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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VFKX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00761

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245521**
2.STATE VENDOR OR MEDICAID NO.
(L2) **785540100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/04/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)
13.Total Certified Beds **50** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Brenda Fischer, Unit Supervisor 05/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/08/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245521
May 8, 2018

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

Dear Mr. Polovick:

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

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

Effective April 13, 2018 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
May 8, 2018

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

RE: Project Number S5521027

Dear Mr. Polovick:

On March 23, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 9, 2018. 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 4, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 18, 2018 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 9, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 13, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 9, 2018, effective April 13, 2018 and therefore remedies outlined in our letter to you dated March 23, 2018, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VFKX

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(L4) **406 EAST HIGHWAY 71, PO BOX 38**
(L5) **CLARISSA, MN** (L6) **56440**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/09/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, HFE NE II 04/09/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Debby Baker, Enforcement Specialist 04/25/2018 (L20)

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

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

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3. Both of the Above :

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02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 23, 2018

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

RE: Project Number S5521027

Dear Mr. Polovick:

On March 13, 2018, 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 electronically delivered CMS-2567 whereby corrections are required.

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

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

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

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

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

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

<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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fischer@state.mn.us
Phone: (320) 223-7338
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 18, 2018, 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 18, 2018 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 9, 2018 (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 9, 2018 (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, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING _____ B. WING _____	03/09/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted March 6, 7, 8, & 9, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On March 6, 7, 8, & 9, 2018, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Central Todd County Care Center was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced	F 554		4/13/18

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

Electronically Signed | 04/03/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING _____ B. WING _____	03/09/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 1 by: Based on observation, interview and document review, the facility failed to ensure an assessment was completed to determine safe medication administration for 1 of 1 resident (R7) observed to self administer medication through a nebulizer (breathing treatment). Findings include: R7's quarterly Minimum Data Set (MDS) an assessment dated 2/26/18, identified R7 had severe cognitive impairment and required extensive assistance to complete activities of daily living (ADLs). R7's Diagnosis Report dated 3/9/18, identified diagnoses of chronic obstructive pulmonary disease and congestive heart failure. During observation on 3/9/18, at 2:38 p.m. R7 was seated with family member (FM)-A in FM-A's room, in the assisted living portion of the building. R7 had a nebulizer mask in place and had finished a nebulizer treatment as noted by the absence of mist. R7 then removed mask, and the nebulizer machine was turned off by FM-A. FM-A placed the mask next to the nebulizer machine on the table. FM-A stated the nursing staff frequently set up R7 with the nebulizer treatment and returned once the nebulizer was completed, adding "They're so busy." On 3/9/18, at 2:40 p.m. trained medical assistant (TMA)-A returned to the FM-A's. TMA-A stated she had left R7 unattended, with the nebulizer running to provide assistance to another resident. R7's Medication Review Report identified an order from 2/3/18, for DuoNeb Solution one vial four times a day for cough, shortness of breath	F 554	Resident R7 was assessed for self-administration of her nebulizer following staff setup and was found to be competent. Primary physician gave order to self-administer her nebulizers based on assessment. All other residents medications were reviewed all other nebulizer orders were on a PRN schedule, so no assessments were performed due to the inconsistency of usage and potential for error. New residents will be assessed with scheduled nebulizers. All other nebulizers require staff supervision. Self-administration policy was reviewed and no changes were necessary. LPN, RN and TMA Staff were education on policy. Audits to be performed on PRN nebs to monitor for supervision. Outcomes of the audits will be presented and reviewed by QAU. Responsibility: DON	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING _____ B. WING _____	03/09/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 2	F 554		

(SOB), and wheezing. Additionally, the DuoNeb Solution was ordered every four hours as needed (PRN) at night for cough. SOB, and wheezing.

R7's medication administration record (MAR) from February 2018, indicated R7 had received the medication four times a day as ordered, with an additional three doses given related to symptoms.
R7's current MAR for 3/1/18-3/9/18 identified she had received routine dosing four times per day, however, did not require additional dosing of medication.

R7's electronic medical record lacked an assessment to self administer medications.

