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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 0BJD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00061

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245573**

2.STATE VENDOR OR MEDICAID NO.
(L2) **454040900**

3. NAME AND ADDRESS OF FACILITY
(L3) **CLARA CITY CARE CENTER**
(L4) **1012 NORTH DIVISION STREET PO BOX 797**
(L5) **CLARA CITY, MN** (L6) **56222**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/31/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **63** (L18)

13.Total Certified Beds **63** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	63			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, HFE NE II — 10/31/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 11/15/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/06/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/01/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 15, 2016

Mr. Michael Stordahl, Administrator
Clara City Care Center
1012 North Division Street P.O. Box 797
Clara City, MN 56222

RE: Project Number S5573025

Dear Mr. Stordahl:

On September 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 1, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On October 31, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 6, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard extended survey, completed on September 1, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 11, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 1, 2016, effective October 11, 2016 and therefore remedies outlined in our letter to you dated September 15, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245573
November 15, 2016

Mr. Michael Stordahl, Administrator
Clara City Care Center
1012 North Division Street P.O. Box 797
Clara City, MN 56222

Dear Mr. Stordahl:

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

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

Effective October 11, 2016 the above facility is certified for or recommended for:

63 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 63 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245573 Y1	A. Building B. Wing Y2	10/31/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY CARE CENTER	1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156	Correction	ID Prefix F0279	Correction	ID Prefix F0309	Correction
Reg. # 483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.25	Completed
LSC	10/11/2016	LSC	10/11/2016	LSC	10/11/2016
ID Prefix F0334	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.25(n)	Completed	Reg. # 483.70(h)	Completed	Reg. #	Completed
LSC	10/11/2016	LSC	10/11/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 11/15/2016	SIGNATURE OF SURVEYOR 10562	DATE 10/31/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/1/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245573	A. Building 01 - MAIN BUILDING 01 B. Wing	10/6/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY CARE CENTER	1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 09/16/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 10/06/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 11/15/2016	SIGNATURE OF SURVEYOR 10562	DATE 10/06/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/30/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245573	A. Building 04 - 2010 KITCHEN ADDITION B. Wing	10/6/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY CARE CENTER	1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 10/06/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** BF/KJ	**DATE** 11/15/2016	**SIGNATURE OF SURVEYOR** 10562	**DATE** 10/06/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 8/30/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245573	CLARA CITY CARE CENTER

Type of Survey (select all that apply):

D					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

D					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 10562			0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours	0.25
Total Clerical/Data Entry Hours.....	3.25
Was Statement of Deficiencies given to the provider on-site at completion of the survey?	N

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 0BJD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00061

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245573**

2.STATE VENDOR OR MEDICAID NO.
(L2) **454040900**

3. NAME AND ADDRESS OF FACILITY
(L3) **CLARA CITY CARE CENTER**
(L4) **1012 NORTH DIVISION STREET PO BOX 797**
(L5) **CLARA CITY, MN** (L6) **56222**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/01/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **63** (L18)

13.Total Certified Beds **63** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	63			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Andrea Koshiol Schmitz, HFE NE II — 10/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 10/27/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/01/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 15, 2016

Mr. Michael Stordahl, Administrator
Clara City Care Center
1012 North Division Street Po Box 797
Clara City, MN 56222

RE: Project Number S5573025

Dear Mr. Stordahl:

On September 1, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the

attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Pam Kerssen, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 Fifth Street NW, Suite A
Bemidji, Minnesota 56601
Telephone: (218)308-2104 Fax: (218)308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 11, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for

its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan

of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 1, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 1, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the

Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING _____ B. WING _____	09/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY CARE CENTER	1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		10/11/16

