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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: RME8

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/05/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Timothy Rhonemus, HFE NE II 05/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 05/12/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/14/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245521
May 12, 2016

Mr. Jason Polovick, Administrator
Central Todd County Care Center
406 East Highway 71, P.O. 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 May 1, 2016 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

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 12, 2016

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

RE: Project Number S5521025

Dear Mr. Polovick:

On March 22, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 10, 2016. 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 May 5, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 5, 2016 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 March 10, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 1, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 10, 2016, effective May 1, 2016 and therefore remedies outlined in our letter to you dated March 22, 2016, 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

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245521 (Y1)	A. Building B. Wing (Y2)	5/5/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL TODD COUNTY CARE CENTER	406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0159 Reg. # 483.10(c)(2)-(5) LSC	Correction Completed 04/08/2016	ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	Correction Completed 04/08/2016	ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 04/08/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) JS/KJ	DATE 05/12/2016	SIGNATURE OF SURVEYOR 29249	DATE 05/05/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/10/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245521 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/5/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL TODD COUNTY CARE CENTER	406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0011	05/01/2016	LSC K0018	05/01/2016	LSC K0025	04/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0038	05/01/2016	LSC K0051	05/01/2016	LSC K0054	05/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0062	05/01/2016	LSC K0144	05/01/2016	LSC K0147	05/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0154	05/01/2016	LSC K0155	05/01/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/KJ	05/12/2016	35482	05/05/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/9/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: RME8

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/10/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Mardelle Trettel, HFE NE II 04/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 04/11/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/14/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 22, 2016

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

RE: Project Number S5521025

Dear Mr. Polovick:

On March 10, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
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 April 19, 2016, 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 April 19, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of

Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 10, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal

regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL TODD COUNTY CARE CENTER	406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate	F 159		4/8/16

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

Electronically Signed | 04/01/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING _____ B. WING _____	03/10/2016

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F 159	Continued From page 1 accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review the facility failed to ensure residents' personal funds in excess of $50.00 were maintained in an interest bearing account for 27 of 47 residents (R2, R4, R5, R6, R8, R9, R11, R12, R13, R19, R20, R22, R25, R27, R28, R29, R31, R34, R35, R38, R39, R50, R54, R55, R57, R58, and R60) whose personal funds were in excess of $50.00 and managed by the facility. Findings include: On 3/9/16, at 8:46 a.m. resident personal funds accounts were reviewed with the office assistant (OA). The OA stated the facility had a separate	F 159	Resident fund policy updated. All resident funds greater than $50 will be held in an interest bearing account beginning 4-1-2016 that is dedicated only to resident trust funds. A system to maintain accurate account transactions and balances has already been established, as well as an audit process for monthly balancing of each resident account. A system to calculate and allocate interest to individual accounts has been created. Interest earnings will be calculated and posted monthly, and	

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F 159	Continued From page 2 trust account for the residents' personal funds monies but she did not know if this account was interest bearing. An interview on 3/9/16, at 12:00 p.m. with the business manager (BM) stated the resident personal funds account was not an interest bearing account. During an interview on 3/10/16, at 9:37 a.m. with the administrator stated the facility was not incompliance with the interest bearing accounts for the residents. The administrator identified the following residents had an account balance greater than $50.00. Review of the resident personal funds accounts identified the following: -R2's trust account had a balance of $159.70 on 3/9/16. -R4's trust account had a balance of $76.65 on 3/9/16. -R5's trust account had a balance of $2,856.00 on 3/9/16. -R6's trust account had a balance of $78.23 on 3/9/16. -R8's trust account had a balance of $461.85 on 3/9/16. -R9's trust account had a balance of $281.98 on 3/9/16. -R11's trust account had a balance of $66.76 on 3/9/16. -R12's trust account had a balance of $149.26 on 3/9/16. -R13's trust account had a balance of $196.75 on 3/9/16. -R19's trust account had a balance of $115.36 on 3/9/16. -R20's trust account had a balance of $86.95 on	F 159	account statements will be sent to financial representative quarterly and as requested. A communication will be sent to all responsible parties regarding the change in the account status. Correction date: April 8, 2016. Responsibility for correction: Administrator.	