During interview on 3/9/18, at 2:31 p.m. registered nurse (RN)-B stated during administration of a nebulizer treatment , R7 at times was noted to be "out of it" and did attempt to self remove mask, requiring redirection on two occasions while nebulizer was completed.

During interview on 3/9/18, at 3:00 p.m. the director of nursing identified a resident should only be allowed to self administer medication after set up, after an assessment had been completed to determine ability and a physician order was obtained.

The facility policy Self-Administration of Medications dated 3/15, directed staff to obtain a physician order for self administration of medication only after residents were assessed to have the cognitive and physical abilities to self administer medications.

The facility policy Medication Administration dated

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F 554	Continued From page 3 11/17, identified under Procedure, 4. Administer oral medications and remain with residents while he/she takes the medication unless they have the order to self administer medication after set-up.	F 554		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident	F 565		4/13/18

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F 565	Continued From page 4 representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their responses to food concerns raised at the resident council meetings were documented and presented back to the council. There were twelve residents (R36, R21, R22, R8, R10, R27, R17, R34, R15, R19 and R25) identified to have participated in resident council meetings in the past two months. Findings include: On 3/6/18, the facility provided resident council minutes from the past month's meetings, and a representative from the resident council, R10, gave permission for the survey team to review the meeting minutes. On 1/15/18, the resident council met and meeting minutes identified officers R8, R27 and R36, but did not list or identify other residents in attendance. The minutes indicated "Food" as an area of concern. The minutes had a section "New Business Summary", which had five sections: Current Situation; What is our Goal?; What needs to get done to get there?; Who will help us get there?; and Current Status. Under the new business summary, there was no mention of "food." However, the minutes contained a copy of a flyer inviting residents to attend a Resident Food Committee meeting set for Monday, January 29, 2018. The agenda included "food temperature, likes and dislikes. Fall/Winter menus, new topics?"	F 565	Dietary Manager to modify minutes to include action items with personnel assignments and outcomes to the meeting minutes in order to document actions taken to resolve dietary concerns. These revised meeting minutes will be posted in the dining areas, and will also be presented at the next resident council meeting and a standing agenda items, as well as at the next food committee meeting. Residents regularly participating in food committee will be notified of posting of new Food Committee Meeting Minutes posting and review at the next resident council meeting. Review of meeting minutes prior to posting will be performed by administrator. Meeting minutes (including actions taken) will be reviewed at by the QAU. Responsibility: Dietary Manager	

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A document, Resident food Committee, Central Todd County Care Center, indicated food committee was held on 1/29/18, and attended by R27, R8, R22, R25, R10, R17, R34, R15 and R19. Areas of concern included:

-pancakes still need to be improved upon. Dietary manager will look into purchasing a different brand to see if this will make a difference.
-some residents would like to see more pudding on the menu instead of fruit, some do not.

-food suggestions:
-more dill pickles and bread & butter pickles with meals
-more pork chops, meatloaf, summer sausage, bigger shrimp, and BBQ ribs with bone in
-at 3 p.m. coffee socials, more cakes with frosting
--individual likes/dislikes were let known to kitchen staff

On 2/19/18, the resident council met with R17, R21, R8, R36, R17, and R10 in attendance. In the new business summary section, food was identified under current situation, and action was "set up another food service meeting"; Activity director contact Dietary manager to set up meeting; Activities Director and dietary manager identified as responsible. Under current status: On-going; expressed possible monthly buffet style meals. Dietary supervisor updated in person on 2/19/18. The minutes did not list or describe specific food complaints voiced by residents at the meeting, or from the food committee meeting, or what actions the facility took to address those concerns.