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

Electronically Signed | 09/23/2016

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F 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to timely provide a liability/ appeal rights notice or denial letter, prior to discharge from Medicare services, for 1 of 3 residents (R60) reviewed in the sample. Findings include: R60 was discharged from Medicare services on 5/3/16, as indicated on a Notice of Medicare Non-Coverage (form CMS 10123), signed by R60 on 5/2/16. In an interview on 9/1/16 at 11:37 a.m., registered nurse (RN)-A stated on 5/2/16, the facility received a doctor's order to discharge R60 to assisted living. R60 would be getting outpatient services there, including therapies. RN-A said R60's denial letter indicated "skilled services were noted to end on 5/3/16." During an interview on 9/1/16 at 2:52 p.m.,	F 156	It is the policy of the Clara City Care Center that residents are provided with a timely liability/appeal rights notice or denial letter prior to discharge from Medicare services. The Notice of Medicare Non-Coverage is delivered as per the attached CMS Form-10123 Instructions. In the event that a resident elects to be voluntarily discharged from the facility prior to the end of their Medicare covered services, a chart note indicating such will be made rather than issuing a Notice of Non-Coverage. A policy regarding this has been implemented and Nurse Managers were educated by Director of Nursing on the proper timing of Notices of Medicare Non	

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F 156	Continued From page 3 physical therapy assistant (PTA)-A said R60's physical therapy was discontinued on 4/28/16. PTA-A also said R60 continued to receive both speech therapy and occupational therapy until 5/3/16. PTA-A stated on 5/3/16, all of R60's skilled services ended, and also R60 was going to an assisted living facility. Although R60's skilled services at the nursing facility were ending on 5/3/16, there was no indication R60 received the Medicare non-coverage notice two days before his coverage ended, as required. In an interview on 9/1/16, at 3:26 p.m., the director of nursing (DON) said liability notices should be given timely "if possible." The DON stated it was often difficult to know exactly when a resident was leaving, "especially if no solid discharge plan is in place." The DON said "by regulation, [the notice] should have been given." A facility policy regarding liability notices was requested, but none provided. The facility provided a document entitled "Form Instructions for the Notice of Medicare Non-Coverage," undated, which directed: the Notice of Medicare Non-Coverage "must be delivered at least two calendar days before Medicare covered services end."	F 156	Coverage and when to give per CMS instructions on 9/12/2016. The DON or designee will complete monthly audits of Medicare denials for 3 months and report audit results at QA. If positive results, the audits will be done on a random basis. The facility receives CMS email notifications and will be made aware of any upcoming changes to the NOMNC guidelines and educate staff accordingly if changes occur.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279		10/11/16

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F 279	Continued From page 4 needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan to include access site, special care, and emergency procedures for 1 of 1 residents (R49) who received hemodialysis at an outside facility, and failed to develop a comprehensive care plan identifying rejection of care behaviors for 1 of 1 residents (R18) reviewed for activities of daily living (ADL's). Findings include: DIALYSIS: R49's quarterly Minimum Data Set (MDS) dated 7/25/16, identified R49 had intact cognition, had end stage renal disease (ESRD), and received hemodialysis at an outside facility. R49's care plan, dated 5/6/16, identified she went to dialysis three times per week. Further, the care plan identified several interventions for R49 including, "Blood pressure should be obtained on	F 279	It is the policy of the Clara City Care Center that all residents will have an individualized, comprehensive plan of care developed no later than 21 days after admission and revised as needed and with subsequent assessments. A specific dialysis care plan was developed for R49 on 9/2/16 after discussing her care with staff at the dialysis unit, which includes instructions in case of emergency as per dialysis, location and contact information for the dialysis unit, dialysis schedule, nephrologist's name, and specific instructions for monitoring of the fistula. A copy of this care plan was placed in the resident's chart, in the charge nurse communication book, and the CNA communication book. Refusal of care was added to R18's comprehensive care plan on 9/1/16 and a behavioral symptoms care plan was initiated on 9/2/16.	

