



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 9, 2025

Licensee

Central Todd County Care Center

406 Highway 71 East

Clarissa, MN 56440

RE: Project Number(s) SL30447016

Dear Licensee:

On May 13, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 15, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 15, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 15, 2025, found not corrected at the time of the May 13, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a)

The details of the violations noted at the time of this follow-up survey completed on May 13, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders outlined on the state form; however, plans of correction are not required to be submitted for approval.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and/or state form with your organization's Governing Body.

Sincerely,

A handwritten signature in cursive script that reads "Jessica Chenze". The ink is dark and the signature is fluid.

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/13/2025
NAME OF PROVIDER OR SUPPLIER CENTRAL TODD COUNTY CARE CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 406 HIGHWAY 71 EAST 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) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30447016-1 On May 13, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on January 15, 2025. At the time of the survey, there were 18 residents; 8 receiving services under the Assisted Living License. As a result of the follow-up survey, the following order is issued.	{0 000}			
{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	{0 630}	Not reviewed during this survey.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 650}	Continued From page 1	{0 650}			
{0 650} SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}			
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	{0 660}	Not reviewed during this survey.		

Minnesota Department of Health

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{0 660}	Continued From page 2 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}	Not reviewed during this survey.		
{0 730} SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous	{0 730}			

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{0 730}	Continued From page 3 assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by:	{0 730}			
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	0 775	Not reviewed during this survey.		

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0 775	Continued From page 4 Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level two violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 15, 2025, at 9:00 a.m., surveyor toured the facility with licensed assisted living director (LALD)-B. Survey staff observed that the new egress bedroom windows in Resident apartment #102 and #202 had not been installed yet. During the survey the LALD-B explained to the surveyor that they were applying for a permit with Minnesota Department of Labor and Industry and could not install the windows until the proper permits are in place. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 775			
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs	{01440}			

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{01440}	Continued From page 5 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by:	{01440}	Not reviewed during this survey.		
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557;	{01500}			

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{01500}	Continued From page 6 (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations,	{01500}			

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{01500}	Continued From page 7 isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01500}	Not reviewed during this survey.		
{01560} SS=C	144G.64 (a; 5), (b) Training in Dementia, Mental Illness, and De- (5) new staff members may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required dementia, mental illness, and de-escalation training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; (5) person-centered planning and service delivery; (6) recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor-related disorders, personality and psychotic disorders, substance use disorder, and substance misuse; (7) de-escalation techniques and communication; and (8) crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis	{01560}			

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{01560}	Continued From page 8 lifelines. This MN Requirement is not met as evidenced by:	{01560}	Not reviewed during this survey.		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}			

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{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	{01650}	Not reviewed during this survey.		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the	{01910}			

Minnesota Department of Health

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{01910}	Continued From page 10 resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 20, 2025

Licensee

Central Todd County Care Cente

406 Highway 71 East

Clarissa, MN 56440

RE: Project Number(s) SL30447016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 15, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at

the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor

State Evaluation Team

Email: jessie.chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER CENTRAL TODD COUNTY CARE CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 406 HIGHWAY 71 EAST 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) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30447016 On January 13, 2025, through January 15, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 16 residents; 8 receiving services under the Assisted Living Facility license. Immediate correction orders were identified on January 13, 2025, for project SL30447016-0, for tag identification 0820 and 2310, both issued at scope and levels of widespread, level three (I).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 630	Continued From page 1	0 630			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included hypertension and hyperlipidemia.	0 630			

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0 630	Continued From page 2 R1's Service Plan dated December 27, 2023, noted R1 received services including medication management and bathing. R1's IAPP dated May 25, 2021, noted R1 did not pose a potential risk to others. However, it lacked identification of whether or not R1 was susceptible to abuse by other individuals. R2 R2's diagnoses included hypertension and diabetes type 2. R2's Service Plan dated February 26, 2024, noted R2 received services including nursing services and medication setup. R2's IAPP dated February 26, 2024, noted R2 did not pose a potential risk to others. However, it lacked identification of whether or not R2 was susceptible to abuse by other individuals. On January 15, 2025, at 11:45 a.m., registered (RN)-D and clinical nurse supervisor (CNS)-A stated all residents were considered vulnerable adults, and added the electronic record form lacked an individualized assessment of the resident's susceptibility to abuse by other individuals. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly	0 650			

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0 650	Continued From page 3 scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for two of three employees (clinical nurse supervisor/CNS-A, unlicensed personnel/ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	0 650			