During the survey on 3/7/18, at 3:04 p.m. a

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meeting was held with council members R17, R25, R21, R8, R27, and R10 in attendance. R10 stated the resident council met on a monthly basis, and except for the activities department, facility staff usually did not attend the meetings. When asked what concerns the council had, R17 responded "Food!", and R25 responded, and stated the "food is bad." When asked about more specific concerns, R8 stated some cooks did a better job in preparing what was on the menu. R25 stated a recent meal was kielbasa sausage that was cut up, was burnt and "it got real hard" and was really not edible. R21 stated some of the entrees needed to be "cooked better" and added "but I don't have to do the dishes." R17 stated emphatically much food was "sent back and wasted." R10 denied a lot of wasted food, but stated there was "inconsistency" in preparation of the same foods, but was unable to give a specific example. R27 had no comment about the food. Continuing the discussion at 3:18 p.m. R25 stated there was a food committee meeting where residents met with the head of the kitchen. R17 stated sure they talked to us "but where's the report?" R10 also stated she was a "writer" and they should have a follow up, because "how else do you measure progress?" During the discussion R8, R21, R10 and R17 agreed with R25 who stated, "our beef" is that we had the meeting, felt it was not acted upon. R10 stated there was "no formal" response at the resident council meeting about the food issues raised.

When interviewed on 3/9/18, at 11:37 a.m., the dietary manager (DM) stated food concerns have been brought up in the resident council, as well as from the quarterly food committee. The DM stated she did not attend council meetings. The

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DM stated after a council meeting she will learn of residents' concerns, and then "I go out and talk to them." The DM stated she has had numerous discussions about food complaints with R25, R17 and others, and stated has spoken with those residents individually and offered options to meet their wants. The DM stated, however, she did not go back to the council and share what has been done, for example, when residents expressed wanting summer sausages, more pork chops, or pickles on the menu more frequently. The DM stated she "just made the changes." The DM stated she did not report to the resident council the findings from the food committee, because many of the same people who came to that meeting were also on the council. The DM also stated she did not have specific notes or documentation of what was done in response to residents' complaints or suggestions. The DM stated she did not go back to the council with what has done, but added, that information "should be shared."

When interviewed on 3/9/18, at 1:13 p.m., the administrator stated when residents voiced concerns, or had complaints about food, the dietary manager just stepped in, talked with individual residents, and made the changes. The administrator explained the process how the facility addressed concerns raised from the council, and stated after a meeting, department heads received a copy of the minutes, and it was their responsibility to review and address any concerns. The administrator stated staff do not typically attend the council unless invited, and after a meeting, the activity director told staff if they had a specific "to do," like a housekeeping or maintenance request, they are addressed by staff, on a one-to-one basis. The administrator

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F 565	Continued From page 8 stated "maybe that needed to change" and have a standing agenda item to have head staff be present at the resident council and talk about specific resident concerns. The administrator stated he felt food concerns were addressed, but what's missing was "the documentation" to show we have discussed and addressed it with the council. A facility policy regarding resident council, and responding to grievances was requested, but none was provided.	F 565		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		4/13/18

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F 609	Continued From page 9 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse prohibition policy and report an allegation of abuse to the State agency within two hours of occurrence for 1 of 1 resident (R21) reviewed for abuse prohibition. Finding include: The undated facility policy, Individual Resident Vulnerable Protection Plan, indicated the facility "will not condone any form of resident abuse." The policy identified resident-to-resident abuse as reportable abuse, and further indicated all forms of abuse, including resident-to-resident abuse, must be reported immediately. The policy indicated the Administrator assumed the responsibility for the overall coordination and implementation of the abuse prevention program, and further that "Inquiries concerning the reporting of abuse to state agencies should be referred to the administrator." R21's quarterly Minimum Data Set (MDS) an assessment dated 2/1/18, indicated she had severe cognitive impairment. R39's quarterly MDS dated 1/11/18, indicated she had severe cognitive impairment. An undated facility Investigation Report Summary identified a resident-to-resident incident between	F 609	Administrator was educated on the 2-hour reporting requirement for resident to resident abuse. Policy was reviewed and modified to clarify resident to resident abuse reporting timeliness. Staff were educated on the policy changes for reporting abuse immediately (<2hours) for resident to resident abuse. All incidents will be reviewed daily (Monday through Friday) by IDT team for compliance in reporting to timelines. All abuse incidents and IDT team review outcomes will be reviewed by QAU committee. Responsibility: Administrator	

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R21 and R39. The document indicated on 12/22/17, at 6:00 p.m. R39 hit R21's hand with a spoon while R21 was reaching for the sugar at the evening meal. R39 thought the sugar was hers. The report indicated staff intervened and there were no injuries or complaints of pain. The report indicated this incident was reported to the State Agency the following day, on 12/23/17, at 5:09 p.m. or approximately 23 hours after the incident occurred.