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F 279	Continued From page 5 right arm only due to fistula (connection between artery and vein used to start dialysis) on left upper arm", "No water pitcher in room", "Monitor fluid intake monthly or PRN [as needed]", "Monitor for s/sx [signs and symptoms] of dehydration and/or fluid imbalance and notify MD/Dialysis", "Monitor weight weekly or PRN", "Provide bag lunch for resident to take with her to dialysis on MWF [Monday, Wednesday, Friday]", and "Provide Dialysis, diabetic diet (high protein, 2 gm [grams] Na+ [Sodium], low K+ [Potassium], low phosphorus) and 1500 ml [milliliter] FR [Fluid Restriction]." However, R49's care plan lacked any information or guidance on how to care for R49 in an emergency situation should R49 be unable to attend a scheduled dialysis appointment, monitoring and caring of the dialysis access site (fistula) for complications and or signs or symptoms of infection, or identify interventions to reduce R49's elevated risk for bleeding. In addition, the care plan lacked any information of where R49 received her dialysis treatments, the dialysis facility phone number, or whom R49's nephrologist (kidney specialist) was or how he or she was to be reached. During observation on 8/30/16, at 3:39 p.m., R49 was sitting in her wheelchair in her room reading the newspaper; R49 had a fistula in her upper left arm. When interviewed on 8/31/16, at 2:28 p.m., licensed practical nurse (LPN-D) stated if R49 was bleeding from her dialysis access she would have to ask her supervisor or the director of nursing (DON) what to do. Further LPN-D stated, "I am not sure what to do if [R49] started	F 279	Nail care for all diabetic residents, which is completed by the charge nurses has been added to treatment sheets in EMAR, as a reminder to document refusals. The DON or designee will audit the “Body Audit Forms” of 10% of residents on a random basis weekly to ensure that they being filled out completely and provide reminders and education on the importance of doing so as needed on an ongoing basis. Reminders to report and document refusal of care have been communicated to all direct care staff on an individual basis as well as through IDT. RN Managers responsible for care plan completion and the Social Services Designee received education from the DON regarding these changes on 9/23/16. The Clara City Care Center policy on care planning was reviewed and updated to include special care, and behavioral symptoms CAAs triggered by refusal of care. The DON or designee will audit 10% of the care plans of all current residents weekly until all care plans have been audited to ensure that any special care areas and refusals of care are included in the comprehensive care plan. If positive results, the audits will be changed to randomly on an as needed basis. Results of these audits and any concerns noted will be discussed at quarterly QA meetings.	

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F 279	Continued From page 6	F 279		

bleeding." LPN-D stated there were no orders in R49's chart about her dialysis except for her renal diet, there was no care plan for dialysis, and there were no treatment orders for R49 either. In addition, LPN-D stated she was not sure who R49's nephrologist was, what his or her phone number was, nor did she know the number to the dialysis unit.

During interview on 9/1/16, at 10:42 a.m., LPN-E stated R49 had an order for a dialysis diet and for a Boost Protein Shake, but no other dialysis specific orders. LPN-E added, R49 did not have a dialysis specific care plan, but that would make sense since she was on dialysis. Further, LPN-E said, it would be "very helpful" to have a dialysis care plan so we would know how to care for her. LPN-E stated she did not know who R49's nephrologist was or his or her phone number.

When interviewed on 9/1/16, at 11:03 a.m. registered nurse (RN)-B stated she did not know who R49's nephrologist was or his or her direct phone number; staff would have to do some research to find the number. RN-B stated R49 did not have a dialysis specific care plan, it is just "mixed in" with other problem areas in her care plan. RN-B added, R49 "should have" a dialysis care plan with specific dialysis information to assist staff in giving them direction on how to care for a dialysis patient.

During interview on 9/1/16, at 11:15 a.m., RN-A stated she completed all the care plans for the residents in the nursing home and added, R49 "should have" a dialysis care plan because this needs to be addressed. RN-A stated we "do not" have a care plan that addresses dialysis. RN-A added, the dialysis care plan should include:

