



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered  
May 14, 2026

Administrator  
Clarkfield Care Center  
805 FIFTH STREET, BOX 458  
CLARKFIELD, MN 56223

RE: CCN: 245551

Cycle Start Date: April 8, 2026

Dear Administrator:

On April 8, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing  
Compliance Analyst | Federal Enforcement  
Health Regulation Division  
**Minnesota Department of Health**  
[Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)  
Office: 651-201-4112





Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 24, 2026

Administrator  
Clarkfield Care Center  
805 FIFTH STREET, BOX 458  
CLARKFIELD, MN 56223

RE: CCN:245551

Cycle Start Date: April 8, 2026

Dear Administrator:

On April 8, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

## DEPARTMENT CONTACT

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

Nicole Dahl, RN, Regional Operations Supervisor  
Marshall District Office  
Health Regulation Division  
Minnesota Department of Health  
1400 East Lyon Street, Suite 102  
Marshall, Minnesota 56258-2504  
Email: [Nicole.Dahl@state.mn.us](mailto:Nicole.Dahl@state.mn.us)  
Office: 507-476-4230

## **PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section

above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

## **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 8, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 8, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

## **INFORMAL DISPUTE RESOLUTION (IDR)**

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>  
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

[https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

### **INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)**

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

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

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens  
State Fire Safety Supervisor  
Health Care & Correctional Facilities  
MN Department of Public Safety-Fire Marshal Division  
445 Minnesota St., Suite 145  
St. Paul, MN 55101  
Email: [travis.ahrens@state.mn.us](mailto:travis.ahrens@state.mn.us)

Web: [www.sfm.dps.mn.gov](http://www.sfm.dps.mn.gov)

Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing  
Compliance Analyst | Federal Enforcement  
Health Regulation Division  
**Minnesota Department of Health**  
[Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)  
Office: 651-201-4112

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245551</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED  <b>04/08/2026</b>
NAME OF PROVIDER OR SUPPLIER  <b>Clarkfield Care Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>805 FIFTH STREET, BOX 458 , CLARKFIELD, Minnesota, 56223</b>	
(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
E0000	Initial Comments  On 4/6/26 through 4/8/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance.  The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		04/24/2026
F0000	INITIAL COMMENTS  On 4/6/26 through 4/8/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.  The following complaints were reviewed: H55511094C (iQIES #1193280) and H55511095C (iQIES #00112745) . NO deficiencies were cited.  The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.  Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		04/24/2026
F0880 SS = F	Infection Prevention & Control  CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control	F0880	F0880 – Infection Prevention & Control: Failure to Document Date of Transmission-Based Precautions Implementation  1. Deficiency Identification	05/08/2026

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 reverse for further 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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F0880 SS = F	Continued from page 1 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program.  The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:  (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;  (ii) When and to whom possible incidents of communicable disease or infections should be reported;  (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;  (iv) When and how isolation should be used for a resident; including but not limited to:  (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and  (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.  (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F0880	Continued from page 1  Citation: F0880 – Infection Prevention & Control Regulation: 42 CFR §483.80(a)(2)(E) Deficiency: Based on interview and document review, the facility failed to document the date when transmission-based precautions (TBP) were implemented for 2 of 3 residents (R2 and R27) reviewed for infection control.  2. Corrective Action for Residents Affected  [x] The medical records of R2 and R27 were immediately reviewed.  [x] The correct dates of TBP implementation were obtained from nursing notes and staff interviews.  [x] The residents' records were updated to accurately reflect the date TBP was initiated.  [x] The residents' current care plans were reviewed to ensure all infection control interventions are in place and documented.  3. Corrective Action for Other Residents  [x] An audit was conducted of all residents currently or recently on TBP within the past 30 days.  [x] Any missing or incomplete documentation regarding TBP implementation dates was identified and corrected.  [x] Residents identified as potentially affected were reviewed to ensure TBP was appropriately implemented and documented.  4. Systemic Changes  [x] The Infection Control Policy was revised to require documentation of the exact date and time TBP is initiated in the resident's medical record.	05/08/2026