When interviewed on 3/8/18, at 1:15 p.m. licensed practical nurse (LPN)-B recalled the incident in the dining room between R21 and R39. LPN-B stated R21 was touching the sugar basket on the table, trying to get a packet out or look at one, and R39 felt they were hers, and R39 hit R21. LPN-B stated she did not witness the incident, that it was reported to her, and added that if the resident hit another resident "that would be abuse" and a reportable incident. LPN-B stated when abuse or alleged abuse occurs, she would update the director of nursing and the family "right away," and also stated in this case, she reported immediately to the administrator. LPN-B stated we follow our "chain of command."

When interviewed on 3/8/18, at 1:22 p.m., the director of nursing (DON) stated there was a resident-to-resident alteration between R21 and R39, and questioned if R39 had intent. The DON stated R39 reacted to R21 taking the sugar, but R39 "knew enough" to want to hit R21 over the knuckles. The DON stated that could be abuse, and added, that is why you investigate. The DON stated if there is an allegation of abuse, staff were trained to immediately report to the administrator and me. The DON stated this incident should have been reported immediately.

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F 609	Continued From page 11 During interview on 3/9/18, at 1:03 p.m., the administrator stated he took the call from the nurse regarding the incident an 12/22/17, between R21 and R29, but then did not make the report to the State Agency until the next day. The administrator stated the allegation was not reported within 2 hours. The Administrator stated the facility's focus was to recognize abuse, and make sure we put something in place to prevent any potential abuse, and in hindsight, the nurse did a good job and did it right (reported it timely). The administrator stated the were looking at changing the facility procedure to have the charge nurse be able to enter the allegation into the system to report to the state, "like they already do" for reporting injures of unknown origin.	F 609		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication.	F 636		4/13/18

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F 636	Continued From page 12 (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)	F 636		

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F 636	Continued From page 13 (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess the nutritional status using the Resident Assessment Instrument (RAI) process for 1 of 2 residents (R17) reviewed for nutrition. Findings include: R17's admission Minimum Data Set (MDS) an assessment dated 9/27/17, identified R17 was cognitively intact and needed set help only to eat. The MDS identified a height of 72 inches with a weight of 191 pounds. Further it was unknown if R17 had gained or lost greater than 5 percent of his body weight in the last month or 10 percent of his body weight in the last 6 months. R17 had a therapeutic diet order. R17's nutritional status Care Area Assessment (CAA) worksheet dated 10/2/17, identified a comprehensive assessment was indicated as R17's body mass index (BMI) was to high at 25.9 (18.5- 24.9) and R17 had received a therapeutic diet. The CAA identified R17's nutritional status as an actual problem. The analysis of findings included system pre-populated checks, from the MDS which included: R17 had an inability to perform ADLs (activities of daily living) without significant physical assistance; poor memory; diagnoses of depression, pain and diabetes; taking diuretics. The resident input section was blank. The CAA indicated R17's nutritional status would be care planned; however, no overall objective for the care plan was identified. No referrals were indicated as warranted. The CAA did not provide a further analysis including a	F 636	Education of Dietary Manager provided to the completion of the Care Area Assessment, including proper documentation in the medical record. R17 CAA was completed and supplementation was initiated. During the assessment R17 stated that he was satisfied with his current weight but would like to try the supplements to help get some more nutrition. Triggered weight review meeting occurred and CAA's reviewed for completeness for all other residents with comprehensive assessments in progress and nutritional status triggering. Will also implement dietician review of all new residents at the scheduled review (monthly) to assess and plan for dietary interventions. Dietary Manager to review applicable CAA□s with RN to ensure proper documentation and intervention over the next quarter. Outcomes of dietary CAA□s and interventions to be reviewed at QAU. Responsibilty: Dietary Manager	

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review of indicators and supporting documentation identifying the problem, causes, contributing factors, strengths, needs and plan for the management of R17's nutritional status.

During interview on 3/9/18, at 12:58 p.m. certified dietary manager (CDM) stated she was responsible for completing the nutritional status CAA's when they are triggered from the MDS. The CDM explained the only parts of the CAA she filled out was if it was an actual or potential problem; if they needed referrals and if the nutritional status was to be care planned. Further, she did not complete and further assessment within the CAA worksheet and stated she may be doing the CAA wrong.

