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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 7ZS6

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 **10/8/2021** (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:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Karen Aldinger, Unit Supervisor 11/29/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/29/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

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

Revised Letter

Electronically delivered
November 30, 2021

CMS Certification Number (CCN): 245521

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

This letter replaces the previous letter sent on 11/29. This letter has the correct bed count of 45.

Dear Administrator:

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 August 5, 2021 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 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/or 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
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 29, 2021

CMS Certification Number (CCN): 245521

Administrator
Central Todd County Care Center
406 East Highway 71, Po Box 38
Clarissa, MN 56440

Dear Administrator:

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 August 5, 2021 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/or 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
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 29, 2021

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

RE: CCN: 245521
Cycle Start Date: August 5, 2021

Dear Administrator:

On October 12, 2021, we notified you a remedy was imposed. On October 8, 2021 the Minnesota Department of Health and on November 1, 2021 the department of Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 31, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 5, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 12, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 5, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 31, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 7ZS6

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/05/2021** (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:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Timothy Rhonemus, HFE NE II 10/05/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/07/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
September 3, 2021

Administrator
Central Todd County Care Center
406 East Highway 71, Po Box 38
Clarissa, MN 56440

RE: CCN: 245521
Cycle Start Date: August 5, 2021

Dear Administrator:

On August 5, 2021, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

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:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 November 5, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by February 5, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@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 _____	C 08/05/2021

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 On 8/2/21 through 8/5/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator	E 041		9/30/21

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

Electronically Signed | 09/16/2021

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 _____	C 08/05/2021

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 041	Continued From page 1 must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the	E 041		

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 _____	C 08/05/2021

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 041	Continued From page 2 availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per 2012 edition of the Life Safety Code NFPA 101 section 9.1.3.1 and NFPA	E 041	o The emergency generator was found to be failing during routine functional testing. CTCCC immediately procured a portable backup generator (rental) while a	

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 _____	C 08/05/2021

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 041	Continued From page 3 99 (2012 edition), Health Care Facilities Code, sections 6.4.4.1.1.4, and NFPA 110 the Standard for Emergency and Standby Power Systems, section 8.4..1 and 8.4.2.1. This deficient condition could have affect all 30 residents of the facility. Findings include: 1) On 08/04/2021 between 09:00 AM to 01:00 PM, it was revealed that a monthly for August 2020 was not completed on the rented generator. 2) On 08/04/2021 between 09:00 AM to 01:00 PM, it was revealed that weekly generator inspections were not completed from 08/2020 through 09/10/2020 for the rented generator. These deficient condition was verified by the Maintenance Director and Administrator on 8/4/21, at 1:00 p.m.	E 041	replacement generator could be built and installed. During the time of the replacement generator, weekly testing was performed to ensure functionality, but LSC weekly and monthly testing was not performed and documented on the rental unit per code. o A generator testing policy was created to describe weekly and monthly testing requirements and to incorporate new weekly and monthly testing logs. Additionally, the policy documents the need to test temporary units if the main unit is down for service or replacement. o Staff education on the generator testing policy was performed. o Audits of weekly and monthly testing documentation will be performed for the next 3 months and reviewed at quarterly QAU meeting. o Completion date: 9/30/2021 o Responsibility: Maintenance Supervisor	
F 000	INITIAL COMMENTS On 8/2/21 through 8/5/21, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5521018C (MN00074671) H5521019C (MN00071123) H5521020C (MN00071042)	F 000		

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 _____	C 08/05/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 4 H5521021C (MN00067524) H5521022C (MN00067522) H5521023C (MN00066268) H5521024C (MN00055799) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 604		9/30/21

