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	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Todd County Care Center	406 East Highway 71 Clarissa, MN 56440

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to conduct a comprehensive, complete investigation,, including a root cause analysis (RCA) and provide sufficient protection to other residents while the investigation was completed for 1 of 3 residents (R1) who was reviewed for accidents. This had the potential to affect all 19 residents who required staff assistance with a gait belt to transfer.Findings include: R1's quarterly Minimum Data Set, dated [DATE], identified she was admitted to the facility on [DATE], from home/community. She had severely impaired cognition with disorganized thinking, without behaviors. She required substantial/maximal assistance with all transfers. No falls since admission.R1's face sheet dated 10/29/25, identified diagnoses: Alzheimer's, urge incontinence, multiple fracture of ribs left side, dislocation of left shoulder joint, morbid obesity, joint disorders, osteoarthritis, fracture of upper end of left humorous, and fracture of left acetabulum (hip joint).R1's quarterly fall safety assessment dated [DATE], identified one to two falls in the last six months, no falls since admission. Identified R1 had right upper extremity impairment due to history of right arm fracture and wore arm brace daily. Has had no impairment of the left arm. Identified R1 pivot transfers with staff assist of one and four wheeled walker (4WW). Fall risk score was18 and indicated high risk for falls.R1's progress notes from 10/10/25, identified: -10/10/25 at 8:10 a.m. At approximately 7:00 a.m., licensed practical nurse (LPN) notified writer resident had fallen. Upon entering room, resident sat upright on her bottom on the floor, back was up against the nursing assistant (NA) legs with her legs stretched out towards the window. NA reported that when resident was pivot transferring with assist of one, she tripped over her feet and NA had lowered her to the ground. R1 complained of left hip pain. No redness, swelling, open areas or bruising noted to left hip. No other injuries found upon assessment. R1 denied maltreatment/abuse, stated no, no one hurt me she just fell. Denied head strike, wearing shoes, gait belt, and used 4WW at the time of fall. R1 was assisted off the floor with three assist EZ lift, transferred into her wheelchair, and assisted to commode with EZ stand. No complaints of left hip pain stated her right shoulder hurt, but shoulder pain was chronic and unrelated to fall. Range of motion (ROM) was limited in right shoulder due to previous injury and left hip was limited at first while sitting on the ground (stated it was painful when lifted to put the sling strap under her thigh). After she was placed in wheelchair and used sit to stand lift no more complaints of hip pain. Family, director of nursing (DON), and administrator notified.10/10/25 at 1:05 p.m., R1 sat in recliner with legs elevated. She now complained of severe pain to her left hip/groin that radiated down to knee and numbness to buttocks. She had very limited ROM, could only lift leave an inch or so off the footrest, bent knee about 10 degrees. Left leg appeared shorter that the right while she sat in recliner. R1 winced, grimaced and verbalized pain through assessment and with light touch to her upper left leg. Ice pack applied on top of left groin. As needed (PRN) tramadol administered and primary provider (MD) here to round shortly with priority. Family updated.-10/10/25 at 1:57 p.m., Seen by medical doctor (MD) on rounds. Orders given for R1 to be seen in clinic or ER for pelvic/hip x-ray. Transferred to ER at 2:54 p.m.-10/10/25 at 5:56 p.m., Called received from local ER and updated R1 had broken and dislocated left shoulder and three broken ribs. R1 was going to have surgery.R1's left shoulder x-ray dated 10/10/25 at 3:45 p.m., identified large Hill-Sachs fracture deformity (a bone injury on the humeral head/upper arm bone ball of the shoulder joint resulting from a shoulder dislocation) with suspected nondisplaced humeral fracture. (the bone fragments, cracked or broken have not significantly shifted but remain in their correct alignment) (can be caused by trauma or fall) and anterior dislocation (front/forward movement of the arm out of socket and occurs when holding arm away from the body usually caused by trauma)Mildly displaced left posterior left side rib fractures 5th, 6th, 7th, and likely 8th. Facility 5-day investigative report summary dated 10/17/25 at 4:54 p.m., R1 had an unsuccessful staff assisted transfer that resulted in her being lowered to the floor by staff. Element of the care plan that was not followed: R1 transfers with assist of one. While not explicitly written in the care plan, gait blet was required and not used for this transfer. R1 had refused gait belt in the past, but not with this transfer. R1 was referred to emergency department (ED) and evaluation showed dislocation of shoulder with fracture of the humoral head that may have been chronic due to presentation and three rib fractures were acute. Shoulder was reduced prior to return to facility. Summary of interview(s) with other residents who may have had contact with the alleged perpetrator (AP) not appliable (na). Action taken to prevent reoccurrence to subjected resident and other residents: gait belt audits conducted each shift to monitor compliance. Continued transfer audit will continue

