#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: Q179

#### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY 1	THE STAT	E SURVEY AG	ENCY	F	Facility ID: 00761
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245521  2.STATE VENDOR OR MEDICAID NO.     (L2) 785540100	(L1) 245521 (L3) CENTRAL TODD COUNTY ( TATE VENDOR OR MEDICAID NO. (L4) 406 EAST HIGHWAY 71, PO ( (L2) 785540100 (L5) CLARISSA, MN					56440	4. TYPE OF ACTION:  1. Initial 3. Termination 5. Validation 7. On-Site Visit	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	IERSHIP	7. PROVIDER/SUI	PPLIER CATEGOR 05 HHA	RY 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 9. Other  8. Full Survey After Complaint	
6. DATE OF SURVEY <b>09/11/</b> 8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 09/30	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12.Total Facility Beds  13.Total Certified Beds	60 (L18) 60 (L17)	B. Not in Com	equirements	m	2. Tech 3. 24 H 4. 7-Da 5. Life	nical Personnel	Following Requirements:	tor
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MI	EETS		
18 SNF 18/19 SNF 60	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	SHOW LTC CANCELI	.ATION DATE):	,				
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY API	PROVAL	Date:
Brenda Fischer, Un	it Superviso	or	09/11/2015	(L19)	Kate Joh	nsTon, Pr	ogram Specialis	01/07/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAL	OFFICE OR S	SINGLE STAT	E AGENCY	
19. DETERMINATION OF ELIGIBILITY  _X 1. Facility is Eligible to Part	icipate		IPLIANCE WITH ( HTS ACT:	CIVIL	2. (		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	A-1513)
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE OF PARTICIPATION 02/01/1988	23. LTC AGREEMI BEGINNING		24. LTC AGREEM ENDING DAT		26. TERMINAT  VOLUNTARY  01-Merger, Closu	00	INVOLUNT	L30) <u>ARY</u> eet Health/Safety
(L24)	(L41)		(L25)		_	n W/ Reimbursemen		eet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE A. Suspension of		(L44)		03-Risk of Involut 04-Other Reason i	•	OTHER 07-Provider 00-Active	Status Change
(L27)	B. Rescind Sus	pension Date:						
28. TERMINATION DATE:	20	. INTERMEDIARY/C	(L45)		30. REMARKS			
20. TERMINATION DATE.	2,	03001	Andrew No.		Jo. REMINING			
	(L28)	00001		(L31)				
31. RO RECEIPT OF CMS-1539								
31. RO RECEII I OI CMS-133)	32	. DETERMINATION ( 09/02/2015	OF APPROVAL DA	ATE	Posted 01/11	/2016 Co.		



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



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

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 /	(Y2) Multiple Construction		(Y3) Date of Revisit
	Identification Number	A. Building		9/11/2015
	245521	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 3 CLARISSA, MN 56440	88

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	(Y4)	Item		(Y5)	Date	(Y4	) Item		(Y5)	Date
			Correction					Correction					Correction
ID Deefin	E0000		Completed		ID Danfin	F00F0		Completed		ID Danfin	F0444		Completed
ID Prefix			08/21/2015		ID Prefix			08/21/2015		ID Prefix			08/21/2015
Reg. # LSC	483.25				Reg. # LSC	483.30(e)				Reg. # LSC	483.65		_
				ļ	LSC				+	LSC			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	-		-		ID Prefix	-				ID Prefix			_
Reg.#					Reg. #					Reg. #			
LSC					LSC					LSC			_
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #			-		Reg. #					Reg. #			_
LSC					LSC								_
	-								+				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			-		ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			_
LSC				ļ	LSC				_	LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			-		ID Prefix					ID Prefix			
Reg.#					Reg. #					Reg. #			
LSC					LSC					LSC			<del>-</del>
Reviewed By		Reviewed I	=	Da		Signature o	f Surve					Date:	
State Agency	′	I	BF/KJ	01	/07/20	16			105	562		09/11	/2015
Reviewed By	·	Reviewed I	Зу	Da	te:	Signature o	f Surve	yor:				Date:	
CMS RO													
Followup to	Survey Compl	eted on:					-				a Summary of	· · ·	
	7/16/	2015				Unc	orrecte	d Deficiencies	(CN	IS-2567) Sent	to the Facility?	YES	NO

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 245521	(Y2) Multiple Constru A. Building B. Wing	Building 01 - MAIN BUILDING 01		(Y3) Date of Revisit 9/4/2015
Name	of Facility			Street Address, City, State, Zip Code	
CE	NTRAL TODD COUNTY CARE CENTER			406 EAST HIGHWAY 71, PO BOX 3 CLARISSA, MN 56440	8

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	(Y4)	Item		(Y5)	Date	(Y4	l) Item		(Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			08/21/2015		ID Prefix			09/01/2015		ID Prefix			09/01/2015
Reg. #	NFPA 101				Reg. #	NFPA 101				-	NFPA 101		_
LSC	K0046				LSC	K0054				LSC	K0056		_
			Correction					Correction					Correction
ID Danfin			Completed		ID Danfin			Completed		ID Deefer			Completed
ID Prefix								=					_
Reg. #					Reg. #					Reg. #			_
LSC					LSC					LSC			
			0					0					0
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg.#			-		Reg. #			
LSC					LSC								_
				_					+				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			•		ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			<del>-</del> -
			Correction					Correction					Correction
ID Drofiv			Completed		ID Drofiv			Completed		ID Drofiv			Completed
													_
Reg. #					Reg. #					Reg. #			_
LSC					LSC					LSC			_
Reviewed By	Revie	wed E	Ву	Da	te:	Signature of	f Surve	yor:				Date:	
State Agency	,	r	TL/KJ	0	1/07/20			2720	0_			09/0	4/2015
Reviewed By	Revie	wed E	Ву	Da	te:	Signature of	f Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed on	1:				Check f	for anv	Uncorrected I	Defi	ciencies. Was	a Summary of	-	
	7/14/2015						-				to the Facility?	YES	NO

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: Q179

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY AG	ENCY	I	acility ID: 00761
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245521     2.STATE VENDOR OR MEDICAID NO.     (L2) 785540100	LSTATE VENDOR OR MEDICAID NO. (L4) 406 EAST HIGHWAY (L2) 785540100 (L5) CLARISSA, MN					56440	4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)		7. PROVIDER/SUI	PPLIER CATEGOR	RY 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit  8. Full Survey After Co	9. Other mplaint
6. DATE OF SURVEY <b>07/16/</b> 8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 09/30	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12.Total Facility Beds	<b>60</b> (L18) <b>60</b> (L17)	X B. Not in Com	e Register of the American Company of the American Com	m	2. Tech 3. 24 H 4. 7-Da 5. Life	nical Personnel	Following Requirements:  6. Scope of Servi 7. Medical Direc 8. Patient Room S 9. Beds/Room  (L12)	tor
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY ME	EETS		
18 SNF 18/19 SNF 60	19 SNF	ICF	IID		1861 (e) (1) or 1	1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	SHOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	/EY AGENCY API	PROVAL	Date:
Austin Frey,	HFE NE II		08/17/2015	(L19)	Kate Joh	nsTon, Pr	ogram Specialis	08/31/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAI	OFFICE OR S	SINGLE STAT	E AGENCY	
19. DETERMINATION OF ELIGIBILITY  1. Facility is Eligible to Part	icipate		IPLIANCE WITH ( HTS ACT:	CIVIL	2. C		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	A-1513)
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE OF PARTICIPATION 02/01/1988 (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEMI ENDING DAT (L25)		26. TERMINAT  VOLUNTARY  01-Merger, Closur  02-Dissatisfaction	00		L30) 'ARY eet Health/Safety eet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L44)		03-Risk of Involur 04-Other Reason f	•	OTHER 07-Provider 00-Active	Status Change
	D. Resemu Sus	pension Date.	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (	OF APPROVAL DA	ATE	Posted 09	9/02/2015 C	0.	
	(L32)			(L33)	DETERMINA	TION APPRO	VAL	



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:

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor 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.

Central Todd County Care Center August 3, 2015 Page 4

#### 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

Central Todd County Care Center August 3, 2015 Page 5

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

Central Todd County Care Center August 3, 2015 Page 6

Feel free to contact me if you have questions.

Sincerely,

Kamala Fishe Downing

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

PRINTED: 08/24/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
		245521	B. WING _		07/16/2015
	ROVIDER OR SUPPLIER  TODD COUNTY CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	JLD BE COMPLETION
F 000	INITIAL COMMENTS	3	FO	000	
F 309 SS=D			F3	309	8/21/15
	by: Based on observation review, the facility fair assess the change in cognitively impaired in involved in a sexual in resident (R45). Furth ensure proper leg suresidents (R42) reviewed.	on, interview and document led to comprehensively behavior for 1 of 1 residents (R27) who was relationship with another ermore, the facility failed to poport was provided for 1 of 3 wed for positioning and supported in her wheelchair.		Failure to comprehensively assess change in behavior:  -R27's care plan was changed to re MD statement regarding mental ca and decision making capability. MI determined that resident no longer the ability to make significant decis (i.e. engaging in a sexual relations) -Interventions added to R27's care	eflect pacity D had ions hip).
ADODATODY	whose legs were not			(i.e. engaging in a sexual relations)	hip).

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

(X6) DATE

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.