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F 159	Continued From page 3 3/9/16. -R22's trust account had a balance of $80.92 on 3/9/16. -R25's trust account had a balance of $84.00 on 3/9/16. -R27's trust account had a balance of $200.00 on 3/9/16. -R28's trust account had a balance of $308.30 on 3/9/16. -R29's trust account had a balance of $105.98 on 3/9/16. -R31's trust account had a balance of $97.00 on 3/9/16. -R34's trust account had a balance of $132.17 on 3/9/16. -R35's trust account had a balance of $112.00 on 3/9/16. -R38's trust account had a balance of $568.89 on 3/9/16. -R39's trust account had a balance of $422.46 on 3/9/16. -R50's trust account had a balance of $66.95 on 3/9/16. -R54's trust account had a balance of $601.57 on 3/9/16. -R55's trust account had a balance of $328.70 on 3/9/16. -R57's trust account had a balance of $160.00 on 3/9/16. -R58's trust account had a balance of $174.00 on 3/9/16. -R60's trust account had a balance of $84.01 on 3/9/16. Although residents had funds ranging from $76.65 to $2,856.00, none of the residents were receiving interest in their accounts. Review of the facility policy Resident Funds	F 159		

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F 159	Continued From page 4 Policies undated indicated all accounts will be reviewed during the last of each month. Any amount over $50.00 will be deposited in an individual interest-bearing account at the bank. The account will be under the resident's name and Social Security number, but will be under the control of Central Todd County Care Center.	F 159		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225		4/8/16

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F 225	Continued From page 5 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the state agency (SA) and complete a thorough investigation for 1 of 1 resident (R32) with bruises of unknown origin. Findings include: R32's annual Minimum Data Set (MDS) dated 8/20/15, identified R32's diagnoses included: dementia, heart failure, glaucoma, Parkinsonism and contracture of left hand. The MDS further indicated R32 had severe cognitive impairment, required extensive to complete assistance for all activities of daily living (ADL's) and could not walk. R32's care area assessment (CAA) dated 8/20/15, indicated R32 had impaired communication and decreased ability to make self understood or to understand others. Facility Incident Report #2086 dated 9/5/15, at 10:00 p.m. indicated R32 had bruising located to the right upper forearm, mid right forearm, left forearm and left wrist. Old yellow bruising also noted to R32's right upper arm, right hip and mid left thigh. R32 was unable to report how the	F 225	Incident report filed to OHFC regarding R32 and bruises noted during survey. Investigation also completed and reported. All injuries of unknown source that were not witnessed by staff or can be explained by the resident will be reported per vulnerable adult reporting policy as of 3/10/2016. Reasonable and/or probable causes of the injuries will be included in the investigation/report, but will not be used to reclassify incidents as was prior practice. Staff have been educated on change of practice, and daily review of incident trending monitors compliance to reporting. Trending of overall incident investigations and causation will continue to be reviewed at quarterly QA meetings. Date of Completion: April 8, 2016. Responsibility: Administrator	

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F 225	Continued From page 6	F 225		

bruising was obtained. The incident report indicated R32 wore a splint to the left hand which posed risk for injury and received a low dose of aspirin. The Incident Report indicated staff thought bruise on left mid thigh was caused by staff lifting R32. An entry on the Incident Report dated 9/6/15, identified R32 recently received intramuscular (IM) Rocephin (antibiotic) injections. The report lacked any description or measurements of R32's multiple bruises. Further, the Incident Report did not identify the cause of R32's bruises on the right and left forearm, right upper forearm and left wrist. There were no witnesses to the injuries that were identified on the report.

Review of R32's medication administration record dated 8/23/15 through 9/1/15, indicated R32 received IM injections to the right leg, left thigh, right and left deltoid (upper, outer arm) and right and left buttocks. The administration records did not indicate R32 received any injections to the right upper forearm, mid right forearm, left forearm or left wrist.

Progress note dated 9/8/15, noted the incident on 9/6/15 was reviewed. The note indicated R32 was bruised in multiple locations on bilateral arms, and right hip and left thigh. Progress note identified R32 was very fragile and bruised easily. The note indicated the bruising on R32's left arm could be related to splint use, and identified R32 had recent IM injections which would explain the bruises on upper arm, thigh and hip. Transfer audits were completed and staff education was provided where needed. No further evidence of an investigation was provided.