When interviewed on 3/9/18, at 1:31 p.m. the director of nursing (DON) stated R17's nutritional status CAA was not completed. Further, the CAA completion was important and should take into account the residents choices and preferences as well as their overall nutritional status and goals. The information was needed to effectively care plan.

The MDS 3.0 Manual v1.15R dated 10/1/17, identified "The Nutritional Status CAA process reflects the need for an in-depth analysis of residents with impaired nutrition and those who are at nutritional risk. CAA documentation helps to explain the basis for the care plan by showing how the IDT [interdisciplinary team] determined that the underlying causes, contributing factors, and risk factors were related to the care area condition for a specific resident; for example, the documentation should indicate the basis for these decisions, why the finding(s) require(s) an intervention, and the rationale(s) for selecting

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CENTRAL TODD COUNTY CARE CENTER	406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 15 specific interventions. Based on the review of the comprehensive assessment, the IDT and the resident and/or the resident ' s representative determine the areas that require care plan intervention(s) and develop, revise, or continue the individualized care plan."	F 636		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive reassessment using the Resident Assessment Instrument (RAI) process, following the initiation of hospice services for 1 of 1 resident (R35) reviewed for hospice. Findings include: The MDS (Minimum Data Set) 3.0 Manual v1.15R dated 10/1/17, identified a comprehensive MDS assessments included both the completion of the MDS as well as completion of the Care Area Assessment (CAA) process. Further,	F 637	Staff education was provided to MDS nurse, specifically page 2-16 of the RAI Manual regarding the timeliness of completion of Significant Change of Status Assessment (SCSA). Two residents with SCSA were audited and found to be compliant. Continue to audit completion dates of all SCSA's for the next quarter and review outcomes at following QAU meeting. Responsibility: DON	4/13/18

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F 637	Continued From page 16	F 637		

comprehensive MDS's included a Significant Change in Status Assessment (SCSA), which was required when a resident was admitted to hospice services. The SCSA MDS and CAA completion date could be no later than the 14th calendar day after determination that a significant change in status occurred.

R35's Certification of Terminal Illness dated 2/22/18, identified a hospice start of care date of 2/22/18.

On 3/9/18, at 10:54 a.m. R35's SCSA was viewed in the electronic medical record (EMR). The SCSA was dated 3/5/18, and indicated the MDS was in progress. The summary identified the MDS was set for completion on 3/19/18, 11 days after the required completion date. The validation section included 46 errors and 2 warnings. The sign section included 531 unsigned areas with 50 signed areas. The CAA summary section indicated the section was in progress.

When interviewed on 3/9/18, at 1:57 p.m. registered nurse (RN)-A , who worked with the MDS assessments, stated she was under the impression the assessment reference date needed to be set within 14 days of a hospice admission. She was not aware the MDS and CAA's were to be completed by the 14th days of a hospice admission.

On 3/9/18, at 2:03 p.m. the director of nursing (DON) stated R35 was admitted to hospice services on 2/22/18. The DON viewed the MDS manual and stated the the significant change assessment was to be completed no later than 14 days following admission to hospice services. Further, R35's SCSA should have been

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F 637	Continued From page 17 completed the day before on 3/8/18 and was not complete.	F 637		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement interventions to prevent weight loss for 1 of 2 residents (R17) reviewed for weight loss. Findings include: R17's admission Minimum Data Set (MDS) dated 9/27/17, identified R17 was cognitively intact and	F 692	R17 has been assessed and his plan of care has been modified with interventions to maintain current weight, which he has stated he is satisfied. Policy for Resident Weights was reviewed and revised. Staff education provided to Care Coordinator and Dietary Manager regarding policy and expectation. Weights and interventions/justification were reviewed for all other current residents and no	4/13/18