**Electronically Signed** 

08/12/2015

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245521	B. WING		07/16/2015
	ROVIDER OR SUPPLIER  TODD COUNTY CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION
F 309	3/27/15, identified R2 transfers and ambula disease (progressive memory and other mognitive impairment R27's annual MDS, of this resident was abland displayed no belwas determined to be impaired.  Review of R27's prog 6/7/15, identified new were occurring with rR45's admission MD subsequent 4/14/15 indicated R45 was concurred the following the month of documented the following progress notes: 1/31/15: R27 made or readiness.  A review of R27's quindicated R27 had sewith no behaviors ob of mental status chair	IOR num Data Set (MDS), dated 27 was independent with ation, had Alzheimer's disease that destroys ental function), and severe dated 9/29/14, indicated that e to express preferences, naviors. R27's mental status e moderate cognitively  gress notes, dated 1/31/15 to v escalating sexual behaviors esident R45. Review of S, dated 1/15/15 and quarterly MDS, both ognitively intact.  January 2015, the facility ewing behavior in the comments about her sexual earterly MDS dated 12/29/14, evere cognitive impairment, served, and no acute onset inge. This was a change from	F 309	reflect restrictions on sexual relationship(s) due to physician determinationchart review of all other residents was performed to assess potential for impresidents indicating or demonstrating interest in pursuing a sexual relationship(s)All residents will be monitored change cognition/pursuit of sexual relationshivia IDT team review of current charting/verbal report on a daily basis -Policy "Resident Relations" was initi for staff to follow in the event that resident's desire to pursue a sexual relationshipStaff education provided on new pol and R27's care plan changes/interventions  Failure to ensure proper leg support -R42 received foot rests on wheelchard -R42's care plan was revised to reflet leg elevation habit during locomotion -All other residents were assessed for proper leg position and care planning reflects refusal of recommended leg supportFoot pedals for all resident assigned wheelchairs have been made available resident/staff usageOngoing monitoring of leg position/for	paired ges in ip(s) s. ated icy, air ct her or d ble for
	During the month of had documented the progress notes:	9/29/14 when she had been sely cognitively impaired.  February 2015, the facility following behaviors in the ag assistant) requested that		support will be performed via IDT teareview of current charting/verbal reports as well as formal review on MDS schedulePolicy "Wheelchair foot pedals/rests Policy" was initiated and staff were educated.	orting

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	ROVIDER OR SUPPLIER  TODD COUNTY CARE (	ENTER		STREET ADDRESS, CITY, STAT 406 EAST HIGHWAY 71, PO E CLARISSA, MN 56440	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)	DATE
F 309	(R45) room. R27 was making sexually explii (R45). Staff asked R2 R27 eventually did, he R45 informed the stamake him uncomforta 2/17/15: "[R27] Made NA 'I have a boyfriend 2/21/15: R27 attempte evening cares stating R45. Staff was able to During the month of M documented the follow progress notes: 3/7/15: Resident walk resident (unknown) CNA [certified nursing 3/8/15: Resident was by a R45's room, and 3/8/15: R27 was over resident through the coor, involved in a se	orker come to a resident's there and would not leave cit comments to resident 7 to leave the room, which owever, R27 later returned. Iff that R27's comments ble. the following comments to d" ed to enter R45 room during that she had a book for o verbally redirect R27.  March 2015, the facility wing behaviors in the ed up to NA and a female and [exposed herself] and g assistant]." seen by NA, as she passed	F 3	-Fall/Safety assessm reflect/review foot/fet wheelchair, if applica per MDS schedule/si - DON responsible for	et support while in able and is perform ig changes	ed
	indicated the family a making socially inapp assessment indicated was progressing, and behaviors she never lassessment identified cognition and residen comprehend complex [FM]-A does the major for the best interest or	nad before. Further, the l, "due to current state of				

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	ROVIDER OR SUPPLIER	ENTER	•	۱	STREET ADDRESS, CITY, STATE, ZIP CODE 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440	, , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	potential rationale for sexual behaviors, nor mental capacity to ma a sexual relationship despite her cognitive.  During the month of A documented the follow progress notes: 4/8/15: R27 was obseinteraction with R45. 4/10/15: R27 was obsexposed. 4/22/15: R27 was ver pulling on a nurse's ato her continuously salike me?' 4/22/15: R27 was obsinteraction with R45. following the encount ensured both residen.  R27's medical record Fax dated 4/23/15, the has been sexually agresidents and behavior Is there any medication behavior?" The physorder for, "Celexa [an [milligrams] i [one] PC diagnosis of, "Demen disturbance." The no assessment of R27's sexual behavior, nor assessment of R27's decisions about a sexual progress notes of 4/22.	the sudden increase in whether R27 had the ake a decision to engage in with another resident (R45) impairment.  April 2015, the facility wing behaviors in the erved by a NA during an served in R45's room  by aggressively tugging and rm and pulling writer closer aying, 'I like you, don't you served involved in an Staff documentation er indicated they had ts "were safe."  included a Physician Call at identified, "Resident [R27] gressive with staff and or is increasingly disturbing on that can decrease sexual ician had responded with an anti-depressant] 10 mg of [by mouth] daily", with a tia [with] behavioral te did not identify any change and increase in was there a documented mental capacity to make	F	309			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 309	resulting in no injury the initiation of med increased sexual dis In further review of Edated 4/24/15, indica social worker (LSW) (FM-A) in regards to due to aggressive sedocumentation indicatincrease in her grabl making more sexual staff and making more public areas. The LSR 27 had been engage for quite a while with continued to progress indicated FM-A had could restrict these wresponded that R27' restricted, and that Ephysician. There was had assessed the rebehaviors, nor had the capacity to determin to a sexual relations.  A progress note docindicated the LSW here from FM-A. The note scheduled a doctor's appointment with R25/5/15. The note furtinformation for obtain conservatorship of Econcern that R27 word engaged in this type note later that day, in	The note also referenced ication 4/23/15, due to R27's plays towards R45 and staff.  R27's progress notes, a note ated the facility's licensed had contacted R27's family the new medication ordered exual behaviors. The ated staff had noticed an bing out at the male nurses, ly inappropriate comments to re of these comments in SW also informed FM-A, that ging in a sexual relationship a male resident that is. The documentation asked the LSW if the facility visits, and the LSW had is rights would then be FM-A should talk with R27's is still no indication the facility sident's increase in they assessed R27's mental is whether she could consent hip.	F 309		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245521	B. WING		07/16/2015	
	ROVIDER OR SUPPLIER	: CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440	, 0000000	
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F 309	appointment, as we some neuropsych to resident was with he capacity.  Progress notes from conversation betwe to R27's medical apnotes indicated FM-went well and that F pursuing guardians! MD-A had informed most likely resurfactors as having, "Imp [related to] Alzheimevidenced by] BIMS 10/31/13)." The faci "communicate reganeeds, allow her to regarding tasks of cacility identified that on 10/31/13) which 4/41/15 to include "Alzheimer's AEB (ac desires sexual activimale residents, allowith the communicate reganeeds, allow her to regarding tasks of cacility identified that on 10/31/13) which 4/41/15 to include "Alzheimer's AEB (ac desires sexual activimale residents, allowith the capacity in the	mining 5/5/15 doctor's  Il as talking about getting esting done to see where the er mental competency and  In 5/7/15 documented a en LSW and FM-A in regards pointment on 5/5/15. The IA had stated the appointment IM-A would possibly be nip. FM-A had stated that him these behaviors would e.  I reviewed 6/16/15, identified paired cognitive function r/t er's Disease AEB [as Is score, confusion (initiated on lity identified an intervention to ording resident's capability and make decisions as she is able laily living and activities." The t R27 had behaviors (initiated was revised on 3/8/15 and Alteration in behavior r/t is evidenced by)"Resident ity AEB history of seeking out wing male resident in room."	F 30	9		
	behaviors, nor any determine whether to make a decision relationship despite severe cognitive im  During interview on social worker LSW-	ot identify a rationale for R27's facility assessment to R27 had the mental capacity to engage in a sexual being identified as having pairment and confusion.  7/14/15, at 3:50 p.m. licensed A stated that R27's behaviors M-A and MD-A to be "not her				

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F 309	thought to have beer illness based. Howe had wanted to honor consulted with the re official appointed as and their rights) in ar decision" for R27. R and lacked any docu had been decided be facility. LSW-A stated concerns regarding F decision to engage ir verified FM-A had be to consult with R27's neurology consultation consultation had been Further, LSW-A stated R27's physician had consulted in determin capacity to make a direlationship other that the medication interving R27's hyper-sexuality. R27's hyper-sexuality. R27's physician's proform the second production in behavior addressing her aggrecreating boundaries and medication." This prodocumented the folicial little concerned the little bit more distant not witnessed this."	at the behaviors were in more cognitive loss and ver, LSW-A said the facility R27's rights, so they'd gional Ombudsman (an an advocate for a resident in attempt to "make the best 27's record was reviewed mentation indicating what etween the Ombudsman and id that FM-A expressed R27's ability to make the in a sexual relationship, and iven encouraged by the facility physician, and to obtain a ion. However, no neurological in completed for R27 to date. Indicated the date of	F 3	09		

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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 309	behaviors. MD-A state Alzheimer's demental capacity to recomprehend the conversation and the facility had never concognitive assessments assual behaviors had behaviors had been ability to make a sexual behaviors had been ability administrationary (DON), the of the conversation lack of assessment capacity to take particularly was unaware lacked capacity to take particularly was unaware lacked documentational assessed earlier in a began, nor had she recent hospitalization further mental status. Although the facility cognitively impaired sexual behaviors, where was a change indication the facility assessment to determental capacity to reconsenting sexual recons	axa for dementia with sexual ated that even with R27's ia, the resident had the nake decisions and resquences back when the red to progress, however thy, the resident (R27) no ty. Further, MD-A stated the insulted with her regarding int of R27's mental capacity or decisions at the time when her individual been progressing.  7/16/15, at 11:00 a.m. with ator, LSW-A and director of surveyor informed the facility with MD-A, in regards to the regarding R27's mental at in a sexual relationship. The end MD-A felt R27 currently make a decision in regards to be a LSW-A stated the facility on that R27 had been the year when the behaviors been reassessed since a in which had resulted in a change.  had identified R27 as being and demonstrating increased hich was new for R27, the oleted a comprehensive behaviors to determine why. In addition, there was no	F 309		

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTIC CORRECTIVE ACTION SHOULD EFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 309	Continued From page	e 8	F3	09		
	be capable of assistir determination of men POSITIONING:	ng the facility in making a tal capacity.				
	5/8/15, identified R42					
	was seated in her roo She was seated in a showever only had one right side causing her un-supported. R42's R42 stated she did no pedal was, "What foo 8:20 a.m. R42 was se table in the dining roo continued to have one left foot was dangling foot was approximate floor. On 7/15/15, at her wheelchair in the dryer. R42 had no fo causing both of her fe approximately 4-5 inc During interview on 7 assistant (NA)-B state foot pedals, but was re pedal was anymore. supportive devices ur long time." Further, N	foot did not touch the floor. of know where her other foot t pedals?" On 7/14/15, at eated in her wheelchair at a om eating breakfast. R42 e right foot pedal only, her un-supported. R42's left ely 4 to 5 inches from the 7:31 a.m. R42 was seated in hair salon underneath a hair ot pedals on the chair, eet to dangling un-supported				

