CENTERS FOR MEDICARE & MEDICAID SERVICES

| | | | | | ND TRANSMITTAL E SURVEY AGENCY | | D: RME8 acility ID: 00761 |
|--|--|---|--|-------------------------------|--|--|---|
| 1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245521 2.STATE VENDOR OR MEDICAID NO. (L2) 785540100 5. EFFECTIVE DATE CHANGE OF OWN (L9) | | 3. NAME AND ADI (L3) CENTRAL T (L4) 406 EAST HI (L5) CLARISSA, 1 | ODD COUNTY (GHWAY 71, PO) MN PPLIER CATEGORY | CARE CEN BOX 38 | (L6) 56440 | 4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation 7. On-Site Visit 8. Full Survey After Co | 7 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other |
| 6. DATE OF SURVEY 05/05/3 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other | (L34) (L10) | 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF | 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP | 10 NF 11 ICF/IID 12 RHC | 13 PTIP 22 CLIA 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 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 60 (L37) (L38) 16. STATE SURVEY AGENCY REMARKS | 60 (L18) 60 (L17) 19 SNF (L39) | B. Not in Comp Requirements a ICF (L42) | nce With quirements Based On: ccceptable POC pliance with Program and/or Applied Waive IID (L43) | | And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): | 6. Scope of Servi | tor |
| 17. SURVEYOR SIGNATURE Timothy Rhonem | us, HFE NE | Date : | 05/05/2016 | (L19) | 18. STATE SURVEY AGENCY AP Kate Johns Ton, Pro | | Date:05/12/2016 (L20) |
| | PART II - TO | BE COMPLETE | D BY HCFA RE | GIONAL | OFFICE OR SINGLE STAT | E AGENCY | |
| DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Parti 2. Facility is not Eligible | cipate (L21) | | IPLIANCE WITH C | IVIL | Statement of Financi Ownership/Control I Both of the Above : | ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA | L-1513) |
| 22. ORIGINAL DATE OF PARTICIPATION 02/01/1988 (L24) 25. LTC EXTENSION DATE: (L27) | 23. LTC AGREEMI BEGINNING I (L41) 27. ALTERNATIVI A. Suspension of | DATE E SANCTIONS of Admissions: | 4. LTC AGREEME ENDING DATE (L25) | | 26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal | INVOLUNT 05-Fail to Me nt 06-Fail to Me | ARY eet Health/Safety eet Agreement Status Change |
| , | B. Rescind Sus | pension Date: | (L45) | | | | |
| 28. TERMINATION DATE: | | . INTERMEDIARY/C | ARRIER NO. | | 30. REMARKS | | |
| | (L28) | | | (L31) | | | |

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

04/14/2016

(L32)

31. RO RECEIPT OF CMS-1539



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



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

| | | P081 | -CERI | IFIC | AHON | KE | VISII RE | <u>:PURI</u> | | | |
|------------------------------------|--|--|-------------------------|------------------|--------------------------------|----------------------|--------------------------------------|------------------------------|---|---------|-----------------|
| PROVIDER / SUPPL | | MULTIPLE CONS | TRUCTION | | | | | | | DATE C | F REVISIT |
| IDENTIFICATION NI 245521 | | A. Building B. Wing | | | | | | | Y2 | 5/5/201 | 6 _{Y3} |
| NAME OF FACILITY | , | • | | | s | STREET | ADDRESS, CIT | Y, STATE, ZIF | CODE | | |
| CENTRAL TODD | COUNTY CAR | RE CENTER | | | 4 | 106 EAS | T HIGHWAY 71, | PO BOX 38 | | | |
| | | | | | c | CLARISS | SA, MN 56440 | | | | |
| program, to show corrected and the | those deficiend date such corr and the identif | alified State surveyonies previously repo ective action was a fication prefix code p | orted on the ccomplishe | CMS-2 d. Each | 567, Statemen deficiency sł | ent of Do hould b | eficiencies and e fully identifie | Plan of Cor d using eithe | rection, that have er the regulation o | r LSC | |
| ITEM | | DATE | ITEM | | | | DATE | ITEM | | | DATE |
| Y4 | | Y5 | Y4 | | | | Y5 | Y4 | | | Y5 |
| ID Prefix F0159 | | Correction | ID Prefix | F0225 | | | Correction | ID Prefix | F0226 | | Correction |
| Reg. # |)(2)-(5) | Completed | Reg. # | 483.13 - (4) | (c)(1)(ii)-(iii), (c) |)(2) | Completed | Reg. # | 483.13(c) | | Completed |
| LSC | | 04/08/2016 | LSC | | | | 04/08/2016 | LSC | | | 04/08/2016 |
| ID Prefix | | Correction | ID Prefix | | | | Correction | ID Prefix | | | Correction |
| Reg. # | | Completed | Reg. # | | | | Completed | Reg. # | | | Completed |
| LSC | | | LSC | | | | | LSC | | | - |
| ID Prefix | | Correction | ID Prefix | | | | Correction | ID Prefix | | | Correction |
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| LSC | | | LSC | | | | | LSC | | | - |
| REVIEWED BY | REVI | EWED BY | DATE | | SIGNATURE | OF SU | RVEYOR | | | DATE | |

Form CMS - 2567B (09/92) EF (11/06)

FOLLOWUP TO SURVEY COMPLETED ON

(INITIALS)

(INITIALS)

REVIEWED BY

JS/KJ

05/12/2016

DATE

STATE AGENCY

REVIEWED BY

CMS RO

3/10/2016

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

TITLE

29249

DATE

05/05/2016

YES NO

POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 | | DATE OF REVISIT | |
|--|--|---|-----------------|----|
| | | | 5/5/2016 | |
| 245521 _{Y1} | 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 quali | fied State surveyor for the Medicare, Medicaid | and/or Clinical Laboratory Improvement Amendments | | |

program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| ITE 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 1 | 01 | 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 1 | 01 | 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 1 | 01 | 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 1 | 01 | 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 | | | |
| REVIEWE STATE AG | | REVIEWED BY (INITIALS) TL/KJ | DATE 05/12/2 | 2016 | SIGNATURE OF SU | | 5482 | | DATE 05/0 |)5/2016 |
| REVIEWE CMS RO | D BY | REVIEWED BY (INITIALS) | DATE | | TITLE | | | | DATE | |
| FOLLOW 3/9/2016 | UP TO SURVEY C | OMPLETED ON | | | I ANY UNCORRECTE ED DEFICIENCIES (| | | | YES | в 🗆 по |