Facility Incident Report #2089 dated 9/6/15, at

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10:15 p.m. indicated R32 had a blue/purple bruise to the right outer eye which measured 4.3 centimeters (cm) and had redness across the eye lid. The Incident Report indicated R32 received eye drops on 9/6/15, at 8:30 p.m., R32 opened eye with ease when drops were given. R32 was unable to report how the bruise happened. The Incident Report indicated R32 had no behaviors with cares, and was possible R32's glasses were pushed far into eye, no trouble giving eye drops to both eyes, and no bruising was present on left eye.

Progress Note dated 9/9/15, indicated R32 was completely dependent upon staff for all ADL's, and due to arm stiffness/contractures was unable to lift hands to eyes. The note identified R32 received eye drops, wore glasses daily and bruised extremely easy. The Progress Note also identified the eye bruise was R32's 7th bruise within the past 6 months, no trends identified as R32 typically received bruises to arms and hands. No further evidence of an investigation was provided.

On 3/10/16, at 9:23 a.m. nursing assistant (NA)-B reported R32 was dependent on staff for all cares. NA-B stated R32 did not resist cares, was calm, and did not speak. NA-B confirmed R32 had history of multiple bruises.

On 3/9/16, at 11:56 a.m. registered nurse (RN)-A reported when a resident has a bruise of unknown origin staff would assess the bruise or injury and try to figure out potentially what could have been the cause. RN-A stated if staff come up with a cause then the bruise would not be reportable to the administrator or state agency (SA).

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F 225	Continued From page 8 On 3/9/16, at 12:04 licensed practical nurse (LPN)-A stated she would report to the administrator right away any bruises on the face, genital areas, breast and buttocks and/or multiple injuries or bruises of unknown origin. LPN-A stated the administrator then determines if the bruises or injuries should be reported to the SA. On 3/10/16, at 9:37 a.m. RN-B stated R32 did not have behaviors during cares, did not hit out or refuse cares. RN-B stated when a resident has a bruise of unknown origin staff are interviewed, and if staff come up with a reason how the bruises occurred she would not contact the administrator. On 3/9/16, at 12:25 p.m. the director of nursing (DON) stated she was aware of R32's bruises reported on 9/5/15, and reported R32 had injections around that timeframe. The DON verified the Incident Report dated 9/5/15 did not identify a cause for all the bruises reported. The DON was not aware of R32's bruise on the right eye reported on 9/6/15. The DON confirmed the bruise was in a suspicious area, then stated R32 did receive eye drops and the bruise could have happened from the resident rubbing the eye. The DON stated she would have reported the incident that occurred on 9/6/15 to the administrator if she was aware of it at that time, then stated when she reviewed the incident report it was well after the fact. The DON stated bruises or injuries of unknown origin are assessed and staff are interviewed. A registered nurse documents how staff felt the bruise or injury happened after reviewing the medical record, assessments and interviews. If the RN could not find a reason or cause, then she would be notified for further	F 225		

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F 225	Continued From page 9	F 225		

review. The DON stated she is not made aware of incidents until she reviews the incident reports for the facility's quality assurance meeting for tracking and trending purposes, The DON stated she had no concerns or trends to report to the quality assurance meeting regarding R32. The DON confirmed the administrator was responsible for reporting unknown injuries or bruises to the SA. The DON stated any bruise or injury suspicious in nature, areas of the body not vulnerable to trauma or multiple injuries would be reported to the SA.

On 3/9/15, at 12:55 p.m. the administrator confirmed staff are expected to update him on any bruises and/or injuries the resident or staff could not explain. The administrator stated it would depend on the injury if he would submit the incident to the SA, then reported any bruises or injuries in the genital area, breast, buttocks or areas not normally exposed to injuries would be reported. The adminstrator explained each incident is reviewed, and if staff have a probable reason of how a bruise happened, he would not report to the SA. After each incident a RN completes a review and will look back and look at injuries of unknown origin. The administrator reported the risk management team meets monthly and should be looking at frequency and trending of all injuries and bruises of unknown origin. The administrator felt R32's multiple bruises on 9/5/15 could have been caused by the procedure of receiving injections if not in the exact location of the injection due to staff possibly having to pinch together R32's skin, therefore, was not reportable to the SA. The administrator was aware of R32's bruise on the right eye on 9/6/15. He confirmed the bruise on R32's right eye was not reported to the SA. The