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 _____	C 08/05/2021

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 604	Continued From page 5 §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to comprehensively assess the use of a personal chair alarm device as a potential restraint for 1 of 1 residents (R16) reviewed who voiced they felt confined to their chair and did not move due to fear of, and dislike of, the audible noise the device created. Findings include: R16's significant change Minimum Data Set (MDS) dated 6/3/21, included cognitively intact with diagnoses including depression, anxiety and diabetes. R16 required extensive assistance with transfers, ambulation and toileting, had sustained 2 falls since last assessment and did not utilize a restraint. R16's care plan dated 4/13/21, identified a risk for falling and an intervention included, "Floor and chair alarm," with an initiation date of 4/10/21. During observation and interview on 8/2/21, at 2:44 p.m. R16 was observed in her room seated in a wheel chair. R16 had a visible device	F 604	o Reviewed all residents with physical devices (alarms, broad chairs, fall mats, bed being placed against wall etc). o Physical devices assessment created to ensure physical devices are not restricting movement or access to the resident's body which also documents if they feel restrained by device. o R16 assessment completed and careplan updated to reflect her preferences regarding alarm. o Assessments on all other residents with physical devices will be completed. o Revised fall safety assessment to include physical devices as potential restraints. o Revised Fall policy to reflect physical device evaluation. o Initiated physical devices POC task for the CNAs to document if the residents report feeling restrained. o Audits completed on POC documentation will be completed weekly x4, Monthly x 3 and then PRN. Audits will be reviewed at QAU	

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 _____	C 08/05/2021

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 604	Continued From page 6 attached to the back of her wheel chair which had a cord extending under her buttocks. R16 stated it was an alarm, every time she moves, it sets off the alarm loudly. R16 stated, it restricts her from moving around and adjusting herself. R16 stated she was very frustrated by this and it causes her to sit still for fear of setting the alarm off. When interviewed on 8/4/21, at 7:33 a.m. R16 again stated the alarm really bothers her and she is fearful of moving and creating all this noise. When interviewed on 8/4/21, at 9:16 a.m. nursing assistant (NA)-A stated, R16 required extensive assistance with transfers and toileting. R16 has had a pressure alarm for a couple of months now and has expressed she does not like it. It keeps her from moving about. NA-A had discussed this with nurses, but has been told to remind R16 the alarm is to remind her not to get up by herself and wait for assistance. NA-A has done this and R16 stops complaining for a while. When interviewed on 8/4/21, at 9:30 a.m. licensed practical nurse (LPN)-A, stated, pressure alarms are generally used for those who fall frequently. LPN-A did not know who re-evaluates the effectiveness of alarms or if they are causing any issues for the resident, "it is done by those higher up the chain." LPN-A was no aware of any policy concerning alarms, nor had received any training on them. LPN-A was not aware R16 was afraid to move and adjust herself due to setting off the alarm. When interviewed on 8/4/21, at 12:10 p.m. registered nurse (RN)-A and RN-B stated, alarms are initiated for residents who fall frequently and had confusion. Every resident was different and	F 604	o Completion date 9-30-2021. DON is responsible.	

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 _____	C 08/05/2021

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 604	Continued From page 7 an alarm is not appropriate for every resident. R16's alarm had been initially discussed with family and the interdisciplinary team. Re-assessments are conducted quarterly. In the past R16 had complained about the alarm, family had requested it be removed, but then R16 had a stroke and family wanted it back on after that. R16 was not aware of her limitations and would attempt to transfer herself, and would fall. RN-A was not aware R16 was afraid to adjust herself or move about due to setting off the alarm. When interviewed on 8/4/21, at 12:55 p.m. the director of nursing (DON) stated, The decision to use the alarm for R16 was made at family request after a stroke. R16 was once on a bed alarm and w/c alarm on 1/15/20, but was removed on 8/19/20, due to resident and family request. Floor staff typically would only put a pressure alarm on if it were over night or on a weekend, it would be assessed on the following day or after the weekend if it were the best intervention. The team would then comes together and make a decision. She was not aware of R16's dislike of the pressure alarms or that it kept R16 from adjusting herself and moving about, effectively restraining her. A policy was requested that specifically addressed restraints and reassessment of restraint like interventions, pressure alarms, but was not provided.	F 604		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must	F 676		9/30/21