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: RME8

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

| | P | ARTI-TO BE COM | PLETED BY | THE STATE | E SURVEY AGENCY | Fi | acility ID: 00761 |
|---|-----------------------|-------------------------------|----------------------|------------|--|------------------------------------|---------------------------|
| MEDICARE/MEDICAID PROVIDE (L1) 245521 | R NO. | 3. NAME AND AD (L3) CENTRAL T | | | TER | 4. TYPE OF ACTION: | 2 (L8) 2. Recertification |
| 2.STATE VENDOR OR MEDICAID N | 0. | (L4) 406 EAST H | IGHWAY 71, PC |) BOX 38 | | 3. Termination | 4. CHOW |
| (L2) 785540100 | | (L5) CLARISSA, | MN | | (L6) 56440 | 5. Validation 7. On-Site Visit | 6. Complaint 9. Other |
| 5. EFFECTIVE DATE CHANGE OF C | OWNERSHIP | 7. PROVIDER/SU | PPLIER CATEGOI | RY | <u>02</u> (L7) | | |
| (L9) | | 01 Hospital | 05 HHA | 09 ESRD | 13 PTIP 22 CLIA | 8. Full Survey After Con | mpiaint |
| 6. DATE OF SURVEY 03 | / 10/2016 (L34 | ´ | 06 PRTF | 10 NF | 14 CORF | FISCAL YEAR ENDING | DATE: (L35) |
| 8. ACCREDITATION STATUS: | (L10 | | 07 X-Ray | 11 ICF/IID | 15 ASC | | DAIL. (E33) |
| 0 Unaccredited 1 TJC 2 AOA 3 Othe | r | 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | 09/30 | |
| 11LTC PERIOD OF CERTIFICATION | | 10.THE FACILITY | IS CERTIFIED AS | S: | | | |
| From (a): | | A. In Complia | nce With | | And/Or Approved Waivers Of Th | ne Following Requirements: | _ |
| To (b): | | Program Re Compliance | | | 2. Technical Personnel | _ 6. Scope of Servi | ces Limit |
| | | | | | 3. 24 Hour RN | 7. Medical Direct | |
| 12.Total Facility Beds | 60 (L18 | | Acceptable POC | | 4. 7-Day RN (Rural SNF | 8. Patient Room S | ize |
| 13. Total Certified Beds | 60 (L17) | X B. Not in Com | npliance with Progra | ım | 5. Life Safety Code | 9. Beds/Room | |
| | | | and/or Applied Wa | | * Code: B* | (L12) | |
| 14. LTC CERTIFIED BED BREAKDOV | VN | | | | 15. FACILITY MEETS | | |
| 18 SNF 18/19 SN | IF 19 S | SNF ICF | IID | | 1861 (e) (1) or 1861 (j) (1): | (L15) | |
| 60 | | | | | | | |
| (L37) (L38) | (L3 | (L42) | (L43) | | | | |
| 16. STATE SURVEY AGENCY REMA | ARKS (IF APPLICAL | BLE SHOW LTC CANCELI | LATION DATE): | , | | | |
| 17. SURVEYOR SIGNATURE | | Date : | | | 18. STATE SURVEY AGENCY A | PPROVAL | Date: |
| Mardelle Trett | el, HFE NI | E II | 04/06/2016 | (L19) | Kate JohnsTon, P | rogram Specialis | t 04/11/2016 (L20) |
| | PART II - | TO BE COMPLETE | D BY HCFA R | REGIONAL | OFFICE OR SINGLE STA | TE AGENCY | (220) |
| 19. DETERMINATION OF ELIGIBIL | ITY | | MPLIANCE WITH | CIVIL | 21. 1. Statement of Finan | | |
| 1. Facility is Eligible to | Participate | RIGI | HTS ACT: | | Ownership/Control Both of the Above | I Interest Disclosure Stmt (HCFA : | 1513) |
| 2. Facility is not Eligible | | | | | | | |
| | (L2 | 21) | | | | | |
| 22. ORIGINAL DATE | 23. LTC AGR | EEMENT | 24. LTC AGREEM | IENT | 26. TERMINATION ACTION: | (I | .30) |
| OF PARTICIPATION | BEGINN | NING DATE | ENDING DA | ГЕ | VOLUNTARY 0 | <u>INVOLUNT</u> | ARY |
| 02/01/1988 | | | | | 01-Merger, Closure | 05-Fail to Me | et Health/Safety |
| (L24) | (L41) | | (L25) | | 02-Dissatisfaction W/ Reimbursem | ent 06-Fail to Me | eet Agreement |
| 25. LTC EXTENSION DATE: | 27. ALTERN | ATIVE SANCTIONS | | | 03-Risk of Involuntary Termination | <u>OTHER</u> | |
| | A. Susper | nsion of Admissions: | | | 04-Other Reason for Withdrawal | 07-Provider S | Status Change |
| (1.27) | | | (L44) | | | 00-Active | |
| (L27) | B. Rescin | nd Suspension Date: | | | | | |
| | | | (L45) | | | | |
| 28. TERMINATION DATE: | | 29. INTERMEDIARY/C | CARRIER NO. | | 30. REMARKS | | |
| | | 03001 | | | | | |
| | (L28) | | | (L31) | | | |
| 31. RO RECEIPT OF CMS-1539 | | 32. DETERMINATION | OF APPROVAL DA | ATE | Posted 04/14/2016 Co. | | |
| | (1.32) | | | (1.33) | DETERMINATION ADDRO | OVA I | |



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & 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

PRINTED: 04/06/2016 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---|-----|--|-------------------------------|----------------------------|
| | 245521 | | B. WING | | | 03/10/2016 | |
| | PROVIDER OR SUPPLIER | RE CENTER | | 4 | STREET ADDRESS, CITY, STATE, ZIP CODE 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENT | ΓS | F C | 000 | | | |
| | as your allegation on Department's accept enrolled in ePOC, year the bottom of the | of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required of first page of the CMS-2567 nic submission of the POC will cion of compliance. | | | | | |
| F 159 SS=E | on-site revisit of you validate that substa regulations has bee your verification. 483.10(c)(2)-(5) FA | acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with CILITY MANAGEMENT OF | F 1 | 159 | | | 4/8/16 |
| | facility must hold, saccount for the pers | rization of a resident, the afeguard, manage, and sonal funds of the resident facility, as specified in 8) of this section. | | | | | |
| | funds in excess of saccount (or account the facility's operational interest earned caccount. (In pooled | posit any resident's personal \$50 in an interest bearing ts) that is separate from any of ng accounts, and that credits on resident's funds to that d accounts, there must be a g for each resident's share.) | | | | | |
| | funds that do not ex | aintain a resident's personal sceed \$50 in a non-interest terest-bearing account, or | | | | | |
| LARODATOD | that assures a full a | stablish and maintain a system and complete and separate DER/SUPPLIER REPRESENTATIVE'S SIGN | JATI IDF | | 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

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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| F 159 | accounting principl funds entrusted to behalf. The system must president funds with of any person othe. The individual finar through quarterly sthe resident or his. The facility must not Medicaid benefits were sident's account SSI resource limit is section 1611(a)(3)(amount in the account resident's other resident may lose of the facility failed to funds in excess of interest bearing ac (R2, R4, R5, R6, R820, R22, R25, R2838, R39, R50, R5838, R39, R50, R5938, R3938, R3 | ling to generally accepted es, of each resident's personal the facility on the resident's percelude any commingling of facility funds or with the funds rethan another resident. Incial record must be available tatements and on request to or her legal representative. Incitity each resident that receives when the amount in the reaches \$200 less than the for one person, specified in (B) of the Act; and that, if the bunt, in addition to the value of resource limit for one person, the eligibility for Medicaid or SSI. In the personal standard or the personal standard o | F 15 | Resident fund policy updated resident funds greater than \$6 held in an interest bearing acc beginning 4-1-2016 that is deto resident trust funds. A syst maintain accurate account trained balances has already been established, as well as an aut for monthly balancing of each account. A system to calculate allocate interest to individual abeen created. Interest earnin calculated and posted monthly | 50 will be count dicated only tem to unsactions en dit process resident e and accounts has gs will be | | |

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| F 159 | monies but she did interest bearing. An interview on 3/9 business manager personal funds acc bearing account. During an interview the administrator st incompliance with t | e residents' personal funds not know if this account was /16, at 12:00 p.m. with the (BM) stated the resident ount was not an interest on 3/10/16, at 9:37 a.m. with tated the facility was not he interest bearing accounts | F 15 | account statements will be financial representative quested. A communicat to all responsible parties rechange in the account state: April 8, 2016. Resporrection: Administrator. | earterly and as it it it it is it is a sent it is a sent it is it is it is a sent it is it | | |
| | following residents greater than \$50.00 Review of the resididentified the follow -R2's trust account 3/9/16R4's trust account on 3/9/16R5's trust account on 3/9/16R6's trust account 3/9/16R8's trust account 3/9/16R11's trust account 3/9/16R12's trust account 3/9/16R12's trust account 3/9/16R13's trust account 3/9/16R19's trust account 3/9/16. | ent personal funds accounts | | | | | |

| | MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | | | |
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| F 159 | 3/9/16R25's trust accoun 3/9/16R27's trust accoun 3/9/16R28's trust accoun 3/9/16R29's trust accoun 3/9/16R31's trust accoun 3/9/16R34's trust accoun 3/9/16R35's trust accoun 3/9/16R36's trust accoun 3/9/16R50's trust accoun 3/9/16R50's trust accoun 3/9/16R55's trust accoun 3/9/16R55's trust accoun 3/9/16R55's trust accoun 3/9/16R56's trust accoun 3/9/16R60's trust accoun 3/9/16R60's trust accoun 3/9/16R60's trust accoun 3/9/16R60's trust accoun 3/9/16. | t had a balance of \$80.92 on t had a balance of \$84.00 on t had a balance of \$200.00 on t had a balance of \$308.30 on t had a balance of \$105.98 on t had a balance of \$97.00 on t had a balance of \$132.17 on t had a balance of \$132.17 on t had a balance of \$132.00 on t had a balance of \$568.89 on t had a balance of \$422.46 on t had a balance of \$66.95 on t had a balance of \$601.57 on t had a balance of \$160.00 on t had a balance of \$160.00 on t had a balance of \$174.00 on t had a balance of \$84.01 on had funds ranging from on none of the residents were | F 1 | 59 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION DING | | | E SURVEY PLETED |
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| F 159 | reviewed during the amount over \$50.00 individual interest-b The account will be and Social Security control of Central To | dicated all accounts will be a last of each month. Any 0 will be deposited in an earing account at the bank. under the resident's name number, but will be under the odd County Care Center. | | 159 | | | A/8/16 |
| F 225 SS=D | been found guilty of mistreating resident had a finding entered registry concerning of residents or mist and report any know court of law against indicate unfitness for other facility staff to or licensing authority. The facility must entinvolving mistreatm including injuries of misappropriation of immediately to the atto other officials in a through established State survey and certain the facility must haviolations are thoroup revent further pote investigation is in processing the side of the facility must have a survey and certain the facility must haviolations are thoroup revent further pote investigation is in processing the facility must have a survey and certain the facility of the facility must have a survey and certain the facility of the facility of the facility and facility of the facility of the facility and facility of the facili | PORT DIVIDUALS It employ individuals who have f abusing, neglecting, or its by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a can employee, which would or service as a nurse aide or the State nurse aide registry ties. Issure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law if procedures (including to the ertification agency). Inve evidence that all alleged ughly investigated, and must ential abuse while the | F 2 | 225 | | | 4/8/16 |

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| F 225 | with State law (includent certification agency incident, and if the appropriate correct | r or his designated to other officials in accordance uding to the State survey and v) within 5 working days of the alleged violation is verified ive action must be taken. | F 225 | | | |
| | by: Based on interview facility failed to immagency (SA) and convestigation for 1 confunction of unknown origin. Findings include: R32's annual Mining 8/20/15, identified Independentia, heart fail and contracture of indicated R32 had required extensive activities of daily living walk. R32's care area as 8/20/15, indicated Incommunication and self understood or Facility Incident Reforearm and left with the right upper forearm and left with roted to R32's right. | v and document review, the nediately report to the state emplete a thorough of 1 resident (R32) with bruises num Data Set (MDS) dated R32's diagnoses included: lure, glaucoma, Parkinsonism left hand. The MDS further severe cognitive impairment, to complete assistance for all ring (ADL's) and could not sessment (CAA) dated R32 had impaired decreased ability to make to understand others. port #2086 dated 9/5/15, at d R32 had bruising located to earm, mid right forearm, left ist. Old yellow bruising also t upper arm, right hip and mid to unable to report how the | | Incident report filed to OHFC regal R32 and bruises noted during surval Investigation also completed and reported. All injuries of unknown source that not witnessed by staff or can be exactly by the resident will be reported per vulnerable adult reporting policy as 3/10/2016. Reasonable and/or procauses of the injuries will be included the investigation/report, but will not used to reclassify incidents as was practice. Staff have been educated change of practice, and daily review incident trending monitors compliant reporting. Trending of overall incident trevestigations and causation will control to be reviewed at quarterly QA meet Date of Completion: April 8, 2016. Responsibility: Administrator | were plained of bable ed in be prior d on w of nce to ent ontinue etings. | |

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| F 225 | indicated R32 wore posed risk for injury aspirin. The Incide thought bruise on lest staff lifting R32. Ardated 9/6/15, identi intramuscular (IM) injections. The rep measurements of Further, the Incider cause of R32's bruif forearm, right uppe were no witnesses identified on the rep. Review of R32's modated 8/23/15 throureceived IM injection right and left deltoic and left buttocks. Inot indicate R32 reright upper forearm forearm or left wrisis. Progress note date 9/6/15 was reviewed was bruised in multiarms, and right hip identified R32 was The note indicated could be related to had recent IM injection bruises on upper an audits were complete provided where need an investigation was | ed. The incident report a splint to the left hand which and received a low dose of nt Report indicated staff eft mid thigh was caused by n entry on the Incident Report fied R32 recently received Rocephin (antibiotic) ort lacked any description or R32's multiple bruises. It Report did not identify the ises on the right and left r forearm and left wrist. There to the injuries that were bort. edication administration record agh 9/1/15, indicated R32 ans to the right leg, left thigh, d (upper, outer arm) and right The administration records did ceived any injections to the , mid right forearm, left t. d 9/8/15, noted the incident on d. The note indicated R32 tiple locations on bilateral and left thigh. Progress note very fragile and bruised easily, the bruising on R32's left arm splint use, and identified R32 tions which would explain the rm, thigh and hip. Transfer eted and staff education was eded. No further evidence of | F 22 | 5 | | | |

| | FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| F 225 | bruise to the right of centimeters (cm) a lid. The Incident Reye drops on 9/6/15 eye with ease wher unable to report ho Incident Report ind with cares, and was pushed far into eye to both eyes, and neye. Progress Note date completely depend and due to arm stiff to lift hands to eyes received eye drops bruised extremely eidentified the eye b within the past 6 m R32 typically receiv No further evidence provided. On 3/10/16, at 9:23 reported R32 was of cares. NA-B stated calm, and did not shad history of multion on 3/9/16, at 11:56 reported when a reunknown origin statinjury and try to figure have been the cause up with a cause the | d R32 had a blue/purple buter eye which measured 4.3 and had redness across the eye eport indicated R32 received 5, at 8:30 p.m., R32 opened a drops were given. R32 was with bruise happened. The ficated R32 had no behaviors a possible R32's glasses were and trouble giving eye drops or bruising was present on left and 9/9/15, indicated R32 was ent upon staff for all ADL's, finess/contractures was unable as The note identified R32, wore glasses daily and easy. The Progress Note also ruise was R32's 7th bruise onths, no trends identified as red bruises to arms and hands. The of an investigation was a a.m. nursing assistant (NA)-B dependent on staff for all a R32 did not resist cares, was peak. NA-B confirmed R32 | F 22 | | | | |

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| F 225 | (LPN)-A stated she administrator right a genital areas, breas injuries or bruises of stated the administrator bruises or injuries or stated the administrator. On 3/10/16, at 9:37 have behaviors dur refuse cares. RN-E bruise of unknown and if staff come up bruises occurred shadministrator. On 3/9/16, at 12:25 (DON) stated she was reported on 9/5/15, injections around the verified the Incident identify a cause for DON was not aware eye reported on 9/6 bruise was in a sus did receive eye drophappened from the DON stated she wo that occurred on 9/6 was aware of it at the reviewed the incide fact. The DON stated she wo that occurred on 9/6 stated she wo that occurred on 9/6 stated she would be supposed from the DON stated she would be su | licensed practical nurse | F 2 | 225 | | | |