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0 650	Continued From page 4 found to be pervasive). The findings include: CNS-A CNS-A was hired on September 7, 2022, to provide direct care services to residents of the facility. CNS-A's employee record lacked documented evidence of: - annual performance review; and - records of orientation including overview of Assisted Living statutes, review of the providers policies and procedures, handling emergencies and using emergency services, reporting maltreatment of vulnerable adults, Assisted Living Bill of Rights, handling of resident complaints, reporting of complaints, and where to report, consumer advocacy services, a review of the types of Assisted Living services the employee would provide and the provider's scope of license, and principles of person-centered planning/service delivery. ULP-C ULP-C was hired on February 23, 2022, to provide direct care services to residents of the licensee. ULP-C's employee record lacked documented evidence of: - records of orientation including overview of Assisted Living statutes, review of the providers policies and procedures, handling emergencies and using emergency services, reporting maltreatment of vulnerable adults, Assisted Living Bill of Rights, handling of resident complaints, reporting of complaints, and where to report, consumer advocacy services, a review of the	0 650			

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0 650	Continued From page 5 types of Assisted Living services the employee would provide and the provider's scope of license, and principles of person-centered planning/service delivery; and - documented evidence of Hand in Hand dementia training. On January 15, 2025, at 10:30 a.m., registered nurse (RN)-D and CNS-A stated the required training had been completed but was not documented in the employee records. In addition, RN-D stated he had completed CNS-A's annual review, but had not documented it as required. The licensee's Personnel Records policy dated revised May 2024, noted personnel files would include records of orientation and performance evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide	0 660			

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0 660	Continued From page 6 technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a current facility TB risk assessment. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 13, 2025, at 10:25 a.m., registered nurse (RN)-D stated the licensee had completed a facility TB risk assessment and would provide a copy. The licensee's Facility TB Risk Assessment dated August 4, 2023, indicated the facility was a low risk level. On January 15, 2025, at 9:50 a.m., RN-D and clinical nurse supervisor (CNS)-A stated they were not aware of the requirement to complete	0 660			

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0 660	Continued From page 7 the risk assessment annually. The licensee's Tuberculosis policy dated reviewed April 2024, noted a TB risk assessment would be completed annually. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. It also indicated a TB infection control program should include a facility TB risk assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any;	0 730			

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0 730	Continued From page 8 (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 730			

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0 730	Continued From page 9 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3's record lacked a discharge summary to include: - diagnoses; - course of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. R3 admitted to the facility on November 26, 2024, and discharged on January 7, 2025, to the attached skilled nursing facility. R3's diagnoses included hypertension and diabetes type 2. R3's Service Plan dated November 26, 2024, noted R3 received services including medication management. R3's record contained a Discharge Day progress noted dated January 2, 2025, that noted the resident was to discharge to the attached skilled nursing facility, and under personal belonging / medications, noted the family was to move items to the nursing home and out of the apartment.	0 730			

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0 730	Continued From page 10 On January 14, 2025, at 12:20 p.m., clinical nurse supervisor (CNS)-A stated she only completed a discharge day note as she was trained to do by the previous CNS. CNS-A stated they do have a discharge summary note available in the electronic medical record, but had not been using it. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730			
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential	0 820			

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0 820	Continued From page 11 to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On January 13, 2025, at 2:10 p.m., surveyor toured the facility with licensed assisted living director (LALD)-B. Survey staff measured the bedroom windows in Resident apartment #102 and #202. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOM: Apartment #202: Bedroom windows measured 10 inches clear width, 54 inches clear height, and 540 square inches total open area. UNOCCUPIED SLEEPING ROOM: Apartment #102: Bedroom windows measured 10 inches clear width, 54 inches clear height, and 540 square inches total open area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD-B that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code	0 820			

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0 820	Continued From page 12 standard for an egress window to be a complying bedroom for resident occupancy. TIME PERIOD FOR CORRECTION: Immediate	0 820			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for	01440			

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01440	Continued From page 13 one of one unlicensed personnel (ULP)-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C was hired on February 23, 2022, to provide direct care services to residents of the licensee. ULP-C's employee record lacked documentation of a supervision of performing delegated tasks within 30 calendar days. On January 15, 2025, at 10:30 a.m., registered nurse (RN)-D and clinical nurse supervisor (CNS)-A stated ULP-C transferred to the assisted living around August 2024, and stated they had not completed a supervision for any of the unlicensed personnel, and were not aware of the requirement to do so. The licensee's Supervision of Staff policy dated reviewed May 2024, noted staff who perform delegated nursing tasks must be supervised within 30 days after the individual began working and as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			