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F 692	Continued From page 18 needed set help only to eat. The MDS identified a height of 72 inches with a weight of 191 pounds (lbs). Further, it was unknown if R17 had gained or lost greater than 5 percent of his body weight in the last month or 10 percent of his body weight in the last 6 months. R17 had a therapeutic diet order. R17's nutritional status Care Area Assessment (CAA) worksheet dated 10/2/17, identified a comprehensive assessment was indicated as R17's body mass index (BMI) was to high at 25.9 with accepted range of 18.5- 24.9 and R17 received a therapeutic diet. The CAA identified R17's nutritional status as an actual problem. The analysis of findings included system pre-populated checks, from the MDS which included: R17 had an inability to perform ADL's (activities of daily living) without significant physical assistance; poor memory; diagnoses of depression, pain and diabetes; taking diuretics. The resident input section was blank. The CAA indicated R17's nutritional status would be care planned; however, no overall objective for the care plan was identified. No referrals were indicated as warranted. The CAA did not provide a further analysis including a review of indicators and supporting documentation identifying the problem, causes, contributing factors, strengths, needs and plan for the management of R17's nutritional status. R17's care plan dated 9/24/17, identified R17 had a therapeutic diet as ordered. R17 received a liberalized geriatric, cardiac diet with regular texture and thin liquids. Staff were to provide positive approach in support of diet regime. R17's physician notes identified the following:	F 692	changes were necessary. A twice monthly meeting will be scheduled and attended in order to review weight triggered residents and to determine interventions or justifications. Meeting occurrences and interventions will be audited twice monthly for completion and documentation. Audit findings will be reviewed at the next QAU meeting. Responsibility: DON	

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F 692	Continued From page 19	F 692		

- H&P (history and physical) dated 9/21/18, needs placement in a setting where he can get care and "good nutrition." No edema was noted.

- Inpatient Discharge Summary dated 10/22/18, indicated a weight of 186 lbs with 1+ pedal edema bilaterally.

- Physician progress note dated 10/26/17, indicated R17 continued to have problems with his appetite. "He does not like the food in the nursing home and complains about it." Extremities show 2 plus ankle edema

- Physician progress note dated 12/28/17, indicated R17's extremities showed no edema.

On 3/6/18, at 3:31 p.m. R17 was seated in a stationary chair in his room, there was no edema in R17's lower extremities. R17 stated he had lost a significant amount of weight since his admission to the facility in the fall. He stated he did not have much of an appetite and did not like the food served at the facility. R17 stated his usual body weight was 199 lbs. and currently weighed 167 lbs. R17 remembered a discussion regarding nutritional supplements; however, he had never received any.

R17's weights identified the following:
- 9/23/18, 191.8 lbs
- 10/23/18, 192.1 lbs
-11/23/18, 171.5 lbs
- 12/23/18, 171.8 lbs
- 1/23/18, 172.6 lbs
- 2/24/18, 169.8 lbs
- 3/9/18, 169.2 lbs

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F 692	Continued From page 20 R17's physician orders included Lasix (medication for fluid overload) 40 milligrams po daily with a start date of 11/3/17. The physician orders did not include any nutritional supplements. R17's nutrition assessments identified the following: - Nutrition Assessment (Comprehensive) dated 9/29/17, identified R17's estimated nutrients provided at meals to be 1800 calories (cal) a day with a estimated nutrient requirement of 2304 cal's per day for a difference of 504 calories a day. R17 was identified as overweight. Admission weight was 191.8 pounds (lbs) with a most recent weight of 192.8 lbs on 9/25/17. The assessment did not list dietary related medications or labs. R17 had no swelling. His food intake was marked intake meets 76-110 percent of planned meals as well as 26-75 percent of planned meals. complaints about the tastes of many foods was marked no. The assessment did not include R17's goal either for weight maintenance or weight loss. The assessment lacked R17's input regarding food preferences. - Quarterly Nutritional Assessment dated 12/28/17, identified a weight of 169.8 lbs for a loss of 22 lbs, indicating a 11.5 percent weight loss since 9/23/17. The assessment indicated R17's food intake was 75 - 100 percent of meals. The assessment did not identify why R17 had a 22 lb weight loss; nor, any interventions to minimize weight loss. no referrals to the dietician were recommended.	F 692		

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F 692	Continued From page 21	F 692		

-Progress note dated 2/27/18, identified an initial nutritional assessment via the registered dietician (RD). Current weight was 168 lbs with a weight history of: January 2018, 171 lbs; December 2017, 170 lbs; November 2017, 169 lbs. The RD indicated R17 was "fairly" consistent with his weight; however, due to his edema it was not a great indicator for nutritional status. The assessment did not address R17's admission weight of 191.8 lbs. The assessment did not address intake; however indicated he had a fair appetite. Further the assessment lacked lab results and resident input. The RD indicated "at this point in time not at nutritional risk", will not place R17 on at risk monitoring.