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 _____	C 08/05/2021

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 676	Continued From page 8 provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide 1 of 1 resident (R16) with their hearing devices to maximize their communication ability and ensure adequate	F 676	o Reviewed all residents who have hearing devices o Ensured that R16's hearing devices are on care plan and assignment sheet for	

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 _____	C 08/05/2021

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 676	Continued From page 9 hearing to promote their quality of life. Findings include: R16's significant change Minimum Data Set (MDS), dated 6/3/21, identified R16 had intact cognition and required extensive assistance with most of her activities of daily living (ADLs). Further, the MDS outlined R16 had minimal difficulty with hearing and included a question which outlined, "Hearing aid or other hearing appliance used[?]" which was answered by staff as, "No." R16's care plan included, "[R16] has alteration in communication r/t [related to] hearing deficit, stroke AEB [as evidenced by] variable bilateral hearing aide use, minimal hearing deficit when not in place, slurred speech at times." "Has bilateral hearing aides, independent with placement and storage." On 8/3/21, at 2:42 p.m. R16 was interviewed. R16 stated she used to have hearing aids which helped her hear better. However, she had not worn them in awhile and thought they had either gone missing or were broken. R16 expressed frustration as nobody from the facility had helped her try to find them as she wanted to wear them to help improve her hearing. R16 did not have any hearing aid(s) or devices present or on her person during this interaction and interview. When interviewed on 8/3/21, at 1:52 p.m. nursing assistant (NA)-A stated she was unaware R16 wore any hearing aides and verified she was not helping R16 to place any hearing devices on a routine, daily basis.	F 676	assistance in placement of hearing aids. o Sensory device policy created to cover initial and on going assessment for any sensory devices including glasses, hearing aides and dentures to document need o Sensory device POC tab was made for CNAs to document use and refusal o Updated all care plans and assignment sheets o Auditing hearing aid placement weekly x 4 monthly x 3 and PRN QAU reviewed. o Completion date 9-30-2021. DON is responsible.	

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 _____	C 08/05/2021

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 676	Continued From page 10 On 8/4/21, at 12:01 p.m. registered nurse(s) (RN)-A and RN-B were interviewed. They had located R16's hearing aids in a denture cup in her room after being made aware by the surveyor they were potentially missing. The hearing aids' batteries were not working, so they replaced them and verified the hearing aids were now working. RN-A and RN-B both expressed R16's hearing aids were not assess to be placed daily. An undated nursing assistant worksheet outlined basic care needs for R16 and did not direct staff to place hearing aides for R16. A policy was requested, but not provided by the facility.	F 676		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		9/30/21

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 _____	C 08/05/2021

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 812	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure expired and/or outdated food products, including both dry stock and refrigerated items, were removed from rotation and not available for resident use or consumption which could cause potential foodborne illness. This had potential to affect 30 of 43 residents identified who could receive these items. Findings include: On 8/3/21, at 9:35 a.m. the main production kitchen was toured. A dry storage area was located adjacent to the kitchen which contained metallic shelving and various items available to resident food use or preparation. A single, unopened 8 ounce (oz) Benefiber container was placed on the shelving which had expired (i.e., use by) on 5/30/21; however, two other containers, which had not yet expired, were placed in front of the expired container on the shelving. In addition, the walk-in cooler was examined which identified a single, unopened 7.4 pound (lb) Molly Kitchen coleslaw container which had expired on 7/30/21. There were no other containers of coleslaw identified in the cooler which could be used instead. On 8/4/21, at 1:35 p.m. the main production kitchen was again toured. The items identified to be expired on the previous tour, completed on 8/3/21, remained in rotation and available for resident use or consumption. At 1:42 p.m. cook (CK)-A was interviewed and verified the expired products were in rotation and available for resident use. CK-A explained items should be	F 812	o Inspected all groceries for expired foods and removed from building. o Reviewed and updated Infection control policy to include First-In-First-Out (FIFO), rotation of stock and removing expired food. o Instituted weekly log to document new groceries are rotated and expired food is removed o Staff educated on FIFO, discard of expired food o Audits weekly x 4, monthly x 3 and PRN o QAU reviewed. o Completion date 9-30-2021. Dietary Supervisor is responsible.	