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(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) COMPLETE DATE
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01500			

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01500	Continued From page 15 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of three employees (clinical nurse supervisor/CNS-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CNS-A was hired on September 7, 2022, to provide direct care services to residents of the	01500			

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01500	Continued From page 16 facility. CNS-A's employee record lacked documented of the following required annual training: - a review of the provider's policies and procedures. On January 15, 2025, at 10:00 a.m., registered nurse (RN)-D and CNS-A stated policies were only reviewed when there were changes, and were not reviewed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced	01560			

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01560	Continued From page 17 by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who requested it, a complete description of the dementia care training program to include the required content. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee provided services under an assisted living license. The licensee's undated Notice of Dementia Training Provided to Staff form noted all staff would be trained on topics including: the Alzheimer's disease process, symptoms, and appropriate physical and behavioral care. At the end of this lesson, the learner will be able to: Define Alzheimer's disease, identify symptoms and possible causes of Alzheimer's Disease, assist the Alzheimer's patient with the activities of daily living, identify ways to problem solve challenging behaviors, communicate effectively and ensure patient-centered planning and service is delivered with every encounter". It noted training would be provided on an annual basis, but lacked information on training provided on hire. On January 13, 2025, at 1:05 p.m., licensed	01560			

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01560	Continued From page 18 assisted living director (LALD)-B stated the disclosure lacked information on the dementia training at the time of hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	01620			

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01620	Continued From page 19 Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment as required for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on January 13, 2025, at 10:25 a.m., RN-D stated assessments were completed on admission, quarterly, and with a change in condition. R2 admitted on January 29, 2024. R2's diagnoses included hypertension and diabetes type 2. On January 14, 2025, at 2:30 p.m., the surveyor met with R2 in her apartment, where she was sitting on the couch watching television. R2's Service Plan dated February 26, 2024, noted R2 received services including nursing services and medication setup. R2's admission assessment was completed on January 29, 2024. R2's record also included assessments dated: - April 30, 2024 (greater than 14 days after	01620			

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01620	Continued From page 20 admission); - August 20, 2024 (greater than 90 days since the last assessment): and - November 19, 2024. On January 15, 2025, at 11:45 a.m., clinical nurse supervisor (CNS)-A stated the August assessment was late, and added she was unaware of the requirement to do a 14-day reassessment. The licensee's Nursing Assessment policy dated reviewed May 2024, noted a reassessment must be conducted no more than 14 days after initiation of services and every 90 days from the date of the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided;	01650			

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01650	Continued From page 21 (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a service plan included the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included hypertension and diabetes type 2. On January 14, 2025, at 2:30 p.m., the surveyor met with R2 in her apartment, where she was sitting on the couch watching television.	01650			

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01650	Continued From page 22 R2's Service Plan dated February 26, 2024, noted R2 received services including nursing services and medication setup. However, it lacked: - a contingency plan that included the circumstances in which emergency medical services were not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On January 15, 2025, at 11:45 a.m., clinical nurse supervisor (CNS)-A stated the above required information was typically written in, but was missed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the	01910			

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01910	Continued From page 23 medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R3) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included hypertension and diabetes type 2. R3 discharged on January 7, 2025, to the attached skilled nursing facility. R3's record contained a Discharge Day progress note January 2, 2025, that indicated the resident was discharged to the attached skilled nursing facility. However, the summary lacked a disposition of medications to include: - the medication name; - strength; - prescription number as applicable;	01910			

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01910	Continued From page 24 - quantity; - to whom the medications were given; - date of disposition; and - names of staff and other individuals involved in the disposition. R3's Service Plan dated November 26, 2024, noted R3 received services including medication management. R3's electronic medication administration record for January 2025, noted the names of medications with staff initials to indicate the medications had been administered by staff. On January 14, 2025, at 12:20 p.m., clinical nurse supervisor (CNS)-A stated a medication disposition had not been completed since R3 discharged to the attached skilled nursing facility and the medications were administered by the same staff, who worked in both facilities and utilized the same medication carts. The licensee's Medication Disposition / Disposal policy dated revised June 2024, noted upon disposition, documentation must include the medication name, strength, prescription number, as applicable, quantity of medication, to whom the medications were given, date of disposition, and names of staff and other individuals involved. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services	02310			