On 3/8/18, at 8:19 a.m. R17 ate breakfast in his room. He independently ate a cereal sized bowl of oatmeal, which he poured some milk over. R17 also drank 4 ounces of milk and 4 (oz) of a mixed juice. R17 stated he had the same meal for breakfast everyday and it was what he wanted. R17 stated at home he used to have some toast, but he did not request toast at the facility because the staff burn it.

On 3/8/18, at 8:37 a.m. nursing assistant (NA)-A entered R17's room to remove his breakfast tray. NA-A stated the dietary department charted intakes on meals consumed.

On 3/8/18, at 12:03 p.m. R17 entered the dining room. The menu listed on the wall of the dining room included: Italian meat sauce over spaghetti noodles, cheddar biscuits, baby carrots and berries. R17 had some berries at his place setting along with 4 oz. of juice and 4 oz of milk. R17 poured a 0.5 oz container of half and half over his berries along with a packet of sugar. At 12:15

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F 692	Continued From page 22	F 692		

p.m. R17 was served a plate of spaghetti with spaghetti sauce with ground burger. The plate did not contain baby carrots or a cheddar biscuit. R17 stated he did not want the baby carrots or cheddar biscuit. R17 proceeded to remove all the sauce from the top of his spaghetti. R17 stated the sauce was "sour" and the facility did not know how to make anything. At 12:30 p.m. R17 finished his meal stating he was full. R17 drank 100 percent of his beverages ate only the noodles of the spaghetti along with the berries.

When interviewed on 3/9/18, at 11:00 a.m. NA-B stated R17 did not like the food the facility served. R17 selects from the menu what he wants. If he does not like the food choices he can order a soup and sandwich. She stated R17 had lost weight since his admission and was weighed daily. NA-B stated the dietary staff record the meal intakes in the electronic medical record (EMR)

During interview on 3/9/18, at 12:58 p.m. certified dietary manager (CDM) stated R17 was not at risk for weight loss and the dietary staff are not currently monitoring his meal intakes, and only monitors R17's intakes during his MDS assessment. The CDM stated she reviewed weights on a monthly basis and reviewed them with the nurse manager, who was out on leave. The nurse manager though his weight loss was fluid related as he fluctuated about 5 lbs throughout the month. She stated she referred R17 to the dietician for review in February 2018, and she did not identify R17 at risk for weight loss. After CDM reviewed R17's admission weight to his current weight, along with his dislike for the facility meals she stated his weight loss was likely a combination of fluid loss as well as poor food

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F 692	Continued From page 23 intake. During interview on 3/9/18, at 1:31 p.m. the director of nursing (DON) stated R17 was very picky with the foods he liked. R17's weight loss was likely a combination of fluid and poor appetite. The dietician did do an assessment on 2/27/18; however, she did not do a face to face with the resident, as she does not visit the facility. The DON stated it was important to get the residents input to accurately assess his nutritional status. On 3/9/18, at 3:42 p.m. the facility registered dietician had been contacted via telephone with no response. The facility policy Resident Nutritional Assessment dated 8/11, indicated resident needs would be determined by a completed assessment. Assessments would be completed on admission and quarterly, unless significant changes occur which was identified by the team.	F 692		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Central Todd County Care Center 01 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/03/2018

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

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K 000	Continued From page 1 CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Central Todd County Care Center is a 1-story building without a basement. The building was constructed at 4 different times. The original building was constructed in 1976 and was determined to be of Type V(111) construction. In 1985, an addition was added to the service wing on the south side and was determined to be of Type V(111). In 1992 an activities/ physical therapy addition was added to the east end of A Wing and was determined to be of Type V(111) construction. In 2002 additions were added to	K 000		