AND PLAN OF (	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	(X3) DATE COMP	SURVEY LETED
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	OVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440	•	
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F 356 SS=C	licensed practical nu seated in her wheeld un-supported. LPN-seen R42 use both for Further, LPN-A state space from her feet to pedals (when used) is position for the reside short."  R42 was observed short."  R42 was observed sher left foot un-supported to the mobile in needs two foot rests. (OT) had last seen hon recommendations positioning had been stated the residents stiffness, pain, and cun-supported. Nursir consulted with the Oconcerns and to, "Trypositioning."  A facility wheelchair requested, but none 483.30(e) POSTED INFORMATION  The facility must posa daily basis: o Facility name. o The current date. o The total number as	n 7/15/15, at 12:26 p.m. rse (LPN)-A observed R42 chair with her left foot A stated she seldom had bot pedals on her wheelchair. d R42 had "4 to 6 inches" of to the floor, and added foot should be at a comfortable ent and "not too long or too  eated in her wheelchair with borted with physical therapist t 12:51 p.m. PT-A stated R42 her chair, but "probably " The occupational therapist er (R42) in March 2015, and s or discussion of wheelchair made at that time. PT-A (R42's) legs were at risk for contracture if left ng staff should have T for R42 positioning y to get an order to do some  positioning policy was was provided.	F 3			8/21/15

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	ROVIDER OR SUPPLIER  TODD COUNTY CARE (	CENTER		40	TREET ADDRESS, CITY, STATE, ZIP CODE 16 EAST HIGHWAY 71, PO BOX 38 LARISSA, MN 56440	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 356	vocational nurses (as - Certified nurse a o Resident census.  The facility must post specified above on a of each shift. Data m o Clear and readable o In a prominent plac residents and visitors  The facility must, upo make nurse staffing of for review at a cost no standard.  The facility must main staffing data for a min required by State law  This REQUIREMENT by: Based on observatio review, the facility fail information for nursin on a daily basis. This all 56 residents residi visitors who wished to  Findings include:  During the initial tour 1:29 p.m. the facility s 7/11/15, and 7/12/15,	t: es. eal nurses or licensed defined under State law). aides.  the nurse staffing data daily basis at the beginning ust be posted as follows: format. e readily accessible to	F	356	Staffing to be posted per requirement. Education provided to staff responsible positing. Policy updated for change in practice/responsibility. Monitoring will conducted to ensure timely posting-Schedule of monitoring will be as follow Daily for 1 week, twice weekly for two weeks, and weekly until the next QAU meeting. Results will be reviewed at Q and further monitoring will be schedule needed. Administrator responsible for correction/compliance	for be vs: AU d if	

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	ROVIDER OR SUPPLIER  TODD COUNTY CARE (	CENTER		40	TREET ADDRESS, CITY, STATE, ZIP CODE 06 EAST HIGHWAY 71, PO BOX 38 ELARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC	UMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH CORRECTIVE ACTION SHOULD BE  LATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)			(X5) COMPLETION DATE		
F 356	number of staff, shift members, and total hithere was no posted the staffing for the cuild be st	name, census, staff type, time, number of staff ours worked. However, information visible regarding rrent day, 7/13/15.  1/14/15, at 9:26 a.m. the R) stated she was the prosting the staff schedule e posting up yesterday  7/15/14, at 12:30 p.m. the he lack of posting on site", and added it would be reported and a staff hours in the lack of the lack morning the staff hours in the law. Each morning the stor (HUC) will post the sworked. Should a change of staffing prior to the HUC DIC will make adjustments. The lack make the saving. "CONTROL, PREVENT which is and maintain an gram designed to provide a magnam designed to provide a magnam designed to provide a magnam designed and transmission.		356			8/21/15
	(a) Infection Control F The facility must esta	Program blish an Infection Control					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		E SURVEY PLETED
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	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP C 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		710/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	in the facility; (2) Decides what pro should be applied to (3) Maintains a reconactions related to infection of the preventing Spread (1) When the Infection determines that a respresent the spread or isolate the resident. (2) The facility must promunicable disease from direct contact will train (3) The facility must remands after each direct hand washing is indicated in the professional practice. (c) Linens Personnel must hand	rols, and prevents infections  cedures, such as isolation, an individual resident; and d of incidents and corrective ections.  d of Infection in Control Program sident needs isolation to f infection, the facility must  crohibit employees with a se or infected skin lesions ith residents or their food, if insmit the disease. require staff to wash their ect resident contact for which cated by accepted	F 4	141		
	by: Based on interview, facility failed to devel program to include th collected infection da transmission to other	and document review the op an infection control the trending and analysis of the treduce the risk of the residents in the facility.  affect all 56 residents whom		-"Infection Control Program policy was revised to includ specific and directed analys -"Infection/Antibiotic Month! Record" was revised to addinformation and signs/sympend dateInfections Monitored on fac	le more sis ly Tracking d demographic otoms start and	

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	ROVIDER OR SUPPLIER  TODD COUNTY CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP C 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 441	Record dated June 2 infections: 1 prophyla (urinary tract infectio (paralysis of the facia report identified each organism identified, with, and the antibiod record did not identifieach resident had, wo finfection started oresident resided in, collected data to det disease was spreadi education to the staffacility Monthly Infections: UTI, C. Disacteria which can colon), MDRO (multipneumonia, influenzand symptoms). The colored identifying the The map did not identified the surgical infection infections: 1 prophyla incision, 1 otitis med suprapubic site, 1 ce addition, the identified the case of conjunction infections: 1 prophyla incision, the identified the case of conjunctions in the surgical infection in the identified the case of conjunctions in the identified	atibiotic Monthly Tracking 2015, identified the following axis, 1 surgical site, 6 UTI n), 1 incision, 1 Bells Palsy al nerve), and 2 skin. The a specific resident, the the antibiotic it was treated it start and stop dates. The y what signs or symptoms when the signs or symptoms or ended, what room each or any analysis of the termine if potentially infectious ing in the facility or if if was deemed necessary. A stion Tracking sheet dated a map of the facility, and a desenting the following type of if (clostridium difficle, a aused inflammation of the drug resistant organism), a, bronchitis, cold s/sx (signs a map had 5 separate rooms one residents as have a UTI. Intify which resident(s) had incisional infection, of skin and the stimulation of the latest and the side of the latest and the latest and the latest and the la	F 4	revised to include more information as the infection tracking relation control audit tem revised to include additionatypes.  -Audit results, monthly tractwill be reviewed at monthly meeting as well as quarterlaternate RN designated a backup in the event of Infe Nurse attrition.  DON responsible for corrections.	cord plate was al infection  king maps/logs / Saftey ly QA meeting. and trained as ction Control	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		TE SURVEY MPLETED
		245521	B. WING _			7/16/2015
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440	•	7710/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE CROSS-RE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	antibiotics). The recogings or symptoms of signs or symptoms of what room each reside analysis of the collect potentially infectious the facility or if educancessary. A facility sheet dated May 201 facility, and a legend following type of infectioning infections: MDRO. The map did resident(s) had the inmedia infection, the sthe cellulitis infection Infection/Antibiotic MA facility Infection/Antibiotic MA facility Infections: 1 prophyla otitis media, 1 herpes rash/skin, and 1 pnetidentified organism repneumonia was identified organism repneumonia was identified organism repneumonia was identified organism responsibility. The recognism or symptoms of signs or symptoms of what room each residentially infectious the facility or if educancessary. A facility	cteria resistant to several and did not identify what ach resident had, when the finfection started or ended, dent resided in, or any ted data to determine if disease was spreading in ation to the staff was deemed Monthly Infection Tracking 5, identified a map of the of colors representing the ctions: UTI, C. Diff, MDRO, a, bronchitis, cold s/sx. The rooms colored identifying the 2 UTI, 3 pneumonia, and 1 In not identify which acisional infection, the otitis suprapubic site infection, or as identified by the onthly Tracking Record.  It ibiotic Monthly Tracking D15, identified the following axis, 1 conjunctivitis, 4 UTI, 1 as zoster (shingles), 1 umonia. In addition, the esponsible for the case of tified as being caused by taphylococcus aureus	F 4	.41		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y
		245521	B. WING		07/16/201	15
	ROVIDER OR SUPPLIER  TODD COUNTY CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMP	X5) PLETION ATE
F 441	Continued From pag	e 15 of colors representing the	F 44	1		
	following type of infe pneumonia, influenze map had 6 separate following infections: The map did not iden the herpes zoster inforash/skin infection, of	ctions: UTI, C. Diff, MDRO, a, bronchitis, cold s/sx. The rooms colored identifying the 5 UTI, and 1 pneumonia. https://doi.org/10.1001/pneumonia.ntify which resident(s) had ection, otitis media infection, or the MRSA pneumonia as ction/Antibiotic Monthly				
	program on 7/16/15, nurse (RN)-A stated program. The infective review of a 24 hour review of a 24 hour review of a 24 hour relet me know" about potential infections a started. The program surveillance, and the (Infection/Antibiotic Nall she used adding, analysis of the data is "on-going" basis, and potential trends of inwould go out and pesure good hand hygi Further, RN-A stated audits and education	dentified data  Monthly Tracking Records) is  "this is the data." The s completed by herself on an dif concerns were noted with fections, RN-A stated she form some audits and make ene was being followed.  The state of the stat				
	10:57 a.m. RN-A sta the facility's Quality A no analysis of it is co created to reduce the transmission in the fa	t interview on 7/16/15, at ted the data was reviewed at Assurance (QA) meeting, but impleted or action plans is risk of infection acility. Further, residents and symptoms of infection are				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRU		(X3) DATE COMF	SURVEY PLETED
		245521	B. WING _			07/	16/2015
	ROVIDER OR SUPPLIER	CENTER		406 EAST H	DRESS, CITY, STATE, ZIP CODE HIGHWAY 71, PO BOX 38 A, MN 56440	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B PROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 441	but one for 2015 was residents had develop infection needing to be A facility Infection Codated 5/2015, identificinfection control programation control and policy identified how to data was collected, be procedure for how to	"symptom tracker" form, not available as no bed signs and symptoms of the placed on the form.  Introl Program Protocol policy ed, "The purpose of the ram is to closely monitor, stigate infections within and educate staff on prevention." Further, the infection control program but lacked any guidance or complete the analysis of the plans to reduce the	F	141			

F5521023

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(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 07/14/2015 245521 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 406 EAST HIGHWAY 71, PO BOX 38 CENTRAL TODD COUNTY CARE CENTER CLARISSA, MN 56440 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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:

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

TITI E

**Electronically Signed** 

08/12/2015

(X6) DATE

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.