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F 279	Continued From page 7 Dialysis clinic information, phone numbers, nephrologist and phone number, access care, when to remove R49's dialysis access dressing, monitoring for bleeding, what to do in an emergency, and what to do if R49 missed a dialysis treatment. RN-A stated she would complete a dialysis care plan for R49. When interviewed on 9/1/16, at 1:30 p.m., DON stated R49 should have a dialysis care plan and, "I expect that [R49] would have a dialysis care plan." DON added she would work on a policy, staff education, and make sure a care plan was developed for R49 for dialysis. ACTIVITIES OF DAILY LIVING: R18's admission MDS, dated 6/20/16, identified R18 was cognitively intact and required limited assistance of one with grooming and extensive assistance of one with bathing. R18's Behavioral Symptoms Care Area Assessment (CAA), dated 6/20/16, indicated R18 had a one-time documented instance of rejection of cares, and rejection of care may increase the risk of falls, skin breakdown, increased incontinence, decline in ADL's, and social isolation for R18. R18's ADL care plan (CP), dated 6/29/16, indicated R18 was in need of assistance to perform ADL's. R18's CP identified interventions of, limited assist of one with grooming and extensive assist of one to transfer in/out of tub and with cleaning and drying. The CP also identified R18 preferred an evening bath/shower	F 279		

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F 279	Continued From page 8 2x (times)/(per) week. The CP did not identify any rejection of care behaviors nor did it contain specific interventions staff could have used to help reduce or prevent R18's refusals of bathing and nail care. During observation on 8/30/16, at 9:44 a.m., R18 had long fingernails with black debris noted underneath her nails. When observed on 8/31/16, at 8:22 a.m., R18 was in the dining room having breakfast. R18 continued to have long, dirty fingernails approximately 1/4" (inch) long with a dark, black substance underneath her nails. During interview on 8/31/16, at 8:40 a.m., nursing assistant (NA-A) stated R18 received her baths on Monday and Friday evenings, and added, R18 "often times" refused her baths and her nail care. When interviewed on 8/31/16, at 8:46 a.m., NA-B stated R18 did not want her nails cut, we have tried, but she refuses. During interview on 8/31/16, at 8:50 a.m. RN-C stated R18 liked her nails long, would at times allow staff to clean her nails, but not always. RN-C added, if a resident is refusing nail care, the nurse should be documenting refusal of nail care on the treatment sheet. When interviewed on 8/31/16, at 8:52 a.m. RN-D stated R18's nails were long, but R18 did not like to have her nails cut, and added, "We should be documenting any refusals of nail care." R18 has a tendency to refuse baths and nail care and, "It should be in her care plan that she refuses her baths and nail care." RN-D stated this	F 279		

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F 279	Continued From page 9	F 279		

information should also be on the certified nursing assistants (CNA's) Focus Sheets so they are aware.

During interview on 8/31/16, at 2:50 p.m. RN-E stated R18 often refused to let staff clean her hands and trim her nails. RN-E added, a Body Audit Form is completed on each resident on their bath day and on this sheet is where it is documented if fingernails and toenails are trimmed or if the resident refused care. R18's nail care is not getting documented as refusals and her bath sheets are not comprehensively filled out completely. RN-E stated, "We should be" completing these forms in detail, and R18's refusals of baths and nail care should be included in her care plan. Her refusals are not in her care plan, but they "Should be."

When observed on 9/1/16, at 3:10 p.m. R18 continued to have long, dirty fingernails, approximately 1/4" long with black debris underneath her nails.

During interview on 9/1/16, at 3:17 a.m. RN-B stated R18 refused to have her nails trimmed, cleaned, and often refused bathing. Further, RN-B added, R18's refusals of care, especially her bathing and grooming, "Should be in her care plan."

A facility Resident MDS and Care Planning Policy and Procedure dated 7/2015, indicated, "An individualized, comprehensive care plan will be started after admission and will be completed no later than day 21 or 7 days after completion of the comprehensive assessment. CAA triggers are used as the basis of the plan of care. Additional areas care planned as determined by the IDT