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| F 225 | review. The DON's of incidents until sh for the facility's qual tracking and trendir she had no concerr quality assurance in DON confirmed the responsible for reporting to the SA. injury suspicious in vulnerable to traum reported to the SA. On 3/9/15, at 12:55 confirmed staff are any bruises and/or could not explain. would depend on the incident to the SA, injuries in the genital areas not normally reported. The admincident is reviewed reason of how a bruise of unknown reported the risk may monthly and should trending of all injurity origin. The administration of the having to pinch togowas not reportable was aware of R32's | stated she is not made aware e reviews the incident reports lity assurance meeting for ag purposes, The DON stated as or trends to report to the neeting regarding R32. The administrator was orting unknown injuries or The DON stated any bruise or nature, areas of the body not a or multiple injuries would be p.m. the administrator expected to update him on injuries the resident or staff. The administrator stated it are injury if he would submit the then reported any bruises or all area, breast, buttocks or exposed to injuries would be instrator explained each and if staff have a probable uise happened, he would not fiter each incident a RN and will look back and look at origin. The administrator anagement team meets a be looking at frequency and the sand bruises of unknown strator felt R32's multiple ould have been caused by the eing injections if not in the ening injections if not in the ening injections if not in the ening injections on the right eye on ed the bruise on R32's right | F 2 | 225 | | | |

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| F 225 | because R32 received and received a low He stated staff revie and he assumed the was likely from the administrator confire "reasonable explant unknown origin, and bruise/injury is no look to be a confire to be a confirmation of injuries and the injury or the least of the injury or the least of the injury is located in a confirmation of injuries and the indicated injuries of the promptly reported to and other entities or required by the law. The facility's undated in the indicated injuries of the indicated inj | e bruise was explained yed eye drops, had fragile skin dose of aspirin (81 mg) daily. Ew all injuries on a daily basis, e nurse was interviewed and eye drop administration. The med the staff look for a ation" for bruises/injuries of d if staff can find one the onger of unknown origin. Ed Reporting Allegations Of lanagement Policy, included ries of unknown origin. jury was not observed by any se of the injury could not be sident; and, picious because of the extent location of the injury (e.g., the lan area not generally a) or the number of injuries ricular point in time or the lover time. Ed Reporting Abuse To State or Entities/Individuals Policy, an unknown source would be of appropriate state agencies or individuals as may be sed Alleged Abuse by, indicated injuries of a promptly reported and an | F2 | 25 | | |
| F 226 SS=D | investigation compl 483.13(c) DEVELO ABUSE/NEGLECT, | P/IMPLMENT | F 2 | 26 | | 4/8/16 |

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| F 226 | policies and proced mistreatment, negle and misappropriation | evelop and implement written dures that prohibit ect, and abuse of residents on of resident property. | F 2 | 226 | | | |
| | by: Based on interview facility failed to imp policies and proced to the state agency investigations for both of 1 resident (R32) prohibition. Findings include: The facility's undate Abuse To Facility by the definition of injura. The source of in person or the source explained by the reboth injury is located in a vulnerable to traum observed at one paincident of injuries of promptly reported to the promptly reported to the source of the source of the injury is located in a vulnerable to traum observed at one paincident of injuries of promptly reported to the source of | spicious because of the extent location of the injury (e.g., the an area not generally na) or the number of injuries articular point in time or the over time. The definition of the extent of the ex | | | Incident report filed to OHFC regar R32 and bruises noted during surve Investigation also completed and reported. Policy for Vulnerable Adult Abuse reporting and investigation have be reviewed and modifications have be made to clarify change in practice. Education has been provided to lice nursing staff regarding change in prand policy. Ongoing monitoring of reporting of potential vulnerable add abuse and neglect will be complete and trending and analysis will be completed and reviewed quarterly k QAU team. Date of Completion: Ap 2016. Responsibility: Administrator | en een ensed ractice ult d daily, by the oril 8, | |

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| | PROVIDER OR SUPPLIER | RE CENTER | • | 406 | REET ADDRESS, CITY, STATE, ZIP CODE 6 EAST HIGHWAY 71, PO BOX 38 .ARISSA, MN 56440 | | |
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| F 226 | The facility's undate Investigations Policunknown source be investigation complement of Pacility Incident Re 10:00 p.m. indicate the right upper fore forearm and left with noted to R32's right left thigh. R32 was bruising was obtain indicated R32 wore posed risk for injury aspirin. The Incide though [sic] bruise by staff lifting R32. Report dated 9/6/15 received intramusc injections. The rep measurements of Further, the Incider cause of R32's bruif forearm, right uppe were no witnesses identified on the rep. | ed Alleged Abuse y, indicated injuries of e promptly reported and an eted. port #2086 dated 9/5/15, at d R32 had bruising located to arm, mid right forearm, left st. Old yellow bruising also cupper arm, right hip and mid unable to report how the ed. The incident report a splint to the left hand which and received a low dose of nt Report indicated staff on left mid thigh was caused An entry on the Incident 5, identified R32 recently ular (IM) Rocephin (antibiotic) ort lacked any description or R32's multiple bruises. It Report did not identify the ses on the right and left r forearm and left wrist. There to the injuries that were | F2 | 226 | | | |
| | bruise to the right of centimeters (cm) at lid. The Incident Reeye drops on 9/6/15 eye with ease wher unable to report how Incident Report indivith cares, and was pushed far into eye | uter eye which measured 4.3 and had redness across the eye eport indicated R32 received 5, at 8:30 p.m., R32 opened a drops were given. R32 was we the bruise happened. The ecated R32 had no behaviors a possible R32's glasses were, no trouble giving eye drops o bruising was present on left | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION NG | | E SURVEY MPLETED | | |
|--|--|--|---------------------|---|----------|----------------------------|
| | | 245521 | B. WING _ | | 03 | /10/2016 |
| | PROVIDER OR SUPPLIER | RE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 226 | Continued From pa | nge 13 | F 22 | 26 | | |
| | 8/20/15, identified If dementia, heart fail and contracture of indicated R32 had required extensive | num Data Set (MDS) dated R32's diagnoses included: lure, glaucoma, Parkinsonism left hand. The MDS further severe cognitive impairment, to complete assistance for all ing (ADL's) and could not | | | | |
| | completely depend and due to arm stift to lift hands to eyes | ed 9/9/15, indicated R32 was ent upon staff for all ADL's, fness/contractures was unable s. The note identified R32 , wore glasses daily and easy. | | | | |
| | reported when a re unknown origin statinjury and try to figu have been the cause up with a cause the | a.m. registered nurse (RN)-A sident has a bruise of ff would assess the bruise or are out potentially what could se. RN-A stated if staff come en the bruise would not be dministrator or state agency | | | | |
| | (LPN)-A stated she administrator right a genital areas, breas injuries or bruises of stated the administ | licensed practical nurse would report to the away any bruises on the face, st and buttocks and/or multiple of unknown origin. LPN-A rator then determines if the should be reported to the SA. | | | | |
| | (DON) stated she v | p.m. the director of nursing vas aware of R32's bruises and reported R32 had | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--------------------|---|-------------------------------|----------------------------|
| | | 245521 | B. WING | | 03 | 3/10/2016 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP 406 EAST HIGHWAY 71, PO BOX 3 CLARISSA, MN 56440 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 226 | injections around to verified the Incider identify a cause fo DON was not aware eye reported on 9/ bruise was in a sudid receive eye drown that occurred on 9 was aware of it at reviewed the incider fact. The DON strunknown origin are interviewed. A registaff felt the bruise reviewing the medinterviews. If the Figure cause, then she were view. The DON of incidents until strucking and trend she had no concert quality assurance DON confirmed the responsible for reporting to the SA. Injury suspicious in vulnerable to traum reported to the SA. Confirmed staff are any bruises and/or could not explain. Would depend on the incident to the SA, injury to the SA, injury suspicious in vulnerable to traum reported to the SA. Injury suspicious in vulnerable to traum reported to the SA. Injury suspicious in vulnerable to traum reported to the SA. Injury suspicious in vulnerable to traum reported to the SA. Injury suspicious in vulnerable to traum reported to the SA. Injury suspicious in vulnerable to traum reported to the SA. Injury suspicious in vulnerable to traum reported to the SA. Injury suspicious in vulnerable to traum reported to the SA. Injury suspicious in vulnerable to traum reported to the SA. Injury suspicious in vulnerable to traum reported to the SA. Injury suspicious in vulnerable to traum reported to the SA. | hat timeframe. The DON at Report dated 9/5/15 did not a rall the bruises reported. The re of R32's bruise on the right 6/15. The DON confirmed the spicious area, then stated R32 apps and the bruise could have resident rubbing the eye. The ould have reported the incident 7/6/15 to the administrator if she that time, then stated when she ent report it was well after the ated bruises or injuries of assessed and staff are istered nurse documents how or injury happened after ical record, assessments and RN could not find a reason or ould be notified for further stated she is not made aware he reviews the incident reports ality assurance meeting for ing purposes. The DON stated ans or trends to report to the meeting regarding R32. The readministrator was porting unknown injuries or the DON stated any bruise or a nature, areas of the body not ma or multiple injuries would be | F 2 | 226 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|--|--|----------|-------------------------------|--|
| | | 245521 | B. WING | | | 03/10/2016 | |
| | PROVIDER OR SUPPLIER | RE CENTER | | STREET ADDRESS, CITY, STATE, ZIP COD 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440 | E | | |
| (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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | IOULD BE | (X5) COMPLETION DATE | |
| F 226 | reported. The admincident is reviewed reason of how a bri report to the SA. A completes a review injuries of unknown reported the risk m monthly and should trending of all injuri origin. The administration of the having to pinch tog was not reportable was aware of R32's 9/6/15. He confirm eye was not reporte administrator felt the because R32 received and received a low stated staff review and he assumed the was likely from the administrator confirmerasonable explanting and the assumed explanting the responsibility. | exposed to injuries would be instrator explained each d, and if staff have a probable uise happened, he would not after each incident a RN and will look back and look at a origin. The administrator anagement team meets d be looking at frequency and es and bruises of unknown strator felt R32's multiple ould have been caused by the ring injections if not in the e injection due to staff possibly ether R32's skin, therefore, to the SA. The administrator is bruise on the right eye on ed the bruise on R32's right | F 2 | 26 | | | |

