual residents who are involved in a personal relationship. The social services director or designee could develop a system to educate staff and complete a monitoring system to ensure residents behavioral assessments are accurate and up to date. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 830		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection	21390		8/21/15

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21390	Continued From page 12 control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review te facility failed to develop an infection control program to include the trending and analysis of collected infection data to reduce the risk of transmission to other residents in the facility. This had potential to affect all 56 residents whom resided in the facility. Findings include:	21390	Corrected	

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21390	Continued From page 13 A facility Infection/Antibiotic Monthly Tracking Record dated June 2015, identified the following infections: 1 prophylaxis, 1 surgical site, 6 UTI (urinary tract infection), 1 incision, 1 Bells Palsy (paralysis of the facial nerve), and 2 skin. The report identified each specific resident, the organism identified, the antibiotic it was treated with, and the antibiotic start and stop dates. The record did not identify what signs or symptoms each resident had, when the signs or symptoms of infection started or ended, what room each resident resided in, or any analysis of the collected data to determine if potentially infectious disease was spreading in the facility or if education to the staff was deemed necessary. A facility Monthly Infection Tracking sheet dated June 2015, identified a map of the facility, and a legend of colors representing the following type of infections: UTI, C. Diff (clostridium difficle, a bacteria which can caused inflammation of the colon), MDRO (multi-drug resistant organism), pneumonia, influenza, bronchitis, cold s/sx (signs and symptoms). The map had 5 separate rooms colored identifying those residents as have a UTI. The map did not identify which resident(s) had the surgical infection, incisional infection, of skin infections as identified by the Infection/Antibiotic Monthly Tracking Record. A facility Infection/Antibiotic Monthly Tracking Record dated May 2015, identified the following infections: 1 prophylaxis, 1 conjunctivitis, 2 UTI, 1 incision, 1 otitis media (middle ear infection), 1 suprapubic site, 1 cellulitis, and 3 pneumonia. In addition, the identified organism responsible for the case of conjunctivitis was identified as being caused by methicillin-resistant staphylococcus aureus (MRSA, a bacteria resistant to several antibiotics). The record did not identify what	21390		

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21390	Continued From page 14 signs or symptoms each resident had, when the signs or symptoms of infection started or ended, what room each resident resided in, or any analysis of the collected data to determine if potentially infectious disease was spreading in the facility or if education to the staff was deemed necessary. A facility Monthly Infection Tracking sheet dated May 2015, identified a map of the facility, and a legend of colors representing the following type of infections: UTI, C. Diff, MDRO, pneumonia, influenza, bronchitis, cold s/sx. The map had 6 separate rooms colored identifying the following infections: 2 UTI, 3 pneumonia, and 1 MDRO. The map did not identify which resident(s) had the incisional infection, the otitis media infection, the suprapubic site infection, or the cellulitis infection as identified by the Infection/Antibiotic Monthly Tracking Record. A facility Infection/Antibiotic Monthly Tracking Record dated April 2015, identified the following infections: 1 prophylaxis, 1 conjunctivitis, 4 UTI, 1 otitis media, 1 herpes zoster (shingles), 1 rash/skin, and 1 pneumonia. In addition, the identified organism responsible for the case of pneumonia was identified as being caused by methicillin-resistant staphylococcus aureus (MRSA, a bacteria resistant to several antibiotics). The record did not identify what signs or symptoms each resident had, when the signs or symptoms of infection started or ended, what room each resident resided in, or any analysis of the collected data to determine if potentially infectious disease was spreading in the facility or if education to the staff was deemed necessary. A facility Monthly Infection Tracking sheet dated April 2015, identified a map of the facility, and a legend of colors representing the following type of infections: UTI, C. Diff, MDRO, pneumonia, influenza, bronchitis, cold s/sx. The	21390		

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21390	Continued From page 15 map had 6 separate rooms colored identifying the following infections: 5 UTI, and 1 pneumonia. The map did not identify which resident(s) had the herpes zoster infection, otitis media infection, rash/skin infection, or the MRSA pneumonia as identified by the Infection/Antibiotic Monthly Tracking Record. When interviewed about the infection control program on 7/16/15, at 9:51 a.m. registered nurse (RN)-A stated she was responsible for the program. The infection data is gathered from review of a 24 hour report, along with nurses who "let me know" about new signs and symptoms of potential infections and/or antibiotics being started. The program uses an on-going surveillance, and the identified data (Infection/Antibiotic Monthly Tracking Records) is all she used adding, "this is the data." The analysis of the data is completed by herself on an "on-going" basis, and if concerns were noted with potential trends of infections, RN-A stated she would go out and perform some audits and make sure good hand hygiene was being followed. Further, RN-A stated her analysis, and completed audits and education completed with past identified trends had not been documented, "I didn't write anything down for that." During a subsequent interview on 7/16/15, at 10:57 a.m. RN-A stated the data was reviewed at the facility's Quality Assurance (QA) meeting, but no analysis of it is completed or action plans created to reduce the risk of infection transmission in the facility. Further, residents who develop signs and symptoms of infection are tracked on a different "symptom tracker" form, but one for 2015 was not available as no residents had developed signs and symptoms of infection needing to be placed on the form.	21390		

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21390	Continued From page 16 A facility Infection Control Program Protocol policy dated 5/2015, identified, "The purpose of the infection control program is to closely monitor, track, trend, and investigate infections within CTCCC [the facility], and educate staff on infection control and prevention." Further, the policy identified how the infection control program data was collected, but lacked any guidance or procedure for how to complete the analysis of the data, or develop action plans to reduce the spread of infection in the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review their infection control program to ensure policies and procedures are established to include the analysis of collected data, inservice staff regarding policy and procedure, and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		