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F 279	Continued From page 10 (Interdisciplinary Team), additional assessment, diagnoses, facility policy, or other resident-specific concerns."	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the dialysis access site was consistently monitored and assessed to ensure patency of the fistula, plans for emergency management of the access site were developed, and staff were aware of emergency procedures in place for 1 of 1 residents (R49) reviewed receiving dialysis. In addition, the facility failed to identify emergency dialysis contact information. Findings include: R49's quarterly Minimum Data Set (MDS) dated 7/25/16, identified R49 had intact cognition, end stage renal disease (ESRD), and received hemodialysis at an outside facility. R49's care plan dated 5/6/16, identified she went to dialysis three times per week. The care plan included the following interventions: Blood	F 309	It is the policy of the Clara City Care Center to provide for all residents the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. A specific dialysis care plan was developed for R49 on 9/2/16, after discussing her care with the staff at the dialysis unit, which includes instructions in case of emergency as per dialysis, location and contact information for the dialysis unit, dialysis schedule, nephrologist's name, and specific instructions for monitoring of the fistula. A copy of this care plan was placed in the resident's chart, in the charge nurse communication book, and the CNA communication book. The dialysis unit was also contacted by	10/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING _____ B. WING _____	09/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY CARE CENTER	1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11 pressure should be obtained on right arm only due to fistula (connection between artery and vein used to start dialysis) on left upper arm; No water pitcher in room; Monitor fluid intake monthly or PRN [as needed]; Monitor for s/sx [signs and symptoms] of dehydration and/or fluid imbalance and notify MD/Dialysis; Monitor weight weekly or PRN; Provide bag lunch for resident to take with her to dialysis on MWF [Monday, Wednesday, Friday]; and Provide Dialysis, diabetic diet (high protein, 2 gm [grams] Na+ [Sodium], low K+ [Potassium], low phosphorus and 1500 ml [milliliter] FR [Fluid Restriction]. R49's care plan lacked failed to identify: how to care for her in an emergency situation should she be unable to attend a scheduled dialysis appointment; monitoring and treatment of the dialysis fistula including complications such as infection and bleeding; and how to reduce R49's elevated risk for bleeding. In addition, the care plan lacked any information about where R49 received her dialysis treatments and the contact information including the phone number, or whom R49's nephrologist (kidney specialist) was and how he/she was to be reached. On 8/30/16, at 3:39 p.m. R49 was sitting in her wheelchair in her room reading the newspaper. R49 had a fistula in her upper left arm. R49 stated she went to dialysis three times a week, had been on dialysis for almost three years, and had no complications since beginning dialysis. R49 further stated, that although staff checked on her fistula site after her dialysis treatments, she took care of her dialysis site and removed the fistula dressings herself. On 8/31/16, at 2:28 p.m. licensed practical nurse	F 309	the DON on 9/2/16 and again on 9/22/16 to set up an inservice for care center staff. It will be scheduled in the near future. A facility policy for dialysis was developed on 9/12/16, after discussing R49's care with staff at the dialysis unit. RN Managers responsible for care plan completion and the Social Services Designee received education from the DON regarding these changes on 9/23/16. Upon admission of resident's receiving dialysis, the DON will ensure compliance with this policy by auditing the chart of the resident. Results of these audits and any concerns noted will be discussed at quarterly QA meetings.	

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F 309	Continued From page 12	F 309		

(LPN)-D stated if R49 was bleeding from her dialysis access she would have to ask her supervisor or the director of nursing (DON) what to do. LPN-D stated, "I am not sure what to do if [R49] started bleeding." LPN-D stated there were no orders in R49's chart about her dialysis except the renal diet. There were no treatment orders for R49. LPN-D was unaware of any dialysis specific interventions on the care plan. In addition, LPN-D stated she was not sure who R49's nephrologist was, what his/her phone number was, or the number to the dialysis unit.

On 9/1/16, at 10:42 a.m. LPN-E stated R49 had an order for a dialysis diet and a Boost Protein Shake, but no other dialysis specific orders. LPN-E added, R49 did not have a dialysis specific care plan, but that would make sense since she was on dialysis. Further, LPN-E said, it would be "very helpful" to have a dialysis care plan so staff knew how to care for her. LPN-E stated she did not know who R49's nephrologist was or his/her phone number.

On 9/1/16, at 11:03 a.m. registered nurse (RN)-B stated she did not know who R49's nephrologist was or his/her phone number. Staff would have to do some research to find the phone number. RN-B stated R49 did not have a dialysis specific care plan, it is just "mixed in" with other problem areas in her care plan. RN-B added, R49 "should have" a dialysis care plan with specific dialysis information to assist staff in giving them direction on how to care for a dialysis patient.