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F 225	Continued From page 10 administrator felt the bruise was explained because R32 received eye drops, had fragile skin and received a low dose of aspirin (81 mg) daily. He stated staff review all injuries on a daily basis, and he assumed the nurse was interviewed and was likely from the eye drop administration. The administrator confirmed the staff look for a "reasonable explanation" for bruises/injuries of unknown origin, and if staff can find one the bruise/injury is no longer of unknown origin. The facility's undated Reporting Allegations Of Abuse To Facility Management Policy, included the definition of injuries of unknown origin. a. The source of injury was not observed by any person or the source of the injury could not be explained by the resident; and, b. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incident of injuries over time. The facility's undated Reporting Abuse To State Agencies And Other Entities/Individuals Policy, indicated injuries of an unknown source would be promptly reported to appropriate state agencies and other entities or individuals as may be required by the law. The facility's undated Alleged Abuse Investigations Policy, indicated injuries of unknown source be promptly reported and an investigation completed.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		4/8/16

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F 226	Continued From page 11 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse prohibition policies and procedures for immediate reporting to the state agency (SA), and a thorough investigations for bruises of unknown origin for 1 of 1 resident (R32) reviewed for abuse prohibition. Findings include: The facility's undated Reporting Allegations Of Abuse To Facility Management Policy, included the definition of injuries of unknown origin. a. The source of injury was not observed by any person or the source of the injury could not be explained by the resident; and, b. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incident of injuries over time. The facility's undated Reporting Abuse To State Agencies And Other Entities/Individuals Policy, indicated injuries of an unknown source would be promptly reported to appropriate state agencies and other entities or individuals as may be required by the law.	F 226	Incident report filed to OHFC regarding R32 and bruises noted during survey. Investigation also completed and reported. Policy for Vulnerable Adult Abuse reporting and investigation have been reviewed and modifications have been made to clarify change in practice. Education has been provided to licensed nursing staff regarding change in practice and policy. Ongoing monitoring of reporting of potential vulnerable adult abuse and neglect will be completed daily, and trending and analysis will be completed and reviewed quarterly by the QAU team. Date of Completion: April 8, 2016. Responsibility: Administrator	

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F 226	Continued From page 12	F 226		

The facility's undated Alleged Abuse Investigations Policy, indicated injuries of unknown source be promptly reported and an investigation completed.

Facility Incident Report #2086 dated 9/5/15, at 10:00 p.m. indicated R32 had bruising located to the right upper forearm, mid right forearm, left forearm and left wrist. Old yellow bruising also noted to R32's right upper arm, right hip and mid left thigh. R32 was unable to report how the bruising was obtained. The incident report indicated R32 wore a splint to the left hand which posed risk for injury and received a low dose of aspirin. The Incident Report indicated staff though [sic] bruise on left mid thigh was caused by staff lifting R32. An entry on the Incident Report dated 9/6/15, identified R32 recently received intramuscular (IM) Rocephin (antibiotic) injections. The report lacked any description or measurements of R32's multiple bruises. Further, the Incident Report did not identify the cause of R32's bruises on the right and left forearm, right upper forearm and left wrist. There were no witnesses to the injuries that were identified on the report.

Facility Incident Report #2089 dated 9/6/15, at 10:15 p.m. indicated R32 had a blue/purple bruise to the right outer eye which measured 4.3 centimeters (cm) and had redness across the eye lid. The Incident Report indicated R32 received eye drops on 9/6/15, at 8:30 p.m., R32 opened eye with ease when drops were given. R32 was unable to report how the bruise happened. The Incident Report indicated R32 had no behaviors with cares, and was possible R32's glasses were pushed far into eye, no trouble giving eye drops to both eyes, and no bruising was present on left

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	245521	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL TODD COUNTY CARE CENTER	406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440