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to comprehensively reassess and implement interventions to reduce the risk of further falls and injury after re-admission from hospital for 1 of 3 residents (R1) reviewed who had fallen and sustained injuries at the facility. Findings include: R1's quarterly Minimum Data Set, dated [DATE], identified she was admitted to the facility on [DATE], from home/community. She had severely impaired cognition with disorganized thinking, without behaviors. She required substantial/maximal assistance with all transfers. No falls since admission.R1's face sheet dated 10/29/25, identified diagnoses: Alzheimer's, urge incontinence, multiple fracture of ribs left side, dislocation of left shoulder joint, morbid obesity, joint disorders, osteoarthritis, fracture of upper end of left humorous, and fracture of left acetabulum (hip joint),R1's quarterly fall safety assessment dated [DATE], identified one to two falls in the last six months, no falls since admission. Identified R1 had right upper extremity impairment due to history of right arm fracture and wore arm brace daily. Has had no impairment of the left arm. Identified R1 pivot transfers with staff assist of one and four wheeled walker (4WW). Fall risk score was18 and indicated high risk for falls.R1's medical record lacked evidence of a fall assessment completed upon R1's return from the hospital. R1's occupational therapy caregiver education instructions for toileting dated 4/26/23, identified R1 may complete pivot transfers with assist of one and FWW/grab bars in central baths during the daytime. Please use bedside commode at bedtime (HS) toileting. Discontinue EZ stand.R1's medical record lacked evidence of a therapy assessment being completed upon R1's return from the hospital. R1's care plan dated 9/16/25, identified alternation in cognition related to Alzheimer's diagnosis with late onset, short/long term memory loss, severe cognitive impairment identified on 8/2025 that varied from intact to severe historically. History of disorganized thinking at times. Alternations in functional abilities/activities of daily living (ADLs) related to left acetabulum (fracture in the socket-shaped bone that forms the hip joint), history of unsafe transfers, and cognitive deficit. Staff were directed to have provided maximum assistance with all transfers with appropriate mobility aids, safety devices, and using and EZ stand when in pain, transfer and change positions slowly due to risk for falls, history of multiple falls, staff assist required for all transitions, impaired balance, history of unsafe self-transfers, pain, minimal impairment in hearing, alteration in cognition and presence of incontinence.R1's progress note dated 10/11/25 at 9:58 a.m., R1 returned from hospital. Nurse to nurse report: R1 was back to baseline. Stand/Pivot transfer. Reduction to left shoulder post fracture/dislocation. Discharge diagnoses: fracture/dislocation left shoulder and 3 to 4 rib fractures. Norco given prior to leaving hospital at 11:00 a.m. Orders: Miralax 17 grams (g) everyday, Hydrocodone prescription (Rx) to be sent to drug store pharmacy.Progress notes lacked evidence an assessment was completed for transfers after R1 was re-admitted to facility from hospital. R1's discharge from hospital orders dated 10/11/25, included reason for hospitalization: fall with left shoulder fracture/dislocation, multiple rib fractures, and pain control. Orders included: Activity without restrictions. May increase daily walking as able. Call provider if getting worse or increase in problems.During an observation on 10/27/25 at 12:59 p.m., nursing assistant (NA)-A answered R1's call light. R1 sat in wheelchair and stated she had just returned from seeing the doctor about her left arm fracture. NA-A applied a gait belt underneath her breasts, placed the walker in front of her, connected right arm brace strap across her chest, and brakes on wheelchair. NA-A walked around wheelchair and stood behind R1, reached forward and placed her opened hands flat on top of the gait belt on each side of her waistline. NA-A instructed R1 to stand and pushed firmly against her waistline and assisted her to stand. R1pushed up with left hand on wheelchair arm rest, stood up, took one step with left foot and pivoted so that she stood in front of the recliner. NA-A held onto R1's sides to steady her taking one step to her left so that she was positioned on R1' right side next to the recliner. NA-A pushed inward with her hands flat against the gait belt, while R1 placed her left hand on the recliner armrest and lowered herself down onto the recliner. R1's wheelchair remained with left edge of seat next to recliner at an angle so that NA-A stood in between the recliner and the wheelchair during the transfer. NA-A did not place her hands/fingers underneath the gait belt during this observation. NA-A removed the gait belt, elevated R1's feet with recliner footrest, covered her with a blanket, and placed call light on top of blanket. NA-A moved quickly and rushed to complete the transfer. NA-A turned off lights, sanitized her hands and left the room. R1's Kardex was observed inside her closet door last updated on 9/2/25, ensure appropriate mobility aides and safety devices used for transfers/positioning During an