During interview on 9/1/16, at 11:15 a.m. RN-A stated she completed all the care plans for the residents in the nursing home. R49 "should have" a dialysis care plan because this needs to be

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F 309	Continued From page 13 addressed. RN-A stated the facility did not have a care plan that addressed dialysis. RN-A added, the dialysis care plan should include: dialysis clinic information, phone numbers, nephrologist and phone number, access care, when to remove R49's dialysis access dressing, monitoring for bleeding, what to do in an emergency, and what to do if R49 missed a dialysis treatment. RN-A stated she would complete a dialysis care plan for R49. When interviewed on 9/1/16, at 1:30 p.m. the director of nursing (DON) stated R49 should have a dialysis care plan, "I expect that [R49] would have a dialysis care plan." The DON added she would work on a policy, staff education, and make sure a care plan was developed for R49's dialysis needs. A facility policy related to dialysis care was requested, however none was provided.	F 309		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse	F 334		10/11/16

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F 334	Continued From page 14 immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.	F 334		

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F 334	Continued From page 15 (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the pneumococcal conjugate vaccine (PCV13) for 3 or 5 residents (R1, R17, R28,) whose vaccination histories were reviewed. Findings include: The Center for Disease Control and Prevention (CDC) recommended, "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 (pneumococcal polysaccharide vaccine 23) should receive a dose of PCV13. The dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose." R1's immunization report, dated 9/1/16, indicated the 95 year old resident had received a Pneumovax PPSV23 on 12/30/14 upon admission to the facility. There was no evidence she had been offered the PCV13 vaccine since then. R17's immunization report, dated 9/1/16, indicated the 94 year old resident had received a	F 334	It is the policy of the Clara City Care Center to reduce morbidity and mortality from pneumonia for all residents who meet the criteria established by the CDC by offering the pneumococcal vaccine. On 9/19/2016, facility policy for administration of pneumococcal vaccine was reviewed and updated to include PCV 13 as well as PPSV 23. RN Managers responsible for admissions and assisting with review of vaccination records received education from the DON regarding these changes on 9/23/16. The DON or designee will review vaccination records via MIIC and facility medical records of current residents in their assessment period for their next scheduled quarterly MDS as well as new residents upon admission and administer PSV 13 as per policy after providing vaccination information and obtaining consent from the resident or responsible party. Changes and any concerns noted will be discussed at quarterly QA meetings.	

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F 334	Continued From page 16 Pneumovax PCV7 on 1/1/92. There was no evidence she had been offered the PCV13 since her admission to the facility on 6/4/13. R28's immunization report, dated 9/1/16, indicated the 91 year old resident had never received a Pneumovax PPSV23; however, the facility staff reported, per family, R28 had been vaccinated before his admission. There was no evidence he had been offered the PCV13 since his admission on 4/26/10. During an interview on 9/1/16, at 4:15 p.m., the director of nursing (DON) stated she had discussed the PCV13 vaccination with their medical director; however, the facility had not yet implemented a plan for vaccinating residents. She further stated the facility had not ordered the physical vaccine, but once on hand, all eligible residents would be vaccinated from one side of the facility to the other. A facility policy entitled, Administration of Pneumococcal Vaccine, revised 3/31/11, directed staff to screen residents for the Pneumovax PPSV23 vaccination; however, it did not address CDC recommendations for the administration of the PCV13 vaccination.	F 334		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 465		10/11/16