<p><b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b></p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245551</b></p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING</p>	<p>(X3) DATE SURVEY COMPLETED  <b>04/08/2026</b></p>	
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<p>F0880 SS = F</p>	<p>Continued from page 2 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to document the date when transmission-based precautions (TBP) were implemented for 2 of 3 residents (R2 and R27).</p> <p>Findings include:  R2's comprehensive Minimum Data Set (MDS) assessment accepted on 3/18/26, identified his cognition was intact. R2 was dependent on staff for transfers and bathing, he required substantial/maximal assistance with dressing.</p> <p>Review of the facilities resident infection prevention surveillance logs identified R2 had a confirmed upper respiratory infection identified on 1/30/26. He was placed on droplet precautions on 1/31/26 through 2/6/26. He displayed symptoms of fever, new increased cough, shortness of breath, and had oxygen saturations of less than 94% on room air (normal 95% to 100%) which was a reduction of greater than 3% from his baseline. The treatment was oseltamivir (an antiviral medication used to treat infections) 75 milligrams (mg) two times daily for 5 days. The infection was resolved on 2/5/26.</p> <p>Review of R2's nursing progress notes identified on:  1/30/26 at 11:39 p.m., licensed practical nurse (LPN)-A entered a nursing progress note identifying</p>	<p>F0880</p>	<p>Continued from page 2 [x] A new TBP initiation checklist was developed for nursing staff to complete at the time of implementation.</p> <p>[x] Electronic Medical Record (EMR) prompts were added to require entry of TBP start date before orders can be completed.</p> <p>5. Monitoring and Quality Assurance  [x] Weekly audits of all new TBP orders will be conducted for 8 weeks, then monthly for 4 months.</p> <p>[x] Audit results will be reviewed at the monthly Quality Assurance and Performance Improvement (QAPI) meetings.</p> <p>[x] Any discrepancies will be addressed immediately with corrective action and re-education.</p> <p>6. Responsible Parties  [x] Director of Nursing (DON): Oversight of corrective actions and policy updates.  [x] Infection Preventionist: Conducts audits, provides education, and monitors compliance.  [x] Case Manager: Ensure staff adherence to documentation protocols.</p> <p>7. Timelines  [x] Immediate correction for R2 and R27: Completed by 4/29/26.  [x] Audit of all residents on TBP: Completed by 4/29/26.  [x] Policy and EMR updates: Implemented by 5/8/26.  [x] Staff training: Completed by 5/15/26.</p>	<p>05/08/2026</p>

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F0880 SS = F	<p>Continued from page 3 she had completed a respiratory assessment on R2. He had a non-productive cough, auditory wheezing, HIS temperature was 98.8 degrees Fahrenheit (F), and his oxygen saturations were at 90%. His heart rate was 114 beats per minute (BPM) (Normal 60-100 BPM), HIS blood pressure was 154/68 Millimeters of mercury (MM/HG), and his rate of respirations were 20 breaths per minute (BPM) (normal 16-20). R2 was tested for covid infection and the results were negative. Cough syrup was given. The progress note made no mention that R2 had been placed on TBP.</p> <p>1/31/26 at 7:02 a.m., registered nurse (RN)-A identified she had completed a respiratory assessment and noted R2 had increased congestion with A blood pressure of 124/79 MM/HG, a heart rate of 80 BPM, respirations 30 BPM, A non-productive cough, and decreased urine output. She informed R2 she would be calling the emergency department (ED) for guidance.</p> <p>1/31/26 at 7:06 a.m., RN-A identified she called 911 for an emergency transport to the hospital ED.</p> <p>1/31/26 at 12:43 p.m., RN-A identified she had received a call from the hospital with an update on R2. He had been diagnosed with influenza A and A urinary tract infection. They would be discharging R2 back to the facility with new orders.</p> <p>R27's quarterly Minimum Data Set (MDS) assessment accepted on 3/23/26, identified her cognition was intact and she was independent with activities of daily living (ADL)'s.</p> <p>Review of the facilities infection prevention surveillance identified R27 had a confirmed respiratory infection (pneumonia) that was identified on 1/12/26. The symptoms were new/increased cough, reduced oxygen saturations, and pleuritic chest pain. The treatment was cefdinir (antibiotic medication used to treat infections) 300 MG two times a day for 3 days. There was no information in the resident surveillance or medical record to identify when or if R27 had been placed on TBP to reduce the risk of transmission of infection to other residents and staff.</p> <p>Interview on 4/8/26 at 8:01 a.m., with the infection preventionist identified she agreed with the above information and would expect nursing to place residents on TBP upon identifying s/s of infection. In addition, the date that precautions were put into place should have been documented in the medical</p>	F0880	<p>Continued from page 3</p> <p>[x] Ongoing audits: Weekly for 8 weeks, then monthly for 4 months.</p> <p>8. Training and Education</p> <p>[x] All nursing staff will receive in-service training on the revised Infection Control Policy and TBP documentation requirements.</p> <p>[x] Training will include hands-on demonstration of the new TBP initiation checklist and EMR prompts.</p> <p>[x] Competency assessments will be conducted post-training to ensure understanding.</p> <p>9. Documentation</p> <p>[x] All corrective actions, audits, and training records will be maintained in the facility's QAPI binder.</p> <p>[x] Audit tools and checklists will be retained for at least 12 months.</p> <p>[x] Documentation of TBP implementation dates will be reviewed during routine chart audits.</p> <p>10. Follow-Up Plan</p> <p>[x] The Infection Preventionist will report audit findings and compliance rates to the QAPI committee (QAA) monthly.</p> <p>[x] Any identified trends or repeat deficiencies will trigger immediate review and additional corrective actions.</p> <p>[x] The DON will ensure ongoing compliance through random spot checks and staff feedback.</p> <p>[x] The plan of correction will be reviewed and updated as needed based on audit outcomes and</p>	05/08/2026