Facility ID: 00761

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				JIVID IVO.	0930-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245521	B. WING			07/	14/2015
	PROVIDER OR SUPPLIER	ARE CENTER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 106 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Marian.Whitney@sor Angela.Kappenma  THE PLAN OF CODEFICIENCY MUS FOLLOWING INFO	state.mn.us n@state.mn.us  RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done	K	000			
	responsible for corprevent a reoccurre  Central Todd Counbuilding without a karanteed at 4 direction was constructed at 4 direction was constructed to be of 1985, an addition was constructed to the construction of	or title of the person rection and monitoring to ence of the deficiency.  Ity Care Center is a 1-story pasement. The building was fferent times. The original ructed in 1976 and was of Type V(111) construction. In was added to the service wing					
	Type V(111). In 199 therapy addition was Wing and was deteconstruction. In 209 west end of D Wingbetween E and D ware Type V(111) coapartment building which is separated north end of E wingseparated from the	and was determined to be of 22 an activities/ physical as added to the east end of A ermined to be of Type V(111) 02 additions were added to g, to the main entrance and vings dining room, all of which enstruction. An assisted living is attached to the B wing by a 2-hour fire barrier. The g are apartments and enursing home with a 2-hour ilding is divided into 4 smoke e barriers.			Ω U		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245521	B. WING			07/	14/2015
NAME OF PROVIDER OR SUPPLIER  CENTRAL TODD COUNTY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 000	fire sprinkler system NFPA 13 Standard Systems 1999 edit system with smoke spaces open to the automatic fire department of the system with N Alarm Code" 1999 addition has smoke rooms, with autom	age 2 tected by a complete automatic m installed in accordance with for the Installation of Sprinkler ion. The facility has a fire alarm e detection in the corridors and e corridors that is monitored for artment notification in FPA 72 "The National Fire edition. The 2002/ 2003 e detection in the sleeping atic fire detection installed in e Minnesota State Fire Code	K	000			
K 046 SS=D	The requirement a NOT MET as evide NFPA 101 LIFE SA Emergency lighting provided in accord	FETY CODE STANDARD  g of at least 1½ hour duration is ance with 7.9. 19.2.9.1.	К	046			8/21/15
	Based on observa staff, the facility ha emergency lighting accordance with N and 19.2.9.1. This 60 residents, staff	is not met as evidenced by: tions and an interview with s failed to ensure that has been tested in FPA LSC (00) Section 7.9.3, deficient practice could 10 of and visitors in the event of an ation during a power outage.			Annual testing of the Emergency light indicated will be scheduled as part of routine maintenance/inspection that satisfies 7.9.19.2.9.1 Maintenance Supervisor will be responsible for performing and documenting outcome of the emerge lighting testing.	f the	

Event ID: Q17921

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245521				(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		B. WING			07/14/2015			
	ROVIDER OR SUPPLIER	RE CENTER		40	REET ADDRESS, CITY, STATE, ZIP CODE 16 EAST HIGHWAY 71, PO BOX 38 LARISSA, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
K 046 K 054 SS=D	o7/14/2015, during emergency battery maintenance docur the Maintenance So that the facility faile annual 90 minute to emergency lights.  This deficient pract Maintenance Super NFPA 101 LIFE SA All required smoke activating door hold maintained, inspect with the manufacture. This STANDARD is Based on observed determined that aur not been installed in corridors in accordant National Fire Alarm 2-1.3.3 and the Min section 907.2.6.3. Is smoke detector coverage of the Maintenance of the Min section 907.2.6.3. Is smoke detector coverage of the Maintenance of the Min section 907.2.6.3. Is smoke detector coverage of the Maintenance of the Min section 907.2.6.3. Is smoke detector coverage of the Maintenance of the M	veen 8:30 AM to 12:30 PM on the review of available back up exit lighting mentation and interview with upervisor (CB) revealed the d to conduct the required esting of the battery backup ices was confirmed by the rvisor (CB).  FETY CODE STANDARD  detectors, including those I-open devices, are approved, ted and tested in accordance rer's specifications. 9.6.1.3  s not met as evidenced by: tions and staff interview, it was tomatic smoke detectors have all spaces open to the ence with NFPA 72 " The Code" 1999 Edition section the code and staff interview, it was tomatic smoke detectors have all spaces open to the ence with NFPA 72 " The Code" 1999 Edition section the code and staff interview, it was tomatic with section and staff interview, it was tomatic smoke detectors have all spaces open to the ence with NFPA 72 " The Code" 1999 Edition section the code and staff interview, it was to make the code (2007) and the code in the code (2007) and the code in the code in the code in the code (2007) and the code in the c		046	Smoke detector(s) will be installed living room (onsite known as TV roindicated. Once installed, this smodetector will be maintained as perpolicy and schedule. Scheduling of installation, and overmaintenance is the responsibility of Maintenance Supervisor.	oom) oke current rsight of	9/1/15	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245521	B. WING			07/14/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 054	On facility tour betw 07/14/2015, observed room located next	age 4 ween 8:30 AM to 12:30 PM on vations revealed that the living to the main nurses station is r and is not protected with a	K 054	4		
K 056 SS=D	Maintenance Supe NFPA 101 LIFE SA If there is an autominstalled in accorda for the Installation of provide complete of building. The syste accordance with N Inspection, Testing Water-Based Fire supervised. There supply for the syste systems are equip	natic sprinkler system, it is ance with NFPA 13, Standard of Sprinkler Systems, to coverage for all portions of the em is properly maintained in FPA 25, Standard for the , and Maintenance of Protection Systems. It is fully is a reliable, adequate water em. Required sprinkler ped with water flow and tamper e electrically connected to the	K 05			9/1/15
	Based on observation found that the autoinstalled and maint NFPA 13 the Stand Sprinkler Systems the sprinkler system (99) could allow sy causing a decrease	is not met as evidenced by: tions and staff interview, it was matic sprinkler system is not cained in accordance with lard for the Installation of (99). The failure to maintain m in compliance with NFPA 13 stem being place out of service e in the fire protection system ent of an emergency that		Sprinklers have been schedule to replaced with sprinkler head approfor their position.  Maintenance supervisor is responscheduling and oversight of documentation for replacement spheads.	opriate	

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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 245521 07/14/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 406 EAST HIGHWAY 71, PO BOX 38 CENTRAL TODD COUNTY CARE CENTER CLARISSA, MN 56440 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 5 K 056 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).

Event ID: Q17921



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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.

Central Todd County Care Center August 3, 2015 Page 2

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

Kumalu Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00704	B. WING		07/40/045
		00761	B. Willo		07/16/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
CENTRAL	. TODD COUNTY CARE C	ENTER 406 EAS	T HIGHWAY 71, P	O BOX 38	
CENTRAL	. TODD COUNTY CARE C	CLARISS	SA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
	144A.10, this correction pursuant to a survey. Found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart.  Determination of where corrected requires controlled requires controlled when a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessment.	ther a violation has been mpliance with all			
	that may result from norders provided that a	paring on any assessments on-compliance with these written request is made to 15 days of receipt of a for non-compliance.			
	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic ure orders consistent with ment of Health 14-01, available at e.mn.us/divs/fpc/profinfo/inf icensing orders are			

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 08/12/15

TITLE

Minnesota Department of Health

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00761	B. WING		07/1	6/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE		
			HIGHWAY 71, F			
CENTRAL	. TODD COUNTY CARE C	ENTER	, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
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	Department of Health you electronically. Alt is necessary for State enter the word "correct text. You must then in State licensure process completion date, the corrected prior to elect Minnesota Department On July 13-16, 2015 state following correction Please indicate in you correction that you had and identify the date of Minnesota Department the State Licensing Confederal software. Tagassigned to Minnesota Nursing Homes. The state statutilisted in the "Summar column and replaces the correction order. The findings which are statute after the state as evidence by." Following period for Correction PLEASE DISREGARI FOURTH COLUMN WIPROVIDER'S PLAN APPLIES TO FEDER. THIS WILL APPEAR OTHERE IS NO REQUITION TO THE PLEASE DISREGARI THERE IS NO REQUITION TO THE PLEASE OF THE PLEASE O	orders being submitted to though no plan of correction Statutes/Rules, please cted" in the box available for dicate in the electronic as, under the heading date your orders will be stronically submitting to the nt of Health. Surveyors of this sited the above provider and on orders are issued. In electronic plan of we reviewed these orders, when they will be completed. In of Health is documenting correction Orders using numbers have been a state statutes/rules for assigned tag number column entitled "ID Prefix te/rule out of compliance is by Statement of Deficiencies" the "To Comply" portion of This column also includes the in violation of the state ment, "This Rule is not met owing the surveyors findings be thought of Correction and colon.  Deficiencies on the text of Deficiencies of the Heading of the State of Correction and colon.  Deficiencies on the text of Deficiencies of the State of Correction and colon.  Deficiencies on the State of Correction and colon.  Deficiencies of Correction and colon.				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		00761	B. WING		07/16/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
CENTRAL	. TODD COUNTY CARE O	ENTER	ST HIGHWAY 71, SA, MN 56440	PO BOX 38	
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2 830	Continued From page	2	2 830		
2 830	receive nursing care a custodial care, and su individual needs and the comprehensive replan of care as descr 4658.0405. A nursing of bed as much as powritten order from the	eneral. A resident must and treatment, personal and apervision based on preferences as identified in esident assessment and abed in parts 4658.0400 and a home resident must be out ssible unless there is a attending physician that the in bed or the resident	2 830		8/21/15
	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.			Corrected	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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	R27's annual MDS, d this resident was able and displayed no beh prompted the facility t interview for mental s facility identified this a rarely/never understo directed the facility stamental status. R27's determined to be mod Review of R27's prog 6/7/15, identified new were occurring with re R45's admission MDS subsequent 4/14/15 c indicated R45 was co	ated 9/29/14, indicated that to express preferences, aviors. However, the MDS to determine if a "brief tatus be conducted?" The as "no, resident is od." The MDS process aff to skip assessment of mental status was derate cognitively impaired.  ress notes, dated 1/31/15 to escalating sexual behaviors esident R45. Review of S, dated 1/15/15 and quarterly MDS, both gnitively intact.				
	documented the follow progress notes:  1/31/15: R27 made correadiness.  A review of R27's quaindicated R27 had se with no behaviors obsoff mental status chan the previous MDS of identified as moderated.  During the month of Fhad documented the progress notes:  2/15/15: a NA (nursin the licensed social work (R45) room. R27 was making sexually explications.	lanuary 2015, the facility wing behavior in the comments about her sexual arterly MDS dated 12/29/14, were cognitive impairment, served, and no acute onset ge. This was a change from 9/29/14 when she had been ely cognitively impaired.  February 2015, the facility following behaviors in the grassistant) requested that orker come to a resident's of there and would not leave cit comments to resident to leave the room, which owever, R27 later returned.				