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F 465	Continued From page 17 by: Based on observation and interview, the facility failed to provide the housekeeping and maintenance services necessary to maintain sanitary conditions in 6 of 6 shared resident bathrooms (104/106; 108/110; 107/109; 121/123; 124/126; 127/129). This had the potential to affect 11 residents (R31, R44, R69, R10, R18, R1, R35, R67, R28, R46 and 51) reviewed in the sample who used shared bathrooms. Findings include: During an environmental tour on 9/1/16, at 1:46 p.m., with housekeeping (HK) and in presence of the surveyor, resident bathrooms on the "Caring Place" and "West" wings of the facility were reviewed. Bathrooms on these wings were shared, approximately 3' (feet) by 5' in size, and located between side-by-side rooms. The bathrooms had two wooden doors, each allowing access to the adjoining room. The metal door frames in the following shared- resident bathrooms were observed rusted, with uncleanable surfaces: 104/106; 108/110; 107/109; 121/123; 124/126 and 127/129. With the bathroom doors ajar, rusty areas, bare areas and chipped, painted areas were seen on the sides and edges of both metal door frames, inside the bathroom. The rusted areas were visible near the floor, and extended upward, up to 24" [inches] from the floor. The doors also presented with blistered, bubble-like features on the paint-chipped frames, both inside and out of the bathrooms, which also revealed additional rust along their uneven surfaces. Three door frames had intact, plastic corner protectors in place; the remaining protectors were missing.	F 465	The six resident bathrooms that were found to have rust near the floor on the frames will be sanded down and re-painted with a paint designed to resist rust and corrosion. These were bathrooms between rooms 104/106; 108/110; 107/109; 121/123; 124/126; and 127/129. New protective coverings have been ordered to apply to the door frames following the re-painting and sanding. This will allow the frames to hold up to more wear and tear without the paint chipping. All shared bathrooms in the facility have been inspected by the Administrator and Maintenance Director since the survey exit date. Any of the door frames that have similar issues to the ones cited in the survey will also be sanded and re-painted. A protective covering will also be placed on the frame to prevent this problem from occurring in these areas. Moving forward the door frames of the rooms with shared bathrooms will be inspected monthly by the Maintenance Director or Designee in order to ensure all steel door frames are in good repair and cleanable. If any are found to have rust on them they will be repaired in the same manner mentioned above. The Administrator will also inspect all of the shared bathroom door frames quarterly for the next year to ensure all are in good repair and cleanable. A report of the door frames that were fixed will be made and presented at the upcoming QA meeting. The monitoring reports will also be added	

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F 465	Continued From page 18 Chipped paint was also observed on grab bars that were welded to the metal frames in these bathrooms. During an interview on 9/1/16, at 1:49 p.m., housekeeping (HK) said the areas of rust on the doors "made them difficult to clean, to keep clean, and and were really uncleanable." The HK said these rooms [in West and Caring Place wings of facility] "were the oldest in the building," so it was easy to see the rust on the frames. Some of the frames "really bubbled up" when previously painted. The HK said the door frames "need to be sanded and painted." In an interview on 9/1/16, at 2:12 p.m., the director of maintenance (DM) said, after reviewing some of the doors, the rusty surfaces were not cleanable. The DM said at one time there were door protectors glued on, but they broke over time, and no one took off the adhesive. The DM stated how the frames were painted over, and when they rust, it begins to bubble. The DM said they would require "sanding, getting rid of old adhesive, and probably repainting. It would take something to do." In an interview on 9/1/16, at 3:21 p.m., the administrator said he was aware of the rusted and bubbled surfaces on the door frames. The administrator said the building dates back to the 1960's and there was a "need for some maintenance." The administrator said, "We can work on that."	F 465	to the QA meeting for the next year to ensure ongoing compliance.	

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	245573	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/30/2016**

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Clara City Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/26/2016

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

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K 000	Continued From page 1 <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was inspected as two separate buildings: Clara City Care Center is a 1-story building with partial basement. The building was constructed at 5 different times. The original building was constructed in 1966 and was determined to be of Type II(111) construction. In 1970, an addition was constructed and was determined to be of Type II(111) construction. In 1989, an addition was constructed and was determined to be of Type II (111) construction. The 1997 an addition was constructed and was determined to be of Type II(111) construction. The facility added a new kitchen addition in 2010 constructed of type II(111) construction. Because the original building and the 4 additions do not met the construction types allowed for existing buildings, the facility was surveyed as two building. The facility is fully fire sprinkler protected. The	K 000		

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K 000	Continued From page 2 facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 63 beds and had a census of 55 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of 3 corridor doors according to NFPA 101 LSC (00) section 19.3.6.3.1. This deficient practice could affect the safety of 17 of the 55 residents and an undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable.	K 018	The doors for rooms 80 and 94 have been adjusted so that they shut and positively latch as intended. Changes were also made to the door for resident room 115. The door now positively latches to ensure that it will act as a smoke barrier. The Maintenance Director or Designee	9/16/16