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PRINTED: 04/01/2016 FORM APPROVED OMB NO. 0938-0391

| CLIVILL | TO I OIL MEDICALL | & MEDICAID SERVICES | - | | CIVID IVO. | 0930-039 |
|--------------------------|--|--|---------------------|---|------------|----------------------------|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01 | | E SURVEY PLETED |
| | | 245521 | B. WING, | | 03/ | 09/2016 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440 | 1 03/ | 03/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| K 000 | INITIAL COMMENT | гѕ | K 0 | 00 | | |
| | FIRE SAFETY | | | | | |
| i | ALLEGATION OF ODEPARTMENT'S A SIGNATURE AT TH | OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE. | | | | |
| | ONSITE REVISIT OF CONDUCTED TO VISUBSTANTIAL COREGULATIONS HA | F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. | | | | |
| : | Minnesota Departmentime of this survey of Center 01 Main Buissubstantial compliant participation in Med Subpart 483.70(a), 2000 edition of National Association (NFPA) | Survey was conducted by the nent of Public Safety. At the Central Todd County Care Iding was found not in nce with the requirements for Iicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection Standard 101, Life Safety er 19 Existing Health Care. | | | | |
| | PLEASE RETURN CORRECTION FO DEFICIENCIES (K- | R THE FIRE SAFETY | | EDO | | |
| | HEALTH CARE FIR STATE FIRE MARS 445 CEDAR STRE ST. PAUL, MN 551 | SHAL DIVISION ET, SUITE 145 | | EFU | | |
| | Or by email to: Marian.Whitney@s | tate.mn.us | | | | |

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.

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ' ' | IPLE CONSTRUCTION IG 01 - Main Building 01 | | TE SURVEY MPLETED |
|--------------------------|---|---|---------------------|---|---------|----------------------------|
| | | 245521 | B. WING _ | | 03 | 3/09/2016 |
| | 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 CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| K 000 | and Angela.Kappenman THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the deficit 2. The actual, or pr 3. The name and/oresponsible for correct a reoccurre Central Todd Countbuilding without a brown constructed at 4 difficulty building was constructed at 4 difficulty was constructed at 4 difficulty was constructed at 5 difficulty was constructed at 6 difficulty was constructed at 7 difficulty was determined to be or 1985, an addition woon the south side a Type V(111). In 199 therapy addition was wing and was determined for D Wing between E and D was tend of D Wing between E and D was apartment building which is separated north end of E wing separated from the fire barrier. The buildings by 2 hour fire | RRECTION FOR EACH INCLUDE ALL OF THE DRMATION: what has been, or will be, done dency. oposed, completion date. If title of the person rection and monitoring to dence of the deficiency. ty Care Center is a 1-story desemble. The building was ferent times. The original rected in 1976 and was for Type V(111) construction. In was added to the service wing and was determined to be of 22 an activities/ physical desembles added to the east end of A dermined to be of Type V(111) and the main entrance and wings dining room, all of which instruction. An assisted living is attached to the B wing by a 2-hour fire barrier. The grare apartments and nursing home with a 2-hour liding is divided into 4 smoke | K 00 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | | SURVEY |
|--------------------------|--|--|-------------------|--|--|--------|----------------------------|
| | | 245521 | B. WING | | | 03/0 | 9/2016 |
| | PROVIDER OR SUPPLIER | RE CENTER | | 4 | TREET ADDRESS, CITY, STATE, ZIP CODE 06 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | | (X5) COMPLETION DATE |
| K 000 | fire sprinkler syster NFPA 13 Standard Systems 1999 editi system with smoke spaces open to the automatic fire department of the accordance with NI Alarm Code" 1999 addition has smoke rooms, with automatic fire systems. | nge 2 In installed in accordance with for the Installation of Sprinkler on. The facility has a fire alarm detection in the corridors and corridors that is monitored for artment notification in FPA 72 "The National Fire edition. The 2002/ 2003 edetection in the sleeping atic fire detection installed in e Minnesota State Fire Code | K | 000 | | | |
| | | apacity of 60 beds and had a time of the survey. | | | | | |
| K 011 SS=E | NOT MET as evide | 42 CFR, Subpart 483.70(a) is inced by: FETY CODE STANDARD | K | 011 | | | 5/1/16 |
| | nonconforming built barrier having at learning constructed addition. Communi corridors and shall self-closing fire dooresistance rating 18.1.1.4.1, 18.1.1.4.1, 19.1.1.4.2 | a common wall with a ding, the common wall is a fire ast a two hour fire resistance of materials as required for the cating openings occur only in be protected by approved ors with at least 1 1/2 hour fire 4.2, 18.2.3.2, 19.1.1.4.1, | | | | | |
| | Observations, and there is 1 of 5 fire to facility that did not requirements for a accordance with NI Code" 2000 edition | s not met as evidenced by: staff interview revealed that parriers located throughout the meet the opening protective 2 hour fire barrier and is not in FPA 101 "The Life Safety (LSC) section 19.1.1.4.1, ficient practices could allow the | | | Door separating the nursing home from the adjoining assisted living is being replaced with one that has the appropriate rating and accompanying documentation. Correction Responsible Maintenance Supervisor. Expected Information: May 1, 2016. | oriate | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ' ' | TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01 | | E SURVEY IPLETED |
|--------------------------|--|---|---------------------|---|----------------|----------------------------|
| | | 245521 | B. WING | | 03/ | 09/2016 |
| | PROVIDER OR SUPPLIER | RE CENTER | | STREET ADDRESS, CITY, STATE, ZIP C 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440 | ODE | (*) |
| (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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| K 011 | building to another, | stion to travel from one which could negatively impact 'A" wing and an undetermined | ΚO | 11 | | |
| | on 03/09/2016 observed hour fire barrier loc nursing home and | between 8:30 am and 4:45 pm ervations revealed that the 2 ated at the separation of the the link to the assisted living 2 hour fire rated door. | | | | |
| K 018 | Facility Administrate Supervisor. | ice was confirmed by the or and the Maintenance | ΚO | 18 | | 5/1/16 |
| SS=E | required enclosures hazardous areas slas those constructed core wood, or capa 20 minutes. Cleara and floor covering in fully sprinklered strequired to resist the no impediment to the open devices that repushed or pulled are provided with a medoor closed. Dutch permitted. Door framade of steel or oth with 8.2.3.2.1. Rolle CMS regulations in 19.3.6.3 | prridor openings in other than so of vertical openings, exits, or hall be substantial doors, such ed of 13/4 inch solid-bonded ble of resisting fire for at least nice between bottom of door is not exceeding 1 inch. Doors smoke compartments are only the passage of smoke. There is nice closing of the doors. Hold elease when the door is the permitted. Doors shall be and suitable for keeping the doors meeting 19.3.6.3.6 are mes shall be labeled and there materials in compliance or latches are prohibited by all health care facilities. | | | | |
| | 19.3.6.3 This STANDARD i | all health care facilities. s not met as evidenced by: tion and staff interview, the | | All resident room doors we | re reevaluated | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | LE CONSTRUCTION 6 01 - MAIN BUILDING 01 | V . , | E SURVEY IPLETED |
|--------------------------|---|--|---------------------|---|--|----------------------------|
| | | 245521 | B. WING | _ | 03/ | 09/2016 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP O 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440 | ODE | |
| (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) COMPLETION DATE |
| K 018 | facility failed to ma 7 resident room do LSC (00) section 1 practice could afferesidents and an usuand visitors, if smoother the exit accession and the countenable. Findings include: On the facility tour on 03/09/2016 obsideors to resident resi | age 4 intain the smoke resistance of pors according to NFPA 101 9.3.6.3.1. This deficient ct the safety of 24 of the 53 indetermined amount of staff oke from a fire were allowed to ss corridors making it between 8:30 am and 4:45 pm servations revealed that the ooms, A8, A10, A13, A7, B3, t fit tightly in the frame. | K 018 | for fit within frame. All door meet ½ or less criteria will his gaps will be sealed with rate fire-stripping per manufacu specifications. Correction Maintenance Supervisor. E of Completion: May 1, 2016 | pe replaced or ed rers Responsibility: Expected date | |
| K 025 SS=E | Administrator and NFPA 101 LIFE SA Smoke barriers shall be patrium wall. Windo fire-rated glazing of steel frames. 8.3, 19.3.7.3, 19.3 This STANDARD Based on observate facility failed to mand of 5 smoke barrier requirements of N Sections 19-3.7.3 could affect 21 resamount of staff and | dition was verified by the Facility the Maintenance Supervisor. AFETY CODE STANDARD all be constructed to provide at ur fire resistance rating and ordance with 8.3. Smoke ermitted to terminate at an ews shall be protected by or by wired glass panels and 1.7.5 is not met as evidenced by: ation and staff interview, the aintain proper construction of 2 walls according to the FPA 101 - 2000 edition, and 8.3. This deficient practice idents and an undetermined divisitors by allowing smoke to be smoke compartment to | K 025 | Penetrations in smoke bar repaired or sealed. Correct Responsibility: Maintenand Date of Completion: April of | ion ce Supervisor | 4/1/16 |

| OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | | | E SURVEY PLETED |
|---|--|---|--|---|---|
| | 245521 | B. WING | | 03/0 | 09/2016 |
| PROVIDER OR SUPPLIER L TODD COUNTY CA | RE CENTER | 4 | 06 EAST HIGHWAY 71, PO BOX 38 | | |
| (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL | D BE | (X5) COMPLETIO DATE |
| Continued From pa Findings include: | nge 5 | K 025 | | | - |
| on 03/09/2016 observed penetrations in two | ervations revealed smoke barriers, one located in | | | | |
| Administrator and t NFPA 101 LIFE SA | he Maintenance Supervisor. FETY CODE STANDARD | K 038 | | | 5/1/16 |
| accessible at all tim 7.1. 19.2.1 This STANDARD i Based on observar facility failed to mai with the egress required Safety Code (00) surrangements and This decficient pracefficient exiting of a Findings include: On the facility tour on 03/09/2016 observer not readily acreasons. The activity roor that requires special 2. The activity roor inches lower than the standard service of the service | s not met as evidenced by: tion and staff interview the ntain 3 exits in accordance uirements of NFPA 101 Life ection 7.2.1.5.1, locking section 7.2.1.3, floor level. ctice could affect the safe and all residents, staff and visitors. between 8:30 am and 4:45 pm ervations revealed three exits cessible for the following m door has a locking device al knowledge to open. m exit door landing is two he threshold. | | with instructions regarding operations device for safe exit. 2. Activity room door exit landing replaced with one that meets exit specifications. 3. Courtyard gate lock will be refunded as a courtyard gate lock will be refunded with one that meets exit specifications. 5. Employee entrance, Courtya and West exit landings were also identified by maintenance as not rexit specifications due to excessive threshold height disparity. Correction Responsibility: Mainter | on of g will be moved be ard exit meeting ye mance | |
| | PROVIDER OR SUPPLIER L TODD COUNTY CA SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From paragraphics include: On the facility tour on 03/09/2016 observations in two the TV room and or resident room A1. This deficient cond Administrator and the NFPA 101 LIFE SA Exit access is arrar accessible at all time 7.1. 19.2.1 This STANDARD is Based on observational facility failed to main with the egress required Safety Code (00) sarrangements and This decircient exiting of a service of the facility tour on 03/09/2016 observer entered in the service of the activity room that requires species 2. The activity room inches lower than the 3. The courtyard general summary of the service | PROVIDER OR SUPPLIER L TODD COUNTY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 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. 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 | PROVIDER OR SUPPLIER L TODD COUNTY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 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. 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 decicient 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 | PROVIDER OR SUPPLIER L TODD COUNTY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 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. 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 7.2.1.3, floor level. This deficient 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. The activity room door has a locking device that requires special knowledge to open. This activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a | TODO COUNTY CARE CENTER L TODD COUNTY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 Findings include: On the facility tour between 8:30 am and 4:45 pm on 03/09/2016 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 7.2.1.51, locking arrangements and section 7.2.1.51, locking arrangements and section 7.2.1.53, floor level. This deficient 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. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. The activity room door has a locking device that requires special knowledge to open. |

| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE | OLIVILI | TO TOTA WILDIONITE | A MILDIONID OLIVIOLO | | | OWID NO. | . 0000-000 |
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| CENTRAL TODD COUNTY CARE CENTER CHAIR CACH DEFOCIENCIES SUMMARY STATEMENT OF DEFICIENCIES CLARISSA, MN 56440 FREGULATORY OR LSC IDENTIFYING INFORMATION) K 038 Continued From page 6 This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor. K 051 K 051 K 051 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 I and my system is provide effective warning of fire in any part of the building. Fire alarm system is in many part of the building. 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 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, 9.5 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 2.3.6.2. 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 | | | | l ' ′ | | | |
| STREET ADDRESS, CITY, STATE, ZIP CODE 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MM 56440 EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.SC IDENTIFYING INFORMATION) K 038 Continued From page 6 This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor. K 051 NFPA 101 LIFE SAFETY CODE STANDARD SSSE A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Fleetric 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 by manual means and by any required syntikler system alarm, detection device, or detection system Manual alarm boxes are provided by audible and visual signals. In critical care areas, visual alarms are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are usufficient. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.8 Based on observations and staff interview the facility falled to install the smoke detection in accordance with NFPA 72 National Fire Alarm Code (99) section 2-3.6.9.2. 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 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 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 This deficient practice could affect 29 of the 53 This deficient practice could affect 29 of the 53 This deficient practice could affect 29 of the 53 This deficient practice could affect 29 of the 53 This defic | | | 245521 | B. WING | | 03/ | 09/2016 |
| FREETX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K 038 Continued From page 6 This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor. K 051 R 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 is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes in patient sleeping areas shall not be required at exist if manual alarm boxes in patient sleeping areas shall not be required at exist 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, 9.6.1.4 and NFPA 72 National Fire Alarm Code (90) 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 | | | ARE CENTER | | 406 EAST HIGHWAY 71, PO BOX | CODE | |
| This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor. K 051 NFPA 101 LIFE SAFETY CODE STANDARD SS=E 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 | PRÉFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREFI) | (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| and visitors. On the facility tour between 8:30 am and 4:45 pm | K 051 | This deficient cond Administrator and the NFPA 101 LIFE SAAA fire alarm system components appropriate | ition was verified by the Facility the Maintenance Supervisor. IFETY CODE STANDARD It is installed with systems and ved for the purpose in FPA 70, National Electric Code onal Fire Alarm Code to arning of fire in any part of the naystem wiring or other are monitored for integrity. It is alarm system is by manual required sprinkler system exice, or detection system. It is are provided in the path of equired exit. Manual alarm exping areas shall not be manual alarm boxes are stations. Occupant ded by audible and visual are areas, visual alarms are alarm system transmits the tonotify emergency forces in the fire alarm automatically control functions. System ined and readily available. Is not met as evidenced by: tions and staff interview the all the smoke detection in FPA 101 Life Safety Code (00) 6.1.4 and NFPA 72 National 9) section 2-3.6.6.2. This ould affect the ability of the und in a timely manner during could affect 29 of the 53 nedetermined amount of staff | | Identified smoke detector moved away from the diffresmoke detector will be ad utility room on D wing. Da Completion: May 1, 2016 | user, and a ded in the soiled ate of | |

