STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. Building B. Wing	03/18/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a resident's call light was accessible for 1 of 1 residents (R15) reviewed for call light accessibility. Findings include: R15's quarterly Minimum Data Set (MDS) dated [DATE], identified R15 had severely impaired cognition and had a diagnosis that included Alzheimer's disease (disease that cause dementia), non-Alzheimer's dementia. R15 needed maximal assistance with toileting and touching assistance with transfers. R15's care plan revised on 1/15/26, identified R15 was at risk for falls, and staff were to reinforce the need to call for assistance. R15's fall safety assessment dated [DATE], identified R15 of having a moderate risk for falls. During an observation on 3/17/26 at 1:03 p.m., R15 was lying in bed; the call light was not accessible. The call light was clipped to the call light wire that was coming out from the wall. The call light was approximately two feet above the bed and a foot away from the end of the bed, above a small dresser. During an interview/ observation on 3/17/26 at 1:47 p.m., nursing assistant (NA)-A and NA-B, verified R15 was able to use the call light and should have access to the call light when in room. NA-A looked at R15's call light placement and verified R15's call light was not within reach and moved the call light into R15's reach. During an interview on 3/17/26 at 4:12 p.m., director of nursing (DON) indicated R15's fall interventions were appropriate and R15 was able to use the call light. DON's expectations was for staff to follow care plan interventions and to ensure R15's call light was in reach at all times to prevent falls. Facility policy titled Call Light Response dated 7/25, lack information regarding placing call light where accessible to resident.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented in accordance with Centers for Disease Control (CDC) guidelines for 1 of 2 (R19) residents who were reviewed for enhanced barrier precautions. Findings include: Review of Centers for Disease Control and Prevention (CDC) guidance dated 4/1/24, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions included: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. R19's quarterly Minimum Set Data dated 1/27/26, identified R19 had severely impaired cognition and had a diagnosis which included Parkinson's disease (neurological disorder), non-Alzheimer's dementia. R19 was dependent on staff for dressing, toileting, and transfers. R19 had an unstageable pressure ulcer that was present on entry and received pressure ulcer care. R19's signed electronic medication administration record (EMAR) directed staff to change Allevyn (dressing) to buttocks measure and update skin sheet on bath days start date 1/22/26 and discontinued 3/17/26. EMAR identified dressing change was completed on 3/5/26 and 3/12/26. R19's EMAR directed staff to change to Mepilex (dressing) buttocks, measure, and update skin sheet on bath days. EMAR identified the task was completed on 3/18/26. R19's altered skin integrity sheet dated 3/12/26, identified R19 had an open area on left buttocks measuring 4 centimeters (cm) x 4.5 cm. The wound bed is shallow and consists of 10% slough (tissue in the wound bed appearing white or yellow, resulting from wound healing) and 90% granular tissue (pink or red tissue, signifying a sign of wound healing). Edges were irregular and lightly macerated (soft tissue). Blanchable erythema (tissue surrounding a wound). No drainage noted at the time of the dressing change. Skin prep was applied around the wound, and Mepilex applied over the wound. R19's altered skin integrity sheet dated 3/5/26, identified R19 had two small scab areas and one small open area. R19's altered skin integrity sheet dated 2/26/25, identified R19 wound measures 3.5 cm x 7 cm with small shallow areas are bleeding. Erythema (redness of skin) to periwound (tissue surrounding a wound) was blanchable. Large Mepilex placed over coccyx. R19's care plan revised on 10/24/25, identified R19 had alteration in skin integrity related to pressure injury on the left buttocks. The care plan lacked EBP. During an observation/interview on 3/17/26 at 10:04 a.m., there were no signs on R19's door indicating R19 was on EBP or any gowns available for staff to use. Nursing assistant (NA)-C, NA-D, and registered nurse (RN)-A sanitized hands and went into R19 's room. RN-A indicated R19 needed to have a wound dressing changed. NA-C and NA-D assisted R19 into a mechanical standing lift. RN-A brought skin protective wipes, wound wash, gauze, and dressing into the room. RN-A indicated a measuring device was not brought into the room as the wound was measured on Thursdays. RN-A indicated R19 had a pressure wound to the left upper buttocks. RN-A applied gloves and removed the old dressing and indicated there was a small amount of squamous (clear serous fluid) drainage. The wound was shallow, with 75% maturation (newly formed tissue) and 25% of red granulation (pink tissue forms during wound healing) tissue. Wound wash and gauze were used for debridement (removal of dead or damaged tissue) of the wound. RN-A removed gloves, sanitized hands, and applied new gloves. RN-A indicated the wound was approximately 4 cm x 6 cm. RN-A applied skin prep wipe around the wound to help protect the skin, then applied a new dressing. RN-A indicated the wound had been healing and was almost healed two weeks prior, but the wound has since reopened. During an interview on 3/17/26 at 12:34 p.m., RN-A indicated EBP was to be used on residents who had chronic wounds. RN-A indicated R19 was not on EBP, as R19's wound was not chronic, as it had healed in the past. RN-A indicated R19's wound had been open for approximately (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two weeks. During an interview on 3/17/26 at 1:13 p.m., registered nurse care coordinator (RNCC)-A indicated R19 had an open wound measuring 4 cm x 4.5 cm on 3/12/26. RNCC indicated EBP would be started on a resident who had chronic wounds. RNCC verified R19 had a chronic wound and should have been placed on EBP. During an interview on 3/18/26 at 10:21 a.m., director of nursing (DON) indicated EBP was to be used on residents with wounds. DON verified R19 should have been on EBP related to having a wound. DON's expectation would be for EBP to be used per policy to keep residents and staff safe from the spread of multidrug-resistant organisms (MDROs). During an interview on 3/18/26 at 1:56 p.m., infection preventionist (IP)-A verified R19 should have been on enhanced barrier precautions for an open wound. IP indicated EBP was important for the prevention of MDROs. Review of policy titled enhanced barrier precautions for multidrug-resistant organisms (MDROs) dated 4/25, identified Central [NAME] County Care Center would utilize enhanced barrier precautions for residents with chronic wounds, and not those with only shorter-lasting wounds such as breaks in the skin or skin tears covered with a Band-Aid or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Enhanced barrier precautions require the use of a gown and gloves during high-contact care activities, including dressing, grooming, bathing/showering, transferring, toileting, dressing changes, wound care, and changing linens. Review of policy titled wound care dated 1/26 identified EBP should be utilized for residents with chronic wounds.