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	245573	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/30/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY CARE CENTER	**1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 3 Findings include: On the facility tour between 8:00 am to 11:00 am on 08/30/2016, observations and staff interview revealed the following rooms did not have latching doors that open to the corridor. 1. Resident Room 80 & 94 will not shut 2. Resident Room 115 does not positively latch This deficient condition was verified by the Maintenance Supervisor.	K 018	will check the operation of all resident room doors and hallway smoke barrier doors twice monthly for the next quarter. If any are found that do not shut or positively latch they will be adjusted and fixed immediately. In the event that all doors in the compliance checks operate as intended for the next quarter the checks will be changed to monthly thereafter. The Administrator will also check for the proper operation of resident room doors and hallway doors monthly for the next three months. The information from the compliance checks will be incorporated into the QA report. This will ensure ongoing monitoring of resident room doors.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 21 of the 83 residents and an undetermined amount of staff and visitors. Findings include:	K 062	The facility has the five year inspection scheduled on October 6, 2016. Moving forward the Maintenance Director will ensure that this inspection occurs within five years of 10/6/16. The Maintenance Calendar will have this clearly marked four years and 6 months from the date of the last inspection to ensure compliance with the five year sprinkler system inspection. The results of the inspection and the importance of compliance with the five year inspection will be made part of the QA Committee moving forward.	10/6/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/30/2016**

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CLARA CITY CARE CENTER	**1012 NORTH DIVISION STREET PO BOX 797** **CLARA CITY, MN 56222**

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K 062	Continued From page 4 On the facility documentation review between 8:00 am to 11:00 am on 08/30/2016 observations and staff interview revealed the sprinkler system was not being maintained for the following reasons. The last 5 year inspection that was completed on the sprinkler system was 06/01/2011. Per the Maintenance Supervisor a proposal was obtained on 07/27/2016, as of the date of survey the work had not been completed. This deficient condition was verified by the Maintenance Supervisor	K 062		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245573	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING	DATE SURVEY COMPLETE: 8/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY CARE CENTER	1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain electrical devices in accordance with NFPA 70 (99), National Electrical Code this deficient practice could negatively affect the safety of 2 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 11:00 am on 08/30/2016, observations staff interview revealed multiple extension cords in room 82. Extension cords were removed by staff while survey was being completed. This deficient practice was verified by the Maintenance Supervisor.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING **04 - 2010 KITCHEN ADDITION** B. WING _____	**08/30/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY CARE CENTER	**1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE FORM CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 30, 2016. At the time of this survey, Building 02 of Clara City Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/26/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Building 02 of Clara City Care Center consists of a kitchen addition, constructed in 2010. Building 02 is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. In 2015, an addition was added to this area with a link to as Assisted living with a 2-hour fire wall. This area also has a physical therapy area. This area also has no basement and is fully sprinkler protected and smoke detection in corridors, and was determined to be a Type II (III) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a licensed capacity of 63 beds and had a census of 55 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 18.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 91 residents and an undtermined amount of staff and visitors. Findings include: On the facility documentation review between 8:00 am to 11:00 am on 08/30/2016 observations and staff interview revealed the sprinkler system was not being maintained for the following reasons. The last 5 year inspection that was completed on the sprinkler system was 06/01/2011. Per the Maintenance Supervisor a proposal was obtained on 07/27/2016, as of the date of survey the work had not been completed. This deficient condition was verified by the Maintenance Supervisor	K 062	The facility has the five year inspection scheduled on October 6, 2016. Moving forward the Maintenance Director will ensure that this inspection occurs within five years of 10/6/16. The Maintenance Calendar will have this clearly marked four years and 6 months from the date of the last inspection to ensure compliance with the five year sprinkler system inspection. The results of the inspection and the importance of compliance with the five year inspection will be made part of the QA Committee moving forward.	10/6/16

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245573	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	DATE SURVEY COMPLETE: **8/30/2016**

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