| 0 = 1 + 1 = 1 | TO TOTTIFICOTOTICE | A MEDIONID SERVICES | | | OITE ITO. | 0000 000 |
|--------------------------|--|--|---------------------|---|--|---------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01 | | E SURVEY PLETED |
| | | 245521 | B. WING_ | | 03/ | 09/2016 |
| | NAME OF PROVIDER OR SUPPLIER CENTRAL TODD COUNTY CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES | | | STREET ADDRESS, CITY, STATE, ZIP CO 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETIO DATE |
| K 051 | E near room 102 a within 36 inches of smoke detector in tollocated in wing D. This deficient cond | ervations revealed in corridor smoke detector that was a diffuser and a missing the soiled utility room DD | K 0 | 51 | | |
| K 054 SS=F | All required smoke activating door hold maintained, inspect with the manufacturation of the standard of the st | he Maintenance Supervisor. FETY CODE STANDARD detectors, including those d-open devices, are approved, ted and tested in accordance rer's specifications. 9.6.1.3 s not met as evidenced by: eview and staff interview the conducted a complete and initiantion devices and smoke e alarm system in accordance anal Fire Alarm Code (99), Sec. This deficient practice could ats, visitors, and staff if a essed inspection did not be event. | K 0 | Smoke detector sensitivity re reconciled and adjusted as a Fire Inspection Contractor. Stesting may be re-performed necessary to validate reports Completion: May 1, 2016 Remaintenance Supervisor. | ppropriate by Sensitivity if deemed . Date of | 5/1/16 |
| | on 03/09/2016 reco detector sensitivity not match the previ initiation devices te | between 8:30 am and 4:45 pm ord review revealed the smoke report dated 02/08/2016 did lous year for total quantities of sted and the type of smoke d as ion in one report and e other. | | | | |
| K 062 | Administrator and t | ition was verified by the Facility he Maintenance Supervisor. FETY CODE STANDARD | K 00 | 52 | | 5/1/16 |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01 | | E SURVEY PLETED |
|--------------------------|--|---|--------------------|--|--|----------------------------|
| | | 245521 | B. WING | | 03/ | 09/2016 |
| | PROVIDER OR SUPPLIER | RE CENTER | | STREET ADDRESS, CITY, STATE, ZI 406 EAST HIGHWAY 71, PO BOX CLARISSA, MN 56440 | P CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| K 062 SS=F | Required automatic continuously maintal condition and are in periodically. 19.7 9.7.5 This STANDARD is Based on record refacility has failed to the automatic sprin with NFPA 101 Life 19.7.6, and 4.6.12, Sprinkler Systems for the Inspection, Water Based Fire Edeficient practice disprinkler system is fully operational in negatively affect all visitors. Findings include: On the facility tour on 03/09/2016 observealed the sprint per NFPA 25 and the continuously maintal condition for the fold. There was no reconducted in the 3r 2. An escutcheon bathing room in B variety affect and dishwasher station. | e sprinkler systems are ained in reliable operating aspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25, as not met as evidenced by: eview and staff interview, the properly inspect and maintain kler system in accordance Safety Code (00), Section NFPA 13 Installation of (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This oes not ensure that the fire functioning properly and is the event of a fire and could 153 residents, staff and between 8:30 am and 4:45 pm ervations and record review kler system was not inspected ained in a reliable operating llowing reasons. Ecord of an inspection being red quarter of 2015. | K | 1. No documentation for completion/findings were Inspections are schedule documentation is filed in binder. Will review insper for all scheduled inspection documentation filing mon proper scheduling, inspection documentation are comp 2. Escutcheon will be readed. Late of Completion: May Responsibility: Maintena | located. ad, and Fire Marshal action schedule ons, and athly to assure ction, and aleted. applaced. be replaced or | |

| OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED |
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| | 245521 | B. WING | | 03/ | 09/2016 |
| PROVIDER OR SUPPLIER | RE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440 | DE | |
| (EACH DEFICIENC) | MUST BE PRECEDED BY FULL | ID PŘEFIX TAG | (EACH CORRECTIVE ACTION S | HOULD BE | (X5) COMPLETION DATE |
| Generators inspect under load for 30 m in accordance with 3-4.4.1 and 8-4.2 (I 110) This STANDARD in Based on docume interview, the facility generators in accord 2000 NFPA 101 6-4.2 (a) & (b) and could affect all 53 m. Findings include: On the facility tour on 03/09/2016 recording generator cool dow on the inspection record. | ed weekly and exercised ninutes per month and shall be NFPA 99 and NFPA 110. NFPA 99), Chapter 6 (NFPA is not met as evidenced by: ntation review and staff y failed to test the emergency redance with the requirements - 9.1.3 and 1999 NFPA 110 6-4.2.2. The deficient practice esidents, staff, and visitors. | K 1 | Generator inspection form w modified to include logging or and length of cooling period. protocol will be changed to in documentation. Date of Completion: May 1, 2 | f cool down Inspection Inspection Inspection Inspection | 5/1/16 |
| Administrator and the NFPA 101 LIFE SA Electrical wiring an accordance with National Control of the National Electrical wiring and accordance with National Standard Individual Electrical of the section 9.1.2 and National Electrical wire section 9.1.2 and National Electrical Wireless Standard Individual Electrical Electrical Wireless Standard Individual Electrical E | the Maintenance Supervisor. FETY CODE STANDARD d equipment shall be in ational Electrical Code. 9-1.2 19.9.1 s not met as evidenced by: tions and staff interview it was acility failed to maintain the viring per NFPA 101 (99) IFPA 70. This deficient practice as 53 residents and an unt of staff and visitors. | K 1 | Equipment was removed to clearance in front of electrica Wall cover plate was replace fixture was installed on open in the chapel area. Date of 0 | al panels. Id and light Junction box Completion: | |
| | PROVIDER OR SUPPLIER L TODD COUNTY CA SUMMARY STA (EACH DEFICIENCY REGULATORY OR L NFPA 101 LIFE SA Generators inspect under load for 30 m in accordance with 3-4.4.1 and 8-4.2 (I 110) This STANDARD i Based on docume interview, the facilit generators in accord of 2000 NFPA 101 6-4.2 (a) & (b) and could affect all 53 m Findings include: On the facility tour on 03/09/2016 record generator cool dow on the inspection record This deficient cond Administrator and t NFPA 101 LIFE SA Electrical wiring an accordance with Na (NFPA 99) 18.9.1, This STANDARD i Based on observar revealed that the fa facilitys electrical w section 9.1.2 and N could affect 2 of the undetermined amo Findings include: On the facility tour | PROVIDER OR SUPPLIER L TODD COUNTY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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. | ROVIDER OR SUPPLIER L TODD COUNTY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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 | PROVIDER OR SUPPLIER L TODD COUNTY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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 NFPA 99. And 1099 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 STANDARD is not met as evidenced by: Based on observations and staff interview it was revealed that the facility failed to maintain the facility selectrical wiring and equipment shall be in accordance with Mational 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 facility selectrical 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 in the chapel area. Date of (May 1, 2016 Responsibility: Supervisor.) | PROVIDER OR SUPPLIER L TODD COUNTY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SEE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 a.4. 4.1 and 8.4.2 (NFPA 99), Chapter 6 (NFPA 110 c.0) and 1999 NFPA 110 c.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. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor. This STANDARD is not met as evidenced by: Based on observations and staff interview it was revealed that the facility failed to maintain the facility selectrical wring part of the 50 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am and 4:45 pm undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am and 4:45 pm undetermined amount of staff and visitors. |