Minnesota Department of Health

STATE FORM 6899 Q17911 If continuation sheet 4 of 17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
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	NA 'I have a boyfriend 2/21/15: R27 attempted evening cares stating R45. Staff was able to During the month of Mocumented the follow progress notes: 3/7/15: Resident walk resident (unknown)	the following comments to d"  ed to enter R45 room during that she had a book for overbally redirect R27.  March 2015, the facility wing behaviors in the ed up to NA and a female and [exposed herself] and passistant]."  seen by NA, as she passed			
	indicated the family at making socially inapp assessment indicated was progressing, and behaviors she never hassessment identified cognition and residen comprehend complex [FM]-A does the majo for the best interest of safety." The assessm potential rationale for sexual behaviors, nor mental capacity to ma	nad before. Further, the l, "due to current state of t's lack of ability to things, [family member] rity of the decision making of the resident's care and ent did not identify any the sudden increase in whether R27 had the lake a decision to engage in with another resident (R45) impairment.			

Minnesota Department of Health

STATE FORM Q17911 If continuation sheet 5 of 17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		00761	B. WING		07/16/2015	
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2 830	Continued From page	2.5	2 830			
	interaction with R45. 4/10/15: R27 was obsexposed. 4/22/15: R27 was verpulling on a nurse's at to her continuously salike me?' 4/22/15: R27 was obsinteraction with R45. following the encountersured both resident	erved by a NA during an served in R45's room  y aggressively tugging and rm and pulling writer closer aying, 'I like you, don't you served involved in an Staff documentation er indicated they had ts "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.					
	on this date that R27 resulting in no injury. the initiation of medic increased sexual disp.  In further review of R2	had fallen off R45's bed, The note also referenced cation 4/23/15, due to R27's clays towards R45 and staff.  27's progress notes, a note ted the facility's licensed				
	social worker (LSW) h	nad contacted R27's family the new medication ordered				

Minnesota Department of Health

STATE FORM 6899 Q17911 If continuation sheet 6 of 17

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  409 EAST HIGHWAY 71, PO BOX 38  CLARISSA, MN 56440  CROSS REFERENCED TO THE APPROVIDER OF PROVIDER PLAN OF CORRECTION  CROSS REFERENCED TO THE APPROVIDER OF PROVIDER PLAN OF CORRECTION  PROVIDER PLAN OF CORRECTION  CROSS REFERENCED TO THE APPROPRIATE  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 to public areas. The LSW sides informed FIA-4, that R27 had been engaging in a sexual relationship for quite a while with a male resident that continued to progress. The documentation indicated of the A-A had a sked the LSW if the facility had assessed the resident is not behaviors, nor had they assessed R27's mental capacity to determine whether she coud consent to a sexual relationship.  A progress note documented by LSW on 4/28/15, indicated the LSW had received a phone call from FIA-A. The note indicated FM-A had sked the LSW is had received a phone call from FIA-A. The note indicated FM-A had sked the LSW had received a phone call from FIA-A. The note indicated FM-A had sked the LSW had received a phone call from FIA-A. The note indicated FM-A had sked the LSW had received a phone call from FIA-A. The note indicated FM-A had sked the LSW had received a phone call from FIA-A. The note indicated FM-A had sked the LSW had received a phone call from FIA-A. The note indicated FM-A had sked the LSW had received a phone call from FIA-A. The note indicated FM-A wanted information for obtaining guardianship and/or conservatorship of RZ,7 and documented FM-A vanted information for obtaining guardianship and/or conservatorship of RZ,7, and documented for FM-A sequeled information for obtaining guardianship and/or conservatorship of RZ,7, and documented fM-A's concern that RZ? would have never been engaged in this type of behavi	WIIIIICSOL	a Department of Fleatti	1				
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					RVEY FED	
		00761	B. WING		07/16	/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CENTRAL	. TODD COUNTY CARE O	SENTER 406 EAST	HIGHWAY 71, F	PO BOX 38		
CENTRAL	. TODD COUNTY CARE C	CLARISSA	A, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	Continued From page	÷ 7	2 830			
	went well and that FM pursuing guardianship	had stated the appointment I-A would possibly be b. FM-A had stated that im these behaviors would				
	R27 as having, "Impa [related to] Alzheimer evidenced by] BIMS s 10/31/13)." The facilit "communicate regard needs, allow her to m regarding tasks of dai facility identified that I on 10/31/13) which w 4/41/15 to include "Al Alzheimer's AEB (as a desires sexual activity male residents, allowi The care plan did not behaviors, nor any fac determine whether R2 to make a decision to relationship despite b	score, confusion (initiated on y identified an intervention to ing resident's capability and ake decisions as she is able ly living and activities." The R27 had behaviors (initiated as revised on 3/8/15 and teration in behavior r/t evidenced by)"Resident AEB history of seeking outing male resident in room." identify a rationale for R27's cility assessment to				
	social worker LSW-A were felt by both FM-[R27] nature", and that thought to have been illness based. However had wanted to honor consulted with the recofficial appointed as a and their rights) in an decision" for R27. R2 and lacked any docur	more cognitive loss and ver, LSW-A said the facility				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		00761	B. WING		07	7/16/2015
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
OFNITRA	TODD COUNTY CADE	406 EAS	T HIGHWAY 71, PC	BOX 38		
CENTRAI	L TODD COUNTY CARE (	CLARIS:	SA, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	facility. LSW-A stated concerns regarding R decision to engage in verified FM-A had be to consult with R27's neurology consultation consultation had been Further, LSW-A state R27's physician had consulted in determinic capacity to make a derelationship other than the medication intervers. Particularly shyper-sexuality R27's physician's proposition of the sexual state of the sexual st	that FM-A expressed (27's ability to make the a sexual relationship, and en encouraged by the facility physician, and to obtain a n. However, no neurological n completed for R27 to date. d she was not aware if ever been included or ing if R27 had the mental ecision to engage in a sexual n when staff had requested ention 4/23/15 related to the completed for MD-A dated ention 4/23/15 related to the completed for MD-A dated ention 4/23/15 related to the completed for MD-A dated ention 4/23/15 related to the complete form MD-A dated ention 4/23/15 related to	2 830			

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STATE FORM Q17911 If continuation sheet 9 of 17

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, 2IP CODE  406 EAST HIGHWAY 71, PO BOX 38  CLARISSA, MN 56440  [M1]D PRETTY  GRANIDECTENSIVE MUSTER PROFECCIOR OF VALL REQUIATORY OR LSC IDENTIFYING INFORMATION)  PROTTY  REQUIATORY OR LSC IDENTIFYING INFORMATION)  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 of the conversation with MD-A, in regards to the lack of sassessment regarding R27 mental capacity to take part in a sexual relationship. The facility was unaware MD-A felt R27 currently 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 of 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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:				
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, JIP CODE  406 EAST HIGHWAY 71, PO BOX 38  CLARISSA, MN 564-01  CHAPTER CONTROL OF CONTROL OF CONTROL OF CASE OF THE CONTROL OF C			00761	B. WING		07	07/16/2015	
CENTRAL TODO COUNTY CARE CENTER  SUBMERY SYSTEMENT OF DETECTIONS OF THE PROPERTY OF THE PROPER	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	•		
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  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 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 lacked dopacity to take part in a sexual relationship. The facility lacked dopacity to make part in a sexual relationship in the year when the behaviors began, nor had she been reassessed sellier in the year when the behaviors began, nor had she been reassessed sellier in the year when the behaviors began, nor had she been reassessed sellier in the year when the behaviors began, nor had she been reassessed sellier 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 completed an assessment of the behaviors to be therefore the professional who would be capable of assisting the facility in making a determination of mental capacity.  R42's quarterly Minimum Data Set (MDS) dated 5/6/15, identified R42 had severe cognitive impairment, required extensive assistance for activities of daily living (ADLS), and used a wheelchair for her mobility.	CENTRAL	TODD COUNTY CARE O	ENTER		O BOX 38			
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.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	COMPLETE	
was seated in her room watching television (TV).	2 830	sexual behaviors had  During interview on 77 the facility administrat nursing (DON), the su of the conversation w lack of assessment re capacity to take part i facility was unaware I lacked capacity to ma a sexual relationship. lacked documentation assessed earlier in th began, nor had she b recent hospitalization further mental status.  Although the facility h cognitively impaired a sexual behaviors, whi facility had not comple assessment of the be there was a change. indication the facility h assessment to detern mental capacity to ma consenting sexual rel- consulted with a med be capable of assistin determination of ment  R42's quarterly Minim 5/8/15, identified R42 impairment, required activities of daily living wheelchair for her mo	been progressing.  /16/15, at 11:00 a.m. with for, LSW-A and director of arveyor informed the facility ith MD-A, in regards to the egarding R27's mental in a sexual relationship. The MD-A felt R27 currently sike a decision in regards to LSW-A stated the facility in that R27 had been in eyear when the behaviors een reassessed since a which had resulted in change.  and identified R27 as being and demonstrating increased sich was new for R27, the eted a comprehensive haviors to determine why In addition, there was no mad completed an mine whether R27 had the sake a decision to be in a actionship, nor had they sical professional who would sign the facility in making a tal capacity.  at a Set (MDS) dated had severe cognitive extensive assistance for g (ADLs), and used a sibility.	2 830				