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 _____	C 08/05/2021

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 812	Continued From page 12 rotated on a, "first in, first out" basis to ensure oldest items were used and did not expire. CK-A stated she would discard the expired items to prevent them being used. When interviewed on 8/4/21, at 1:54 p.m. the dietary manager (DM) verified the items found were expired and should have been removed from rotation so they would not be used in resident meals or foods. DM stated, there was no formal system to monitor or audit to ensure expired food items were not kept in rotation and available for resident use. During subsequent interview, on 8/5/21 at 9:05 a.m. DM stated, there was only one resident in the facility who currently used the Benefiber product. However, the cole slaw could be prepared and distributed to anyone residing in the facility. A provided electronic mail message (e-mail), dated 8/12/21, identified one container of the identified expired coleslaw could produce up to 29 servings. A facility policy titled, Preparation of Food, dated 3/2019, and Infection Control for the Food service department, dated 3/2010, failed to address rotating food inventory or removing from storage when expired.	F 812		
F 921 SS=C	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 921		9/30/21

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 _____	C 08/05/2021

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 921	Continued From page 13 Based on observation, interview, and document review, the facility failed to ensure the ceiling in 1 of 1 main production kitchens was kept in a clean and sanitary condition to prevent potential contamination of food or cooking surfaces with dust or debris. This had potential to affect all residents, staff and visitors who consumed food from the main production kitchen. Findings include: On 8/2/21, at 4:57 p.m. the main production kitchen was toured which identified four (4) large circumference ventilation openings were present which were spread throughout the kitchen ceiling over various surfaces including the convection oven and food preparation/serving counters. However, immediately surrounding each of these ventilation openings was visible, dark brown and black-colored clumping's of dust and debris which extended for several feet around the ventilation openings and, at times, covered nearby structures (i.e., fire alarm sprinklers) with the same visible clumping dust and debris. The surveyor placed their hand up next to the ventilation openings and verified the air flow was blowing out of these openings and into the kitchen above the various surfaces. On 8/4/21, at approximately 1:40 p.m. (two days later) the ceiling was again observed and continued to have the same visible clumping dust and debris present around the ventilation openings. When interviewed on 8/4/21, at 1:42 p.m. cook (CK)-A verified the condition of the ceiling and stated it needed to be cleaned; however, CK-A added she was unaware who was responsible to ensure the ceiling was cleaned.	F 921	o Ceiling vents, tiles and sprinkler heads were cleaned. o Ceiling vents, tiles and sprinkler heads cleaning was added to infection control policy o Ceiling vents, tiles and sprinkler heads were added to scheduled cleaning list for both maintenance cleaning and deep clean cycles. o Audits will be performed to ensure timely and thorough cleaning after each cycle for up to 6 cycles each depending on the maintenance or deep cleaning cycle. o Completion date 9-30-2021. Dietary Supervisor is responsible.	

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 _____	C 08/05/2021

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 921	Continued From page 14 When interviewed on 8/4/21, at 1:54 p.m. the dietary manager (DM) acknowledged the dust and debris on the ceiling of the kitchen and stated it should have been cleaned prior, as dust or debris could be a potential hazard and get into food while it's being prepared or cooked. DM voiced the maintenance department was responsible to clean the kitchen ceiling and ventilation openings. When interviewed on 8/4/21, at 2:14 p.m. the maintenance manager (MM) stated he was new to his role with the facility but verified their department was in charge of cleaning the kitchen ceilings. However, added there was not a formal cleaning schedule or plan to ensure this was completed on a routine basis. The Infection Control for the Food Service Department policy, last reviewed by the facility on 10/10/19, failed to address ceiling cleaning and maintenance procedures.	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/04/2021**

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
K 000	INITIAL COMMENTS Fire Safety An annual 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 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/16/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/04/2021**

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
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/04/2021**

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
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 45 beds and had a census of 34 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or	K 324		9/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/04/2021**