PRINTED: 04/01/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION IG 01 - MAIN BUILDING 01 | | SURVEY PLETED |
|--------------------------|---|---|---------------------|--|--|----------------------------|
| (2) | | 245521 | B. WING _ | | 03/0 | 09/2016 |
| | PROVIDER OR SUPPLIER | RE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440 | DDE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| K 147 | not maintained in the laundry room, a cowall outlet next to the a cover plate was rethe chapel ceiling. | ont of an electrical panel was he electrical room inside of the ver plate was missing from a he sink in the activity room and missing from a junction box in | K 14 | 7.7 | | |
| K 154 SS=C | Administrator and the NFPA 101 LIFE SA Where a required a out of service for many period, the authority and the building is watch system is prunprotected by the system has been reached the system has been reached to acceptable written be followed in the esprinkler system has for four or more hose accordance with N section 9.7.6.1. The affect the facility's anotification of a fire all 53 residents and visitors and staff. Findings include: On the facility tour on 03/09/2016 recomposition of the facility tour on 03/09/2016 recomposition. | ition was verified by the Facility the Maintenance Supervisor. AFETY CODE STANDARD automatic sprinkler system is nore than 4 hours in a 24-hour by having jurisdiction is notified, evacuated or an approved fire ovided for all parties left shutdown until the sprinkler eturned to service. 9.7.6.1 is not met as evidenced by: It review and staff interview, the provide a complete and policy containing procedures to event that the automatic fire as to be placed out-of-service ours in a 24 hour period. In FPA 101 (00)) Life Safety Code is deficient practice could ability for early response and and would affect the safety of d an undetermined amount of between 8:30 am and 4:45 pm ord review revealed there d out of service policy for the | K 15 | Policy was modified/updated sprinkler system outage produrrent policy did not specifie each requirement. Date of May 1, 2016 Responsibility: Supervisor. | cedure. cally describe Completion: | 5/1/16 |

| | | l ' ' | PLE CONSTRUCTION G 01 - MAIN BUILDING 01 STREET ADDRESS, CITY, STATE, ZIP CODE 406 EAST HIGHWAY 71, PO BOX 38 | COMI | SURVEY PLETED 09/2016 |
|---|--|---|---|--|---|
| DD COUNTY CA | RE CENTER | B. WING _ | 406 EAST HIGHWAY 71, PO BOX 38 | 03/0 | 9/2016 |
| DD COUNTY CA | | | 406 EAST HIGHWAY 71, PO BOX 38 | | |
| SUMMARY STA | | | · | | |
| | TEMENT OF DEFICIENCIES | | CLARISSA, MN 56440 | | |
| , . | TEMENT 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 APPRO DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| ntinued From pa | ge 11 | K 15 | 4 | | |
| s deficient pract | ice was verified by the | | | | |
| | | K 15 | 5 | | 5/1/16 |
| vice for more that authority having ding is evacuate vided for all part tdown until the furned to service. It is STANDARD is sed on a review riew with staff lity does not have for the fire all NFPA 101 (LSC 1.8. This deficienct all 53 of the ervice and no a | an 4 hours in a 24-hour period, jurisdiction is notified, and the ed or an approved fire watch is ies left unprotected by the fire alarm system has been 9.6.1.8 s not met as evidenced by: of documentation and an it was determined that the ea written out of service arm system in accordance C) 2000 edition sections ent practice could negatively residents if the system is out lternative method of | | Fire alarm system outage proced Current policy did not specifically each requirement. Date of Com | dure. / describe pletion: | |
| | | | | | |
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| | s deficient praction tenance Mana PA 101 LIFE SA ere a required fivice for more that authority having ding is evacuated vided for all partition until the formed to service. STANDARD is sed on a review review with staff lity does not have yof or the fire all to the facility to a covering a fire is dings include: the facility tour locally a designated to the facility tour locally a designated the facility and the facility tour locally a designated the facility and the facility tour locally a designated the facility and the facili | the facility tour between 8:30 am and 4:45 pm 03/09/2016 record review revealed there on't a designated out of service policy for the | st deficient practice was verified by the intenance Manager. PA 101 LIFE SAFETY CODE STANDARD For a required fire alarm system is out of vice for more than 4 hours in a 24-hour period, authority having jurisdiction is notified, and the ding is evacuated or an approved fire watch is vided for all parties left unprotected by the town until the fire alarm system has been uned to service. 9.6.1.8 S STANDARD is not met as evidenced by: sed on a review of documentation and an analysis with staff it was determined that the lity does not have a written out of service cy for the fire alarm system in accordance in NFPA 101 (LSC) 2000 edition sections 1.8. This deficient practice could negatively act all 53 of the residents if the system is out ervice and no alternative method of covering a fire is provided. It is facility tour between 8:30 am and 4:45 pm 03/09/2016 record review revealed there and a designated out of service policy for the | Attinued From page 11 Is deficient practice was verified by the Internance Manager. PA 101 LIFE SAFETY CODE STANDARD Interior a required fire alarm system is out of Price for more than 4 hours in a 24-hour period, authority having jurisdiction is notified, and the ding is evacuated or an approved fire watch is priced for all parties left unprotected by the todown until the fire alarm system has been right of service. Interior STANDARD is not met as evidenced by: seed on a review of documentation and an right of service could need that the lity does not have a written out of service could negatively act all 53 of the residents if the system is out ervice and no alternative method of covering a fire is provided. Interior STANDARD is not met as evidenced by: Seed on a review of documentation and an right of service could need that the lity does not have a written out of service could negatively act all 53 of the residents if the system is out ervice and no alternative method of covering a fire is provided. In the facility tour between 8:30 am and 4:45 pm 33/09/2016 record review revealed there and a designated out of service policy for the | Attinued From page 11 Is deficient practice was verified by the intenance Manager. PA 101 LIFE SAFETY CODE STANDARD In a required fire alarm system is out of vice for more than 4 hours in a 24-hour period, authority having jurisdiction is notified, and the ding is evacuated or an approved fire watch is viced for all parties left unprotected by the town until the fire alarm system has been rived to service. 9.6.1.8 Is STANDARD is not met as evidenced by: sed on a review of documentation and an riview with staff it was determined that the lity does not have a written out of service cy for the fire alarm system in accordance 1.8. This deficient practice could negatively act all 53 of the residents if the system is out ervice and no alternative method of covering a fire is provided. It is provided to specify Fire alarm system outage procedure. Current policy did not specifically describe each requirement. Date of Completion: May 1, 2016 Responsibility: Maintenance Supervisor. It is a feficient practice was verified by the material parties and the ding is evacuated or an approved fire watch is vided for all parties left unprotected by the ding is evacuated or an approved fire watch is vided for all parties left unprotected by the ding is evacuated or an approved fire watch is vided for all parties left unprotected by the ding is evacuated or an approved fire watch is vided for all parties left unprotected by the ding is evacuated or an approved fire watch is vided for all parties left unprotected by the ding is evacuated or an approved fire watch is vided for all parties left unprotected by the ding is evacuated or an approved fire watch is vided for all parties left unprotected by the ding is evacuated to specify Fire alarm system outage procedure. Current policy did not specifically describe each requirement. Date of Completion: May 1, 2016 Responsibility: Maintenance Supervisor. |