Minnesota Department of Health

STATE FORM Q17911 If continuation sheet 10 of 17

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDING	A. BUILDING:			
		00761	B. WING		07	//16/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE			
CENTRAL	TODD COUNTY CARE O	CENTER	HIGHWAY 71, P	O BOX 38			
		CLARISS	A, MN 56440				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
2 830	Continued From page	e 10	2 830				
	She was seated in a showever only had one right side causing her un-supported. R42's R42 stated she did not pedal was, "What foo 8:20 a.m. R42 was setable in the dining root continued to have one left foot was dangling foot was approximate floor. On 7/15/15, at her wheelchair in the dryer. R42 had no for causing both of her feapproximately 4-5 incompared.	standard sized wheelchair, e foot pedal in place on the fleft foot to dangle foot did not touch the floor. It is pedals?" On 7/14/15, at eated in her wheelchair at a sum eating breakfast. R42 e right foot pedal only, her un-supported. R42's left sly 4 to 5 inches from the 7:31 a.m. R42 was seated in hair salon underneath a hair of pedals on the chair, eet to dangling un-supported thes 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."						

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MILLIFESOR	a Department or neart	I .				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		00761	B. WING		07/1	6/2015
NAME OF D	ROVIDER OR SUPPLIER	CTDEET AD	DDECC CITY CTA	TE 7/D 000E		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
CENTRAL	TODD COUNTY CARE O	ENTER	HIGHWAY 71, I	PO BOX 38		
			A, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	Continued From page	<del>2</del> 11	2 830			
	(PT)-A on 7/15/15, at	12:51 p.m. PT-A stated R42				
	likes to be mobile in h	er chair, but "probably				
	needs two foot rests."	The occupational therapist				
	(OT) had last seen he	er (R42) in March 2015, and				
	no recommendations	or discussion of wheelchair				
		made at that time. PT-A				
	•	R42's) legs were at risk for				
	stiffness, pain, and co					
	un-supported. Nursing					
	consulted with the OT for R42 positioning concerns and to, "Try to get an order to do some					
	positioning."	to get all order to do some				
	positioning.					
	A facility wheelchair p	ositioning policy was				
	requested, but none v	- · ·				
		, and provided the				
	SUGGESTED METH	OD OF CORRECTION:				
	The director or nursin	g or designee could				
		ng the identification and				
	correction of residents	s found to not be using foot				
	pedals, then audit to	ensure compliance. The				
		or or designee (s)could				
	•	icies and procedures related				
		aviors and mental capacity				
		s who are involved in a				
	personal relationship.					
	•	could develop a system to				
		nplete a monitoring system				
		ehavioral assessments are				
	accurate and up to da	ilG.				
	TIME DEDICE FOR	COPPECTION: Twenty one				
	(21) days	CORRECTION: Twenty-one				
21390	MN Rule 4658.0800 S	Subp. 4 A-I Infection Control	21390			8/21/15
		d procedures. The infection				-
	Jung. I. I Ullulud all			i		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00761	B. WING		07/16/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CENTRAL	TODD COUNTY CARE O	SENTER	HIGHWAY 71, I A, MN 56440	PO BOX 38	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
21390	A. surveillance baccollection to identify nesidents;  B. a system for decontrol of outbreaks of C. isolation and preduce risk of transmit D. in-service edule prevention and control E. a resident head immunization program defined in part 4658. Procedures of resident the prevention and treating the prevention a	include policies and ovide for the following: ased on systematic data dosocomial infections in etection, investigation, and of infectious diseases; precautions systems to dission of infectious agents; cation in infection ol; lith program including an an authorization, and policies and at care practices to assist in eatment of infections; and implementation of cies and infection control tuberculosis program as 1815; eviewing antibiotic use; eview and evaluation of infection control, such as tics, gloves, and	21390		
	by: Based on interview are facility failed to develop program to include the collected infection data transmission to other	t is not met as evidenced and document review te op an infection control e trending and analysis of ta to reduce the risk of residents in the facility. affect all 56 residents whom		Corrected	
	Findings include:				

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Minnesota Department of Health

Minnesota Department of Health						
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			B. WING			
		00761	B. WING		07/1	6/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		406 EAST	HIGHWAY 71,	PO BOX 38		
CENTRAL TODD COUNTY CARE CENTER			A, MN 56440			
	CLIMMA DV CT		1	DDOV/DEDIC DLANLOE CODDECTION		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
21390	Continued From page	12	21390			
21330	Continued From page	: 13	21330			
	A facility Infection/Ant	tibiotic Monthly Tracking				
	Record dated June 20	015, identified the following				
	infections: 1 prophyla:	xis, 1 surgical site, 6 UTI				
	(urinary tract infection	n), 1 incision, 1 Bells Palsy				
	(paralysis of the facial	I nerve), and 2 skin. The				
	report identified each	•				
		ne antibiotic it was treated				
		c start and stop dates. The				
		what signs or symptoms				
		nen the signs or symptoms				
		ended, what room each				
	resident resided in, or					
		rmine if potentially infectious				
	disease was spreadin					
		was deemed necessary. A				
		ion Tracking sheet dated				
	•	a map of the facility, and a				
		esenting the following type of				
		f (clostridium difficle, a				
		aused inflammation of the				
		drug resistant organism),				
	T	, bronchitis, cold s/sx (signs				
		map had 5 separate rooms				
		ose residents as have a UTI.				
	,	tify which resident(s) had				
		incisional infection, of skin				
		d by the Infection/Antibiotic				
	Monthly Tracking Rec					
		- <del></del>				
	A facility Infection/Ant	tibiotic Monthly Tracking				
		115, identified the following				
	•	xis, 1 conjunctivitis, 2 UTI, 1				
		a (middle ear infection), 1				
		Iulitis, and 3 pneumonia. In				
	· ·	d organism responsible for				
	-	ritis was identified as being				
	_	resistant staphylococcus				
		eteria resistant to several				
		ord did not identify what				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMF	PLETED
		00761	B. WING		07	/16/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
	TODD 00111171/04DE (	406 EAST	HIGHWAY 71,	PO BOX 38		
CENTRAL	TODD COUNTY CARE (	CLARISS	A, MN 56440			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETE DATE
21390	21390 Continued From page 14		21390			
		ach resident had, when the				
		f infection started or ended,				
		dent resided in, or any				
	_	ted data to determine if				
		disease was spreading in				
	•	tion to the staff was deemed				
		Monthly Infection Tracking 5, identified a map of the				
	,	of colors representing the				
	-	ctions: UTI, C. Diff, MDRO,				
		a, bronchitis, cold s/sx. The				
		rooms colored identifying the				
		2 UTI, 3 pneumonia, and 1				
	MDRO. The map did	•				
	· ·	cisional infection, the otitis				
	7 7	suprapubic site infection, or				
	the cellulitis infection					
		onthly Tracking Record.				
		onung maaning maaara.				
	A facility Infection/Ant	tibiotic Monthly Tracking				
	-	015, identified the following				
	-	ixis, 1 conjunctivitis, 4 UTI, 1				
	otitis media, 1 herpes	s zoster (shingles), 1				
		ımonia. În addition, the				
	identified organism re	esponsible for the case of				
	pneumonia was ident	tified as being caused by				
		taphylococcus aureus				
	(MRSA, a bacteria re					
	-	ord did not identify what				
		ach resident had, when the				
		f infection started or ended,				
		lent resided in, or any				
	•	ted data to determine if				
	-	disease was spreading in				
	-	tion to the staff was deemed				
		Monthly Infection Tracking				
	•	5, identified a map of the				
		of colors representing the				
		ctions: UTI, C. Diff, MDRO,				
	pneumonia, influenza	, bronchitis, cold s/sx. The				1

Minnesota Department of Health

STATE FORM Q17911 If continuation sheet 15 of 17

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING:			
		00761	B. WING		07	7/16/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
		406 EAS	Γ HIGHWAY 71, PO	BOX 38		
CENTRAL	. TODD COUNTY CARE (	CENTER	A, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21390	Continued From page	e 15	21390			
	following infections: The map did not iden the herpes zoster infe rash/skin infection, or	rooms colored identifying the 5 UTI, and 1 pneumonia. tify which resident(s) had ection, otitis media infection, the MRSA pneumonia as tion/Antibiotic Monthly				
	program on 7/16/15, nurse (RN)-A stated sprogram. The infection review of a 24 hour reliet me know" about restarted. The program surveillance, and the (Infection/Antibiotic Mall she used adding, analysis of the data is "on-going" basis, and potential trends of infection would go out and per sure good hand hygic Further, RN-A stated audits and education	identified data flonthly Tracking Records) is this is the data." The scompleted by herself on an if concerns were noted with ections, RN-A stated she form some audits and make ene was being followed. her analysis, and completed completed with past not been documented, "I				
	10:57 a.m. RN-A stat the facility's Quality A no analysis of it is con- created to reduce the transmission in the fa who develop signs ar tracked on a different but one for 2015 was residents had develop	cility. Further, residents nd symptoms of infection are "symptom tracker" form,				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE S		
	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		J COM E	-125
		00761	B. WING		07/1	6/2015
NAME OF F	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE		
CENTRAI	TODD COUNTY CARE (	ENTER	HIGHWAY 71, I	PO BOX 38		
	T	CLARISSA	, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21390	Continued From page 16		21390			
	dated 5/2015, identificinfection control progressive track, trend, and investigation control and policy identified how to data was collected, be procedure for how to data, or develop actions spread of infection in SUGGESTED METH director of nursing or infection control progressive are establication analysis of collected or regarding policy and pensure compliance.	orevention." Further, the the infection control program ut lacked any guidance or complete the analysis of the on plans to reduce the the facility.  OD OF CORRECTION: The designee could review their ram to ensure policies and lished to include the				