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F 226	Continued From page 13 eye. R32's annual Minimum Data Set (MDS) dated 8/20/15, identified R32's diagnoses included: dementia, heart failure, glaucoma, Parkinsonism and contracture of left hand. The MDS further indicated R32 had severe cognitive impairment, required extensive to complete assistance for all activities of daily living (ADL's) and could not walk. Progress Note dated 9/9/15, indicated R32 was completely dependent upon staff for all ADL's, and due to arm stiffness/contractures was unable to lift hands to eyes. The note identified R32 received eye drops, wore glasses daily and bruised extremely easy. On 3/9/16, at 11:56 a.m. registered nurse (RN)-A reported when a resident has a bruise of unknown origin staff would assess the bruise or injury and try to figure out potentially what could have been the cause. RN-A stated if staff come up with a cause then the bruise would not be reportable to the administrator or state agency (SA). On 3/9/16, at 12:04 licensed practical nurse (LPN)-A stated she would report to the administrator right away any bruises on the face, genital areas, breast and buttocks and/or multiple injuries or bruises of unknown origin. LPN-A stated the administrator then determines if the bruises or injuries should be reported to the SA. On 3/9/16, at 12:25 p.m. the director of nursing (DON) stated she was aware of R32's bruises reported on 9/5/15, and reported R32 had	F 226		

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injections around that timeframe. The DON verified the Incident Report dated 9/5/15 did not identify a cause for all the bruises reported. The DON was not aware of R32's bruise on the right eye reported on 9/6/15. The DON confirmed the bruise was in a suspicious area, then stated R32 did receive eye drops and the bruise could have happened from the resident rubbing the eye. The DON stated she would have reported the incident that occurred on 9/6/15 to the administrator if she was aware of it at that time, then stated when she reviewed the incident report it was well after the fact. The DON stated bruises or injuries of unknown origin are assessed and staff are interviewed. A registered nurse documents how staff felt the bruise or injury happened after reviewing the medical record, assessments and interviews. If the RN could not find a reason or cause, then she would be notified for further review. The DON stated she is not made aware of incidents until she reviews the incident reports for the facility's quality assurance meeting for tracking and trending purposes. The DON stated she had no concerns or trends to report to the quality assurance meeting regarding R32. The DON confirmed the administrator was responsible for reporting unknown injuries or bruises to the SA. The DON stated any bruise or injury suspicious in nature, areas of the body not vulnerable to trauma or multiple injuries would be reported to the SA.

On 3/9/15, at 12:55 p.m. the administrator confirmed staff are expected to update him on any bruises and/or injuries the resident or staff could not explain. The administrator stated it would depend on the injury if he would submit the incident to the SA, then reported any bruises or injuries in the genital area, breast, buttocks or

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F 226	Continued From page 15 areas not normally exposed to injuries would be reported. The adminstrator explained each incident is reviewed, and if staff have a probable reason of how a bruise happened, he would not report to the SA. After each incident a RN completes a review and will look back and look at injuries of unknown origin. The administrator reported the risk management team meets monthly and should be looking at frequency and trending of all injuries and bruises of unknown origin. The administrator felt R32's multiple bruises on 9/5/15 could have been caused by the procedure of receiving injections if not in the exact location of the injection due to staff possibly having to pinch together R32's skin, therefore, was not reportable to the SA. The administrator was aware of R32's bruise on the right eye on 9/6/15. He confirmed the bruise on R32's right eye was not reported to the SA. The administrator felt the bruise was explained because R32 received eye drops, had fragile skin and received a low dose of aspirin daily. He stated staff review all injuries on a daily basis, and he assumed the nurse was interviewed and was likely from the eye drop administration. The administrator confirmed the staff look for a "reasonable explanation" for bruises/injuries of unknown origin, and if staff can find one the bruise/injury is no longer of unknown origin.	F 226		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Central Todd County Care Center 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or Or by email to: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/01/2016

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

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

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K 000	Continued From page 2 fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The 2002/ 2003 addition has smoke detection in the sleeping rooms, with automatic fire detection installed in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 60 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Observations, and staff interview revealed that there is 1 of 5 fire barriers located throughout the facility that did not meet the opening protective requirements for a 2 hour fire barrier and is not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1, 8.2.3.2.3.1.This deficient practices could allow the	K 011	Door separating the nursing home from the adjoining assisted living is being replaced with one that has the appropriate fire rating and accompanying documentation. Correction Responsibility: Maintenance Supervisor. Expected Date of Completion: May 1, 2016.	5/1/16