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to implement standards of practice to ensure a safe transfer for 1 of 3 residents (R1) reviewed for accidents when staff failed to use a transfer belt. This resulted in actual harm when R1 fell during a staff assisted transfer, sustained a fractured and dislocated left arm, multiple rib fractures and was sent to the emergency department (ED) requiring medical treatment and kept overnight for observation and pain control. Findings include: R1's quarterly Minimum Data Set, dated [DATE], identified she was admitted to the facility on [DATE], from home/community. R1 had severe cognitive impairment with disorganized thinking, without behaviors and required substantial/maximal assistance with all transfers. No falls since admission.R1's face sheet dated 10/29/25, identified diagnoses: Alzheimer's, urge incontinence, multiple fracture of ribs left side, dislocation of left shoulder joint, morbid obesity, joint disorders, osteoarthritis, fracture of upper end of left humorous, and fracture of left acetabulum (hip joint),R1's quarterly fall safety assessment dated [DATE], identified one to two falls in the last six months, no falls since admission. Identified R1 had right upper extremity impairment due to history of right arm fracture and wore arm brace daily. Has had no impairment of the left arm. Identified R1 pivot transfers with staff assist of one and four wheeled walker (4WW). Fall risk score was18 and indicated high risk for falls. R1's occupational therapy caregiver education instructions for toileting dated 4/26/23, identified R1 may complete pivot transfers with assist of one and 4WW/grab bars in central baths during the daytime. Please use bedside commode at bedtime (HS) toileting. Discontinue EZ stand.R1's orders identified:-10/27/25, Sling to left upper extremity during day, remove for bathing and at night /bedtime for dislocated shoulder. -10/11/25, Hydrocodone/acetaminophen oral tablet 5/325 milligrams (mg) one tablet by mouth (po) every four hours as needed (PRN) for mild pain. -6/12/25, Tramadol hydrochloride (HCl) oral 50 mg tablet po PRN two times a day (b.i.d.) for chronic pain related to (r/t) chronic non-healing fracture of humerus and hip -6/12/25 Tramadol HCl oral 50 mg tablet po b.i.d. for chronic pain r/t non healing fracture of humerus and left hip.R1's Kardex 9/2/25 (posted in her room inside closet door), identified maximum assist with transfers from sitting to standing and transfers. EZ stand as needed (PRN) if in pain. Does not ambulate. Ensure appropriate mobility aides and safety devices used for transfers/positioning.R1's care plan dated 9/16/25, identified alteration in cognition related to Alzheimer's diagnosis with late onset, short/long term memory loss, severe cognitive impairment, identified on 8/2025, that varied from intact to severe historically and a history of disorganized thinking at times. Identified alterations in functional abilities/activities of daily living (ADLs) related to left acetabulum (fracture in the socket-shaped bone that forms the hip joint), history of unsafe transfers, and cognitive deficit. Staff were directed to have provided maximum assistance with all transfers with appropriate mobility aids, safety devices, and using and EZ stand when in pain, transfer and change positions slowly due to risk for falls, history of multiple falls, staff assist required for all transitions related to impaired balance, history of unsafe self-transfers, pain, minimal impairment in hearing, alteration in cognition and presence of incontinence.R1's progress notes from 10/10/25 through 10/13/25, identified: -10/10/25 at 8:10 a.m., at approximately 7:00 a.m., licensed practical nurse (LPN) notified writer resident had fallen. Upon entering room, resident sat upright on her bottom on the floor, back was up against the nursing assistant (NA) legs with her legs stretched out towards the window. NA reported that when R1 was pivot transferring with assist of one, she tripped over her feet and NA had lowered her to the ground. R1 complained of left hip pain. No redness, swelling, open areas or bruising noted to left hip. No other injuries found upon assessment. R1 denied maltreatment/abuse, stated no, no one hurt me she just fell. Denied head strike, wearing shoes, gait belt, and used 4WW at the time of fall. R1 was assisted off the floor with three assist EZ lift, transferred into her wheelchair, and assisted to commode with EZ stand. No complaints of left hip pain stated her right shoulder hurt, but shoulder pain was chronic and unrelated to fall. Range of motion (ROM) was limited in right shoulder due to previous injury and left hip was limited at first while sitting on the ground (stated it was painful when lifted to put the sling strap under her thigh). After she was placed in wheelchair and used sit to stand lift no more complaints of hip pain. Family, director of nursing (DON), and administrator notified.-10/10/25 at 12:02 p.m., Daughter called back. Writer updated her on fall. No concerns. -10/10/25 at 1:05 p.m., R1 sat in recliner with legs elevated and now complained of severe pain to her left hip/groin that radiated down to knee and numbness to buttocks and had very limited ROM, could only lift leave an inch or so off the footrest, bent knee about 10degrees, R1's left leg appeared shorter that the right