Minnesota Department of Health STATE FORM

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00761	B. WING		07/16/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
CENTRAL	TODD COUNTY CARE O	ENTER	T HIGHWAY 71, PC	) BOX 38	
		CLARISS	SA, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	DRRECTION ORDER			
	144A.10, this correcting pursuant to a survey. found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart.  Determination of where corrected requires corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessments.	ther a violation has been mpliance with all			
	that may result from norders provided that a	earing on any assessments con-compliance with these written request is made to a 15 days of receipt of a for non-compliance.			
	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic ure orders consistent with ment of Health 14-01, available at e.mn.us/divs/fpc/profinfo/inf icensing orders are			

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

08/12/15 Electronically Signed

TITLE

Minnesota Department of Health

WIIIIIICSOL	a Department of Fleatti					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
		00761	B. WING	<del></del>	07/1	6/2015
	20,4252 02 01 22	077557.470	DE00 01TV 0T4	TE 710 0005		
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
CENTRAL	TODD COUNTY CARE O	ENTER 406 EAST H	HIGHWAY 71, F	PO BOX 38		
OLIVINAL	TODD COOKIT CAKE C	CLARISSA	MN 56440			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE	DATE
				DEFICIENCY)		
2 000	Continued From page	: 1	2 000			
	Department of Health	orders being submitted to				
	•	though no plan of correction				
	-	- ·				
		Statutes/Rules, please				
		cted" in the box available for				
	text. You must then in	dicate in the electronic				
	State licensure proces	ss, under the heading				
	completion date, the o	date your orders will be				
	corrected prior to elec-	tronically submitting to the				
	Minnesota Departmer					
	On July 13-16, 2015 s					
		sited the above provider and				
	the following correction	•				
	_					
	Please indicate in you					
	_	ve reviewed these orders,				
	_	when they will be completed.				
		nt of Health is documenting				
	_	orrection Orders using				
	federal software. Tag	numbers have been				
	assigned to Minnesota	a state statutes/rules for				
	Nursing Homes. The	assigned tag number				
	appears in the far left	column entitled "ID Prefix				
		te/rule out of compliance is				
	•	y Statement of Deficiencies"				
		the "To Comply" portion of				
	-	This column also includes				
		in violation of the state				
		ment, "This Rule is not met				
		owing the surveyors findings				
		ethod of Correction and				
	Time period for Corre					
	PLEASE DISREGARI	D THE HEADING OF THE				
	FOURTH COLUMN V	VHICH STATES,				
	"PROVIDER'S PLAN	OF CORRECTION." THIS				
		AL DEFICIENCIES ONLY.				
	THIS WILL APPEAR					
		IREMENT TO SUBMIT A				
		ION FOR VIOLATIONS OF				
	MINNESOTA STATE	SIAIUIES/KULES.				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE: COMPI		
		00761	B. WING		07/16/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CENTRAL	TODD COUNTY CARE O	ENTER	HIGHWAY 71, I A, MN 56440	PO BOX 38	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
2 830	Continued From page 2		2 830		
2 830	2 830 MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		2 830		8/21/15
	receive nursing care a custodial care, and su individual needs and the comprehensive replan of care as descr 4658.0405. A nursing of bed as much as powritten order from the	preferences as identified in esident assessment and libed in parts 4658.0400 and ghome resident must be out essible unless there is a attending physician that the in bed or the resident			
	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.			Corrected	
	3/27/15, identified R2 transfers and ambuladisease (progressive	num Data Set (MDS), dated 7 was independent with tion, had Alzheimer's disease that destroys ental function), and severe			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		00761	B. WING		07/16/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	TE, ZIP CODE	
CENTRAL TODD COUNTY CARE CENTER 406 EAST			HIGHWAY 71, I	PO BOX 38	
		CLARISSA	A, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
2 830	Continued From page	e 3	2 830		
	R27's annual MDS, dithis resident was able and displayed no beh prompted the facility interview for mental significant facility identified this a rarely/never understord directed the facility stimental status. R27's determined to be more Review of R27's prog 6/7/15, identified new were occurring with re R45's admission MDS subsequent 4/14/15 cindicated R45 was contact the residual residu	ated 9/29/14, indicated that a to express preferences, haviors. However, the MDS to determine if a "brief tatus be conducted?" The as "no, resident is od." The MDS process aff to skip assessment of mental status was derate cognitively impaired.  Tress notes, dated 1/31/15 to rescalating sexual behaviors esident R45. Review of S, dated 1/15/15 and quarterly MDS, both ignitively 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				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		00761	B. WING		07	7/16/2015
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
CENTRAL	. TODD COUNTY CARE (	CENTER	T HIGHWAY 71, PC	BOX 38		
		CLARISS	SA, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	NA 'I have a boyfriend 2/21/15: R27 attempt evening cares stating R45. Staff was able to During the month of Mocumented the followard progress notes: 3/7/15: Resident walk resident (unknown) CNA [certified nursing 3/8/15: Resident was by a R45's room, and 3/8/15: R27 was over resident through the door, involved in a se Administrator and DC incident.  R27's Social Service indicated the family a making socially inapp assessment indicated was progressing, and behaviors she never assessment identified cognition and resident comprehend complex [FM]-A does the major for the best interest of safety." The assessment potential rationale for sexual behaviors, nor sexual behaviors, nor sexual	able. I the following comments to d"  ed to enter R45 room during that she had a book for overbally redirect R27.  March 2015, the facility wing behaviors in the end grassistant]."  seen by NA, as she passed exposed herself] and grassistant]."  seen by NA, as she passed exposed herself. Theard while helping another closed shared bathroom exact interaction with R45.  ON were made aware of the end accomments. The draw accomments. The draw accomments are designed as the was displaying that before. Further, the draw, "due to current state of	2 830			
	despite her cognitive  During the month of A					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00761	B. WING		07/16/2015
	PROVIDER OR SUPPLIER	CENTER 406 EAST	DRESS, CITY, STA HIGHWAY 71, I A, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 830	documented the follo progress notes: 4/8/15: R27 was obse interaction with R45. 4/10/15: R27 was obsexposed. 4/22/15: R27 was verpulling on a nurse's at to her continuously stike me?' 4/22/15: R27 was obsinteraction with R45. following the encount ensured both residen R27's medical record Fax dated 4/23/15, the has been sexually agresidents and behavior? The physorder for, "Celexa [ar [milligrams] i [one] P0 diagnosis of, "Demendisturbance." The notassessment of R27's sexual behavior, nor assessment of R27's decisions about a sexual disputation of medicincreased sexual disputation of medicincreased sexual disputation.	wing behaviors in the erved by a NA during an served in R45's room  y aggressively tugging and rm and pulling writer closer aying, 'I like you, don't you served involved in an Staff documentation er indicated they had ts "were safe."  included a Physician Call at identified, "Resident [R27] gressive with staff and or is increasingly disturbing. on that can decrease sexual ician had responded with an anti-depressant] 10 mg D [by mouth] daily", with a tia [with] behavioral te did not identify any change and increase in was there a documented mental capacity to make	2 830		

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(FM-A) in regards to the new medication ordered