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K 000	Continued From page 2 west end of D Wing, to the main entrance and between E and D wings dining room, all of which are Type V(111) construction. An assisted living apartment building is attached to the B wing which is separated by a 2-hour fire barrier. The north end of E wing are apartments and separated from the nursing home with a 2-hour fire barrier. The building is divided into 4 smoke zones by 2 hour fire barriers. The building is protected by a complete automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	K 211	o Fire door inspections protocol was	4/13/18

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K 211	Continued From page 3 had several corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition and the NFPA 80 Standard for Fire Doors and Other Opening Protectives 2010 edition. This deficient practice could affect 50 of 50 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 9:30 a.m. to 1:30 p.m. on 03/13/2018, during a records review and an interview with the Maintenance Supervisor, the facility had not completed the fire door inspection or inspection documentation for all of the fire rated doors located throughout the facility. This deficient condition was confirmed by a Maintenance Supervisor.	K 211	developed and inspections were performed and documented. Training was provided to Maintenance staff regarding inspection of the door. Responsibility: Maintenance Supervisor	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____	K 353		4/13/18

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	245521	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/13/2018**

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CENTRAL TODD COUNTY CARE CENTER	**406 EAST HIGHWAY 71, PO BOX 38** **CLARISSA, MN 56440**

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K 353	Continued From page 4 c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (12), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (10). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 20 of 50 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:30 a.m. to 1:30 p.m. on 03/13/2018, observations revealed that the fire sprinkler head that is located in the A-wing Community Chapel room next to the overhead projector was rusting due to a water leak at the connection between the sprinkler head the the sprinkler piping. This deficient condition was confirmed by a Maintenance Supervisor.	K 353	Sprinkler head assembly had some buildup with an iron appearance that could have affected it functionality. It is believed that this buildup was residual from when the sprinkler head was dripping- during a time when the heat in that space had gone out, causing the sprinkler equipment in that area to get very cold. Dripping ceased when the room was brought back to temperature. All sprinkler heads in that area were inspected for buildup, and were replaced as needed. Education was provided to maintenance staff regarding sprinkler inspection. Responsibility: Maintenance Supervisor	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories	K 901		4/13/18

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K 901	Continued From page 5 Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 50 of 50 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 a.m. to 1:30 p.m. on 03/13/2018, during the documentation review and an interview with a maintenance staff member it was revealed that the facility did not have any risk assessment documentation at the time of the inspection This deficient condition was confirmed by a Maintenance Supervisor.	K 901	Risk assessment was performed on all rooms at the Care Center. Risk assessment will be reviewed/ modified annually or if changes are made to alter class. Responsibility: Maintenance Supervisor	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed	K 914		4/13/18

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K 914	Continued From page 6 locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 50 of 50 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:30 a.m. to 1:30 p.m. on 03/13/2018, during a records review and an interview with the Maintenance Supervisor, the facility could not provide any documentation for the completion of the annual electrical outlet inspection and testing for the electrical outlets located in the patient/resident rooms located	K 914	o Outlets in resident rooms had not been tested per regulation. Outlet inspection protocol was developed, and outlets were inspected. Outlets failing inspection will be repaired or replaced. Outlet inspections will be added to annual maintenance calendar. Responsibility: Maintenance Supervisor	

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K 914	Continued From page 7 throughout the facility. This deficient condition was confirmed by a Maintenance Supervisor.	K 914		
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that the facilities failed to provide continuing education, including safety guidelines and usage requirements in accordance with NFPA 99(12) Section 11.5.2.1. This could negatively affect 50 of 50 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:30 a.m. to 1:30 p.m. on 03/13/2018, during a records review and an interview with the Maintenance Supervisor and the Director of Nursing it was found that the facility did not have a policy or any training documentation verifying that staff involved with the care, use, and handling of oxygen have received initial training and continuing education	K 926	oO2 policy was updated to include annual training for staff able to handle O2 tanks and equipment. Staff were educated on policy modification and proper handling of compressed gases. O2 annual training to be scheduled by nursing department. Responsibility: DON	4/13/18

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K 926	Continued From page 8 concerning the safety guidelines and usage requirements for oxygen. This deficient condition was confirmed by a Maintenance Supervisor.	K 926		