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F0880 SS = F	Continued from page 4 record.  Interview on 4/8/26 at 11:24 a.m., with the administrator identified, she would expect all staff to follow the facilities infection prevention policies and procedures.  Review of the facility provided 1/26/26, Infection Prevention and Control Program policy identified a resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines.  Review of the facility provided 1/16/26, Infection Surveillance policy identified the RN's and LPN's are to participate in surveillance through assessment of resident and reporting changes in condition to the resident's physicians and management staff, per protocol for notifications of changes and in house reporting of communicable diseases and infections. Examples of notification triggers include signs and symptoms of infection, starting an antibiotic, microbiology test is ordered, a resident is placed on isolation precautions, whether empirically or by physician order, or microbiology test results show drug resistance.	F0880	Continued from page 4 regulatory guidance.  Prepared by: Ashley Nicholson, Administrator 4/27/26  Reviewed by:  Alicia Vis, Director of Nursing 4/27/26  This plan of correction constitutes our credible allegation of compliance and we respectfully request consideration for substantial compliance upon completion of the outlined actions.	05/08/2026
F0849 SS = D	Hospice Services  CFR(s): 483.70(n)(1)-(4)  §483.70(n) Hospice services.  §483.70(n)(1) A long-term care (LTC) facility may do either of the following:  (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.  (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.  §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:	F0849	F0849 – Failure to Ensure a Hospice Care Plan Was Provided for Resident R7  1. Deficiency Identification  Citation: F0849 – Hospice Services Provided by Facility/Contractor Regulation Reference: 42 CFR §483.70(g) Deficiency: Based on interview and document review, the facility failed to ensure a hospice care plan was provided for 1 of 1 resident (R7) reviewed for hospice services.  2. Corrective Action for Residents Affected  The Case Manager immediately contacted the hospice provider upon identification of the deficiency.  A comprehensive hospice care plan was developed and implemented for Resident R7 on 4/8/26.	04/27/2026