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K 011	Continued From page 3 products of combustion to travel from one building to another, which could negatively impact all the residents in "A" wing and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am and 4:45 pm on 03/09/2016 observations revealed that the 2 hour fire barrier located at the separation of the nursing home and the link to the assisted living did not have a 1 1/2 hour fire rated door. This deficient practice was confirmed by the Facility Administrator and the Maintenance Supervisor.	K 011		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the	K 018	All resident room doors were reevaluated	5/1/16

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K 018	Continued From page 4 facility failed to maintain the smoke resistance of 7 resident room doors according to NFPA 101 LSC (00) section 19.3.6.3.1. This deficient practice could affect the safety of 24 of the 53 residents and an undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 8:30 am and 4:45 pm on 03/09/2016 observations revealed that the doors to resident rooms, A8, A10, A13, A7, B3, D5, and D8 did not fit tightly in the frame. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 018	for fit within frame. All doors that do not meet ½ or less criteria will be replaced or gaps will be sealed with rated fire-stripping per manufacurers specifications. Correction Responsibility: Maintenance Supervisor. Expected date of Completion: May 1, 2016.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper construction of 2 of 5 smoke barrier walls according to the requirements of NFPA 101 - 2000 edition, Sections 19-3.7.3 and 8.3. This deficient practice could affect 21 residents and an undetermined amount of staff and visitors by allowing smoke to propagate from one smoke compartment to another.	K 025	Penetrations in smoke barriers were repaired or sealed. Correction Responsibility: Maintenance Supervisor. Date of Completion: April 1, 2016.	4/1/16

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K 025	Continued From page 5 Findings include: On the facility tour between 8:30 am and 4:45 pm on 03/09/2016 observations revealed penetrations in two smoke barriers, one located in the TV room and one located in A wing near resident room A1. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 025		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain 3 exits in accordance with the egress requirements of NFPA 101 Life Safety Code (00) section 7.2.1.5.1, locking arrangements and section 7.2.1.3, floor level. This decficient practice could affect the safe and efficient exiting of all residents, staff and visitors. Findings include: On the facility tour between 8:30 am and 4:45 pm on 03/09/2016 observations revealed three exits were not readily accessible for the following reasons. 1. The activity room door has a locking device that requires special knowledge to open. 2. The activity room exit door landing is two inches lower than the threshold. 3. The courtyard gate outside of the dining room exit has a locking device that requires special knowledge to operate. 4. The kitchen rear exit has a landing that is two inches lower than the threshold.	K 038	1. Activity room door has been posted with instructions regarding operation of locking device for safe exit. 2. Activity room door exit landing will be replaced with one that meets exit specifications. 3. Courtyard gate lock will be removed 4. Kitchen rear exit landing will be replaced with one that meets exit specifications. 5. Employee entrance, Courtyard exit and West exit landings were also identified by maintenance as not meeting exit specifications due to excessive threshold height disparity. Correction Responsibility: Maintenance Supervisor. Date of Compliance: May 1, 2016	5/1/16

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K 038	Continued From page 6 This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 038		
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (00) section 19.3.4.2, 9.6.1.4 and NFPA 72 National Fire Alarm Code (99) section 2-3.6.6.2. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect 29 of the 53 residents and an undetermined amount of staff and visitors. On the facility tour between 8:30 am and 4:45 pm	K 051	Identified smoke detector has been moved away from the diffuser, and a smoke detector will be added in the soiled utility room on D wing. Date of Completion: May 1, 2016 Responsibility: Maintenance Supervisor.	5/1/16