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
K 324	Continued From page 3 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the cooking equipment every six months, as stated in the NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control, and Fire Protection of Commercial Cooking Operations, sections 11.2 through 11.4. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 08/04/2021 between 9:00 AM to 1:00 PM, observations revealed that the testing on the hood system did not happen in a timely manner between the semi-annuals. The dates the hood system was tested are 02/03/2021 and 03/05/2020. This deficient condition was verified by the Maintenance Director and Administrator.	K 324	o Scheduled kitchen hood cleaning in August of 2020 was cancelled due to pandemic and was not rescheduled. Schedule was restarted and testing was completed in February and August of 2021, and is scheduled for February of 2022. o Maintenance staff responsible for scheduling the hood cleaning at the time of the deficiency has left employment and has been replaced with new maintenance supervisor. o New maintenance supervisor has been educated on the hood cleaning requirements and documentation of the cleaning. o Scheduled cleanings have been added to Maintenance calendar with indefinite endpoint. o Completion date: 9/30/2021 o Responsibility: Maintenance Supervisor	
K 761 SS=F	Maintenance, Inspection & Testing - Doors	K 761		10/31/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/04/2021**

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
K 761	Continued From page 4 CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to conduct inspections of all fire-rated door assemblies as required by NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15.2 and 7.2.1.15.4 and NFPA 80 (2010 edition), Standard for Fire Doors, and Other Opening Protectives, section 5.2.4.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/04/2021, between 9:00 AM to 1:00 PM, it was revealed that the facility's door inspection was last completed on 04/13/2018. This deficient condition was verified by the Maintenance Director and Administrator.	K 761	o Door inspection training was provided to staff. o Doors with greater than 20minute rating were inspected including fire doors, doors to soiled utility, storage etc. o Door inspection schedule was generated to ensure annual testing is completed. o Door inspection results (current) were reviewed for completeness and findings. o Findings will be addressed. o Completion date 10/31/2021 o Responsibility: Maintenance Supervisor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/04/2021**

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
K 914	Continued From page 5	K 914		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed 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 a review of the available documentation and staff interview, the electrical testing and maintenance was not maintained in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2 through 6.3.3.2.4 and 6.3.4.1.3. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/04/2021 between 9:00 AM to 1:00 PM,	K 914	o Resident room outlet testing completed and documented. o Outlet testing policy was generated and staff education provided. o Outlet testing findings addressed o Completion date (testing) 10/31/2021 o Responsibility: Maintenance Supervisor	10/31/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/04/2021**

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
K 914	Continued From page 6 record review and staff interview revealed there was no documentation for the annual receptacle inspection in resident rooms. This deficient condition was verified by the Maintenance Director and Administrator.	K 914		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing	K 918		9/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/04/2021**

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
K 918	Continued From page 7 the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1 and NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4..1 and 8.4.2.1. These deficient conditions could have a widespread impact on the residents within the facility. Findings include: 1) On 08/04/2021, between 09:00 AM to 01:00 PM, it was revealed that a monthly run test for August 2020 was not completed on the rented generator. 2) On 08/04/2021, between 09:00 AM to 01:00 PM, it was revealed that weekly generator inspections were not completed from 08/2020 through 09/10/2020 for the rented generator. These deficient conditions were verified by the Maintenance Director and Administrator.	K 918	o The emergency generator was found to be failing during routine functional testing. CTCCC immediately procured a portable backup generator (rental) while a replacement generator could be built and installed. During the time of the replacement generator, weekly testing was performed to ensure functionality, but LSC weekly and monthly testing was not performed and documented on the rental unit per code. o A generator testing policy was created to describe weekly and monthly testing requirements and to incorporate new weekly and monthly testing logs. Additionally, the policy documents the need to test temporary units if the main unit is down for service or replacement. o Staff education on the generator testing policy was performed. o Audits of weekly and monthly testing documentation will be performed for the next 3 months and reviewed at quarterly QAU meeting. o Completion date: 9/30/2021 o Responsibility: Maintenance Supervisor	