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	EIED
			D WING			
		00761	B. WING		07/1	16/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CENTRAL	. TODD COUNTY CARE (	CENTER 406 EAST	HIGHWAY 71, I	PO BOX 38		
	. 1022 0001111 071112 0	CLARISSA	A, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	2 830 Continued From page 6		2 830			
	increase in her grabb making more sexually staff and making more public areas. The LSN R27 had been engagifor quite a while with a continued to progress indicated FM-A had a could restrict these vi responded that R27's restricted, and that FN physician. There was had assessed the respendent of the physician of the capacity to determine to a sexual relationsh	ted staff had noticed an ing out at the male nurses, inappropriate comments to e of these comments in in in in in in in in in a sexual relationship in a male resident that is. The documentation is in				
	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.					
	conversation betweer	5/7/15 documented a n LSW and FM-A in regards ointment on 5/5/15. The				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		(X3) DATE	SURVEY PLETED	
		00761	B. WING		07	/16/2015
		00701			07	/10/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	E, ZIP CODE		
CENTRAL	. TODD COUNTY CARE (	SENTER 406 EAS	T HIGHWAY 71, PO	O BOX 38		
OLIVITAL	TODE COOKIT CAKE	CLARIS	SA, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	Continued From page	e 7	2 830			
	went well and that FM pursuing guardianship MD-A had informed h most likely resurface.	p. FM-A had stated that im these behaviors would				
	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."					
	behaviors, nor any far determine whether R2 to make a decision to	27 had the mental capacity				
	severe cognitive impa	-				
	social worker LSW-A	/14/15, at 3:50 p.m. licensed stated that R27's behaviors A and MD-A to be "not her at the behaviors were				
	thought to have been illness based. However had wanted to honor	more cognitive loss and /er, LSW-A said the facility R27's rights, so they'd				
	official appointed as a and their rights) in an	gional Ombudsman (an an advocate for a resident attempt to "make the best 27's record was reviewed				
	and lacked any docur	mentation indicating what tween the Ombudsman and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3)  A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00761	B. WING		07	7/16/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
CENTRAI	TODD COUNTY CARE	SENTER 406 EAS	ST HIGHWAY 71, PC	BOX 38		
CENTRAL	TODD COUNTY CARE	CLARIS	SA, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	facility. LSW-A stated concerns regarding R decision to engage in verified FM-A had be to consult with R27's neurology consultation consultation had been Further, LSW-A state R27's physician had consulted in determinic capacity to make a derelationship other than the medication intervers. R27's physician's profosological form of the medication in the medication in behavior addressing her aggres creating boundaries for medication." This profocumented the follogical little concerned thou little bit more distant a not witnessed this."  In a telephone intervity MD-A stated she had back in May 2015 with having starting Celex behaviors. MD-A stated currently longer has that ability facility had never concognitive assessments.	I that FM-A expressed (27's ability to make the a sexual relationship, and en encouraged by the facility physician, and to obtain a in. However, no neurological in completed for R27 to date. It is dishered to desire the ever been included or sing if R27 had the mental ecision to engage in a sexual in when staff had requested ention 4/23/15 related to desire the expression of the ention 4/23/15 related to desire the expression of the express	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			, 501E51110				
		00761	B. WING		07/	/16/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE			
CENTRAL	TODD COUNTY CARE	ENIER	HIGHWAY 71, F	PO BOX 38			
	CLIMMADVCT		A, MN 56440	DDOMDEDIC DI ANI OF CO	DDECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
2 830	Continued From page	9	2 830				
	sexual behaviors had	been progressing.					
	the facility administra nursing (DON), the strong the conversation we lack of assessment recapacity to take part if facility was unaware lacked capacity to made a sexual relationship. lacked documentation assessed earlier in the began, nor had she began, nor had she began, recent hospitalization further mental status.	e year when the behaviors een reassessed since a which had resulted in change. ad identified R27 as being					
	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						
	impairment, required activities of daily living wheelchair for her mo						
		om watching television (TV).					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. Boilbing.			
		00761	B. WING		07/	16/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CENTRAL	TODD COUNTY CARE (	CENTER	HIGHWAY 71, F	PO BOX 38		
	OUR MARY OF		A, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From page	e 10	2 830			
	She was seated in a showever only had one right side causing her un-supported. R42's R42 stated she did not pedal was, "What foo 8:20 a.m. R42 was setable in the dining root continued to have one left foot was dangling foot was approximate floor. On 7/15/15, at her wheelchair in the dryer. R42 had no for causing both of her fe approximately 4-5 incompared by the state of the pedals, but was repedal was anymore. Supportive devices ur long time." Further, Northough R42's room a other wheelchair pedal wheelchair.  When interviewed on licensed practical nur	standard sized wheelchair, e foot pedal in place on the floot to dangle foot did not touch the floor. It pedals?" On 7/14/15, at eated in her wheelchair at a series of the eating breakfast. R42 e right foot pedal only, her un-supported. R42's left left 4 to 5 inches from the 7:31 a.m. R42 was seated in hair salon underneath a hair of pedals on the chair, seet to dangling un-supported thes from the floor.  1/15/15, at 8:52 a.m. nursing led R42 used to have two not sure where the other She (R42) has not had any other her legs or feet for "a NA-B stated she looked and was unable to find the lal (left side) for R42's  7/15/15, at 12:26 p.m. see (LPN)-A observed R42				
	seen R42 use both for Further, LPN-A stated space from her feet to pedals (when used) s	nair with her left foot A stated she seldom had not pedals on her wheelchair. If R42 had "4 to 6 inches" of the floor, and added foot should be at a comfortable ent and "not too long or too				
	R42 was observed se	eated in her wheelchair with rted with physical therapist				

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Minnesot	<u>a Department of Health</u>	1				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		URVEY ETED	
		A. BUILDING: _	A. BUILDING:			
		00761	B. WING		07/1	6/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
CENTRAL	TODD COUNTY CARE O	SENTER 406 EAST	T HIGHWAY 71, F	PO BOX 38		
OLIVINAL		CLARISS	A, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	Continued From page	2 11	2 830			
	likes to be mobile in heeds two foot rests." (OT) had last seen he no recommendations positioning had been stated the residents (stiffness, pain, and counsupported. Nursing consulted with the OT	g staff should have for R42 positioning to get an order to do some positioning policy was				
	The director or nursin inservice staff regardi correction of residents pedals, then audit to a social services director review and revise pol to assessment of beh for individual resident personal relationship. director or designee of educate staff and con	ng the identification and so found to not be using foot ensure compliance. The part of the corror designee (s) could designed icies and procedures related aviors and mental capacity so who are involved in a and the social services could develop a system to enplete a monitoring system enavioral assessments are				
	TIME PERIOD FOR (21) days	CORRECTION: Twenty-one				
21390	MN Rule 4658.0800 S	Subp. 4 A-I Infection Control	21390			8/21/15
	Subp. 4. Policies an	d procedures. The infection				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00761	B. WING		07/16/2015
NAME OF B		ethert /	DDDESS CITY ST	ATE ZID CODE	•
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST		
CENTRAL	TODD COUNTY CARE	ENTER	ST HIGHWAY 71, SA, MN 56440	PO BOX 38	
0/0.15	CHMMADV CT	ATEMENT OF DEFICIENCIES	, 	PROVIDER'S PLAN OF CORRECTI	ION (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETE
21390	Continued From page	e 12	21390		
	A. surveillance be collection to identify residents;  B. a system for decontrol of outbreaks of the control of the contro	exide for the following: ased on systematic data assocomial infections in etection, investigation, and of infectious diseases; brecautions systems to dission of infectious agents; cation in infection ol; alth program including an an, a tuberculosis program as 0810, and policies and at care practices to assist in catment of infections; and implementation of cies and infection control tuberculosis program as 0815; eviewing antibiotic use; eview and evaluation of infection control, such as tics, gloves, and antaining awareness of bractice in infection control.			
	by: Based on interview at facility failed to develor program to include the collected infection datransmission to other	t is not met as evidenced and document review te op an infection control e trending and analysis of ta to reduce the risk of residents in the facility. affect all 56 residents whom		Corrected	
	Findings include:				

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AND DIAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00761	B. WING		07	/16/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CENTRAI	TODD COUNTY CARE (	CENTER 406 EAST	HIGHWAY 71, I	PO BOX 38		
OLIVITICAL	TODE COUNTY CARE	CLARISSA	A, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
21390	Continued From page	e 13	21390			
	A facility Infection/And Record dated June 20 infections: 1 prophyla (urinary tract infectior (paralysis of the facial report identified each organism identified, the with, and the antibiotic record did not identify each resident had, who finfection started or resident resided in, or collected data to determine disease was spreadired education to the staff facility Monthly Infections: UTI, C. Diffunctions: UTI, C. Diffunctions influenzal and symptoms). The colored identifying the colored identifying the The map did not iden the surgical infection, infections as identified Monthly Tracking Record dated May 20 infections: 1 prophyla incision, 1 otitis media suprapubic site, 1 cel addition, the identified the case of conjunctive caused by methicillinaureus (MRSA, a backling).	tibiotic Monthly Tracking 015, identified the following xis, 1 surgical site, 6 UTI n), 1 incision, 1 Bells Palsy Il nerve), and 2 skin. The specific resident, the he antibiotic it was treated c start and stop dates. The what signs or symptoms hen the signs or symptoms ended, what room each r any analysis of the ermine if potentially infectious ng in the facility or if was deemed necessary. A ion Tracking sheet dated a map of the facility, and a esenting the following type of ff (clostridium difficle, a aused inflammation of the drug resistant organism), h, bronchitis, cold s/sx (signs map had 5 separate rooms ose residents as have a UTI. tify which resident(s) had incisional infection, of skin d by the Infection/Antibiotic				

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		7. BOILDING.			
		00761	B. WING		07/16/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
OFNITRAL	TODD COUNTY CARE	406 EAST	HIGHWAY 71, F	PO BOX 38	
CENTRAL	TODD COUNTY CARE (	CLARISS	A, MN 56440		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
21390	Continued From page	e 14	21390		
21390	signs or symptoms easigns or symptoms of what room each reside analysis of the collect potentially infectious of the facility or if educan necessary. A facility sheet dated May 201 facility, and a legend following type of infections influenzamap had 6 separate of following infections: MDRO. The map did resident(s) had the inmedia infection, the state cellulitis infection Infection/Antibiotic Moreon Market and the cellulitis infection Infections: 1 prophyla otitis media, 1 herpes rash/skin, and 1 pneudentified organism repneumonia was ident methicillin-resistant state (MRSA, a bacteria re	ach resident had, when the finfection started or ended, lent resided in, or any ted data to determine if disease was spreading in tion to the staff was deemed Monthly Infection Tracking 5, identified a map of the of colors representing the of colors in the colors of colors of colors and 1 dentifying the colors of colors representing the colors of colors representing the colors of colors in the colors of	21390		
	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 collect potentially infectious the facility or if educa necessary. A facility	ted data to determine if disease was spreading in tion to the staff was deemed Monthly Infection Tracking 5, identified a map of the			
	facility, and a legend	of colors representing the ctions: UTI, C. Diff, MDRO,			

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pneumonia, influenza, bronchitis, cold s/sx. The

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00761	B. WING		07	7/16/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CENTRAL	. TODD COUNTY CARE O	SENTER 406 EAST	HIGHWAY 71, F	PO BOX 38		
CENTRAL	. TODD COUNTY CARE C	CLARISS	A, MN 56440			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21390	Continued From page	: 15	21390			
	following infections: § The map did not ident the herpes zoster infe rash/skin infection, or	ooms colored identifying the 5 UTI, and 1 pneumonia. tify which resident(s) had action, otitis media infection, the MRSA pneumonia as tion/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."					
	10:57 a.m. RN-A state the facility's Quality Anno analysis of it is concreated to reduce the transmission in the fawho develop signs an tracked on a different but one for 2015 was	cility. Further, residents d symptoms of infection are "symptom tracker" form, not available as no ned signs and symptoms of				

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AND DIAN OF CORRECTION INTERPRETATION NUMBERS		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE COMP				
00761			B. WING			/2015
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
CENTRAL	TODD COUNTY CARE (	ENIER	HIGHWAY 71, I , MN 56440	PO BOX 38		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21390	Continued From page	e 16	21390			
	dated 5/2015, identificinfection control progressive track, trend, and investigation control and policy identified how to data was collected, be procedure for how to data, or develop actions spread of infection in SUGGESTED METH director of nursing or infection control progressive are establication analysis of collected or regarding policy and pensure compliance.	orevention." Further, the the infection control program at lacked any guidance or complete the analysis of the in plans to reduce the the facility.  OD OF CORRECTION: The designee could review their ram to ensure policies and lished to include the				

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