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02310	Continued From page 25 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R1) with an assistive device (consumer bed rail). This resulted in an immediate order for correction on January 13, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a visit to R1's apartment with registered nurse (RN)-D on January 13, 2025, at 2:20 p.m., the surveyor observed R1's bed to have a consumer bed rail on the right side of the twin-sized bed. The bed rail was an upside-down U-shaped rail which was placed between the mattress and box spring. The bed rail went to the floor, and when the mattress was raised, had a bar that was square and reached approximately 3/4 of the width of the mattress. A black strap was wrapped around the two t-sections of the furthest	02310			

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02310	Continued From page 26 end of the bed rail and was clasped around the frame of the left side of the bed. The bed rail was a Healthcraft Smart Rail model number HC2012SRS-TW. R1 stated she had the bed for a very long time and used the bed rail to get in and out of bed and to adjust herself when in bed. R1 was admitted to the facility on May 21, 2021, with diagnoses including unspecified displaced fracture of first cervical vertebra, macular degeneration, carotid artery syndrome, and hypertension. R1's Service Plan dated December 27, 2023, noted R1 received assistance with medication management and bathing. R1's Uniform Assessment Tool on Admission dated November 19, 2024, indicated assistive devices used included a shoehorn, sock donner, and a four wheeled walker. It noted R1 wore glasses, received assistance with bathing, compression stockings, and medication management, was independent with transferring, toileting, ambulation, and mobility. The assessment noted a history of falls and vertigo, and that R1 had difficulty sleeping. On January 13, 2025, at 2:30 p.m., RN-D stated an assessment of the bedrail had not been completed for R1 because it would be a Bed Safety Assessment and R1 did not have a Bed Safety Assessment in their record. In addition, RN-D stated the manufacturer directions for use were not available and they had not referred to the Consumer Product Safety Commission (CPSC) for information related to portable bed rail recalls. On January 13, 2025, at 3:30 p.m., licensed	02310			

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02310	Continued From page 27 assisted living director (LALD)-B stated the maintenance staff had checked for a recall but was not sure when and the documentation had not been saved. R1's record lacked an assessment of the bed rail to include the purpose and intent of the bed rail, the condition and description of the bed rail, the resident's preferences, a physical inspection of the bed rail and mattress for areas of entrapment, stability, and correct installation, and any necessary information related to interventions to mitigate the safety risk or negotiated risk agreements. It also lacked the risk versus benefits, documentation the bed rail was installed and maintained according to the manufacturer's directions, and evidence the bed rail had been checked for a recall. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated December 13, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of	02310			

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NAME OF PROVIDER OR SUPPLIER CENTRAL TODD COUNTY CARE CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 406 HIGHWAY 71 EAST CLARISSA, MN 56440		
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02310	Continued From page 28 the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The MDH website, Assisted Living Resources & Frequently-Asked Questions (FAQs) also indicated "licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information." The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER CENTRAL TODD COUNTY CARE CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 406 HIGHWAY 71 EAST 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) COMPLETE DATE
02310	Continued From page 29 TIME PERIOD FOR CORRECTION: Immediate	02310			

Type: Full
Date: 01/14/25
Time: 11:30:00
Report: 1049251007

Food and Beverage Establishment Inspection Report

Page 1

Location:

Central Todd County Care Cente
406 Highway 71 East
Clarissa, MN56440
Todd County, 77

Establishment Info:

ID #: 0037661
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2187563636
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	0	0

INSPECTOR MET WITH THE ESTABLISHMENT REPRESENTATIVE AND THE MDH NURSE SURVEYOR.

THE NURSING HOME PREPARES AND COOKS ALL FOOD FOR THE ASSISTED LIVING FACILITY. ALL RESIDENTS GO TO THE NURSING HOME SIDE TO EAT. NO FOOD IS BROUGHT TO THE ASSISTED LIVING SIDE TO BE SERVED TO THE RESIDENTS.

THE ASSISTED LIVING KITCHEN IS NOT USED AT ALL. THERE WAS NO FOOD IN THE FRIDGE, HOT HOLDING UNITS WITH FOOD, ETC.

THE ASSISTED LIVING KITCHEN CURRENTLY HAS A POPCORN CEILING, PAINTED DRYWALL WALLS, WOOD/LAMINATE CABINETS, AND LAMINATE FLOORING.

Type: Full
Date: 01/14/25
Time: 11:30:00
Report: 1049251007
Central Todd County Care Cente

Food and Beverage Establishment Inspection Report

Page 2

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1049251007 of 01/14/25.

Certified Food Protection Manager NA

Certification Number: _____ Expires: ____ / ____ / ____

Signed: _____

Establishment Representative

Signed: Stephanie Reynolds

Stephanie Reynolds
Public Health Sanitarian
Fergus Falls
218-332-5179
stephanie.reynolds@state.mn.us