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F0849 SS = D	Continued from page 5 (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.  (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:  (A) The services the hospice will provide.  (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.  (C) The services the LTC facility will continue to provide based on each resident's plan of care.  (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.  (E) A provision that the LTC facility immediately notifies the hospice about the following:  (1) A significant change in the resident's physical, mental, social, or emotional status.  (2) Clinical complications that suggest a need to alter the plan of care.  (3) A need to transfer the resident from the facility for any condition.  (4) The resident's death.  (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.  (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.  (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical	F0849	Continued from page 5  The hospice representative (RN) prepared the care plan, MD reviewed & signed and it was reviewed by the interdisciplinary team (IDT).  Resident R7 and their family were provided with a copy of the hospice care plan.  Resident R7 was discharged from hospice on 4/16/26 due to no longer qualifying.  3. Corrective Action for Other Residents  R7 was the only resident on hospice at this time.  Any future hospice admissions will be reviewed upon admission for an individualized care plan.  4. Systemic Changes  The facility updated its policy and procedure for hospice care coordination to require:  Verification of a hospice care plan within 24 hours of hospice admission.  Documentation of care plan meetings with hospice providers, residents, and families.  A new Hospice Admission Checklist was implemented to ensure all required documentation, including the care plan, is completed upon admission to hospice services.  The IDT meeting agenda was revised to include a standing item for review of hospice care plans.  5. Monitoring and Quality Assurance  The DON or designee will audit all new hospice admissions weekly for 3 months to ensure a care plan is in place within 24 hours.	04/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245551</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED  <b>04/08/2026</b>
NAME OF PROVIDER OR SUPPLIER  <b>Clarkfield Care Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>805 FIFTH STREET, BOX 458 , CLARKFIELD, Minnesota, 56223</b>	
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F0849 SS = D	<p>Continued from page 6 direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.</p> <p>(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.</p> <p>(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.</p> <p>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.</p> <p>§483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.</p> <p>The designated interdisciplinary team member is responsible for the following:</p> <p>(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.</p> <p>(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related</p>	F0849	<p>Continued from page 6</p> <p>Monthly audits of all residents on hospice will be conducted for 6 months, then quarterly thereafter.</p> <p>Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) committee for review and action as needed.</p> <p>6. Responsible Parties</p> <p>Director of Nursing (DON): Oversight of corrective actions, audits, and policy updates.</p> <p>Social Services Designee: Coordination with hospice providers and care plan documentation.</p> <p>Interdisciplinary Team (IDT): Participation in care plan development and review.</p> <p>Staff Educator: Staff training and competency validation.</p> <p>7. Timelines</p> <p>Immediate corrective action for R7: Completed prior to MDH leaving facility on 4/8/26.</p> <p>Review and correction for other hospice residents: Completed immediately, R7 was the only resident on hospice.</p> <p>Policy and checklist updates: Completed within 7 days.</p> <p>Staff training: Completed within 14 days.</p> <p>Initiation of audits: Within 7 days and ongoing as described.</p> <p>8. Training and Education</p> <p>All licensed nursing staff, social services, and IDT</p>	04/27/2026

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F0849 SS = D	<p>Continued from page 7 conditions, and other conditions, to ensure quality of care for the patient and family.</p> <p>(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.</p> <p>(iv) Obtaining the following information from the hospice:</p> <p>(A) The most recent hospice plan of care specific to each patient.</p> <p>(B) Hospice election form.</p> <p>(C) Physician certification and recertification of the terminal illness specific to each patient.</p> <p>(D) Names and contact information for hospice personnel involved in hospice care of each patient.</p> <p>(E) Instructions on how to access the hospice's 24-hour on-call system.</p> <p>(F) Hospice medication information specific to each patient.</p> <p>(G) Hospice physician and attending physician (if any) orders specific to each patient.</p> <p>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.</p> <p>§483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and doc review the fac failed to ensure a Hospice care plan was provided for 1 of 1 resident R7</p> <p>Findings include:</p>	F0849	<p>Continued from page 7 members will receive in-service training on:</p> <p>Hospice care plan requirements.</p> <p>New policy and procedures.</p> <p>Use of the Hospice Admission Checklist.</p> <p>Training will be documented and competency validated by the Staff Educator.</p> <p>New staff will receive training during orientation.</p> <p>9. Documentation</p> <p>All hospice care plans and related documentation will be maintained in the resident's medical record.</p> <p>Audit tools, checklists, and training records will be kept in the QAPI binder.</p> <p>Documentation of corrective actions and ongoing compliance will be available for surveyor review.</p> <p>10. Follow-Up Plan</p> <p>The DON will review audit findings monthly with the QAPI committee.</p> <p>Any identified trends or repeat deficiencies will result in immediate corrective action and retraining.</p> <p>The facility will conduct a follow-up self-audit at 3 and 6 months to ensure sustained compliance.</p> <p>Results and ongoing compliance will be reported to facility leadership and shared with staff.</p> <p>This plan of correction constitutes our credible allegation of compliance. We respectfully request consideration for compliance upon completion of the</p>	04/27/2026