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K 051	Continued From page 7 on 03/09/2016 observations revealed in corridor E near room 102 a smoke detector that was within 36 inches of a diffuser and a missing smoke detector in the soiled utility room DD located in wing D. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 051		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility has failed to conducted a complete and accurate test of the initiantion devices and smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2 and 7-3.2.1. This deficient practice could affect all 53 residents, visitors, and staff if a device that was missed inspection did not function during a fire event. Findings include: On the facility tour between 8:30 am and 4:45 pm on 03/09/2016 record review revealed the smoke detector sensitivity report dated 02/08/2016 did not match the previous year for total quantities of initiation devices tested and the type of smoke detectors was listed as ion in one report and photo electric in the other. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 054	Smoke detector sensitivity reports will be reconciled and adjusted as appropriate by Fire Inspection Contractor. Sensitivity testing may be re-performed if deemed necessary to validate reports. Date of Completion: May 1, 2016 Responsibility: Maintenance Supervisor.	5/1/16
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		5/1/16

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K 062 SS=F	Continued From page 8 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 53 residents, staff and visitors. Findings include: On the facility tour between 8:30 am and 4:45 pm on 03/09/2016 observations and record review revealed the sprinkler system was not inspected per NFPA 25 and the system was not continuously maintained in a reliable operating condition for the following reasons. 1. There was no record of an inspection being conducted in the 3rd quarter of 2015. 2. An escutcheon was missing in the central bathing room in B wing. 3. 4 sprinkler heads in the kitchen near the dishwasher station are turning green and one head near the kitchen hood is covered with an oily substance and dirt. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 062	1. No documentation for inspection completion/findings were located. Inspections are scheduled, and documentation is filed in Fire Marshal binder. Will review inspection schedule for all scheduled inspections, and documentation filing monthly to assure proper scheduling, inspection, and documentation are completed. 2. Escutcheon will be replaced. 3. 4 sprinkler heads will be replaced or cleaned as needed. Date of Completion: May 1, 2016 Responsibility: Maintenance Supervisor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/09/2016**

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K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 53 residents, staff, and visitors. Findings include: On the facility tour between 8:30 am and 4:45 pm on 03/09/2016 record review revealed the generator cool down period has not been logged on the inspection report form. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 144	Generator inspection form will be modified to include logging of cool down and length of cooling period. Inspection protocol will be changed to include proper documentation. Date of Completion: May 1, 2016 Responsibility: Maintenance Supervisor.	5/1/16
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observations and staff interview it was revealed that the facility failed to maintain the facilitys electrical wiring per NFPA 101 (99) section 9.1.2 and NFPA 70. This deficient practice could affect 2 of the 53 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am and 4:45 pm on 03/09/2016 observations revealed the three	K 147	Equipment was removed to ensure 3 foot clearance in front of electrical panels. Wall cover plate was replaced and light fixture was installed on open junction box in the chapel area. Date of Completion: May 1, 2016 Responsibility: Maintenance Supervisor.	5/1/16

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K 147	Continued From page 10 foot clearance in front of an electrical panel was not maintained in the electrical room inside of the laundry room, a cover plate was missing from a wall outlet next to the sink in the activity room and a cover plate was missing from a junction box in the chapel ceiling. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 147		
K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. In accordance with NFPA 101 (00)) Life Safety Code section 9.7.6.1. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all 53 residents and an undetermined amount of visitors and staff. Findings include: On the facility tour between 8:30 am and 4:45 pm on 03/09/2016 record review revealed there wasn't a designated out of service policy for the fire sprinkler system.	K 154	Policy was modified/updated to specify sprinkler system outage procedure. Current policy did not specifically describe each requirement. Date of Completion: May 1, 2016 Responsibility: Maintenance Supervisor.	5/1/16

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K 154	Continued From page 11 This deficient practice was verified by the Maintenance Manager.	K 154		
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a review of documentation and an interview with staff it was determined that the facility does not have a written out of service policy for the fire alarm system in accordance with NFPA 101 (LSC) 2000 edition sections 9.6.1.8. This deficient practice could negatively impact all 53 of the residents if the system is out of service and no alternative method of discovering a fire is provided. Findings include: On the facility tour between 8:30 am and 4:45 pm on 03/09/2016 record review revealed there wasn't a designated out of service policy for the fire alarm system. This deficient practice was verified by the Maintenance Supervisor and the facility Administrator	K 155	Policy was modified/updated to specify Fire alarm system outage procedure. Current policy did not specifically describe each requirement. Date of Completion: May 1, 2016 Responsibility: Maintenance Supervisor.	5/1/16