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F0849 SS = D	<p>Continued from page 8</p> <p>R7's 3/23/26, accepted Significant Change, Minimum Data Set (MDS) assessment identified R7, had severe cognitive impairment and was readmitted following acute care hospitalization with diagnoses including hypertension, dementia, malnutrition, anxiety disorder, depression, macular degeneration (legally blind). He required maximal assistance from staff for activities of daily living (ADLs), and a wheelchair was needed for mobility.</p> <p>R7's 2/26/26 at 3:22 p.m. progress notes identified he was admitted to hospice services with a terminal diagnosis of senile degeneration of the brain.</p> <p>Interview on 4/7/26 at 9:28 a.m. with trained medication aid (TMA)-A identified R7 was on Hospice services. He required he required total assistance with ADLs, except eating which required set up. TMA-A was not aware if there was a hospice schedule or care plan and thought there might have been some information at the nursing station.</p> <p>Interview on 4/7/26 at 9:44 a.m. with licensed practical nurse (LPN)- B identified R7 was still on hospice services, but the frequency of visits had decreased due to his improvement. The hospice nurse was supposed to have made a visit on Monday, but she had not come, and LPN-B was not aware of the reason, or when she planned to visit. There was not a schedule to identify visits, and the facility's care plan noted R7 was on hospice, but failed to identify services hospice was to provide, and services the facility was responsible for. LPN-B reported hospice staff were not able to document in the facility's electronic medical record. They gave staff a verbal update and later faxed a copy of their visit notes to the facility. Documents provided had been scanned into the electronic medical records system.</p> <p>Interview on 4/8/26 at 9:09 a.m. with the hospice registered nurse (RN)-B identified R7 had been improving and had not needed medication for pain or comfort. Hospice had decreased the frequency of their visits following discussion at their Interdisciplinary Team (IDT) meeting due to his improved status. A schedule and integrated care plan should have been developed and provided to the facility at the time of admission, but that had not occurred. She would immediately provide a copy of</p>	F0849	Continued from page 8 outlined corrective actions.	04/27/2026

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F0849 SS = D	Continued from page 9 the hospice care plan to the facility. The agreement of what services and equipment hospice provided should have been in a binder at the nursing station, but nothing was able to be provided by facility staff.  Interview on 4/8/26 at 1:00 p.m. with the director of nursing (DON) identified her expectation that hospice documentation was to include identifying responsibilities for services and equipment hospice was to provide in the care plan provided at the time of admission to hospice.  A policy for hospice services was requested but not provided by the end of the survey.	F0849		04/27/2026

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K0000 Bldg. 01	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>An annual Life Safety Code survey was conducted on 04/07/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Clarkfield Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.</p> <p>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.</p> <p>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required.</p> <p>Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145</p>	K0000		04/24/2026

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 reverse for further 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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K0000 Bldg. 01	<p>Continued from page 1 St. Paul, MN 55101-5145, OR</p> <p>By email to:  FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> <li>1. A detailed description of the corrective action taken or planned to correct the deficiency.</li> <li>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.</li> <li>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.</li> <li>4. Identify who is responsible for the corrective actions and monitoring of compliance.</li> <li>5. The actual or proposed date for completion of the remedy.</li> </ol> <p>Clarkfield Care Center is a 1-story building with partial basement. The building was constructed at 4 different times. The original building was constructed in 1955 and was determined to be of Type II(111) construction. In 1958 an addition was constructed and was determined to be of Type II(111) construction. In 1970, an addition was constructed and determined to be of Type II(111) construction. The most recent addition was constructed in 2004 and determined to be of Type II(111) construction.</p> <p>This facility was surveyed as one building under the 2012 Life Safety Code.</p> <p>The building is fully sprinklered. The 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.</p> <p>The facility has a capacity of 30 beds and had a census of 30 at the time of the survey.</p>	K0000		04/24/2026

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<p>K0000 Bldg. 01</p>	<p>Continued from page 2</p> <p>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:</p>	<p>K0000</p>		<p>04/24/2026</p>
<p>K0353 SS = E Bldg. 01</p>	<p>Sprinkler System - Maintenance and Testing</p> <p>CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing</p> <p>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.</p> <p>9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation, review of available documentation, and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2 (2) and (5). These deficient findings could have a patterned impact on residents within the facility.</p> <p>Findings include:</p> <p>1. On 04/07/2026 at 10:39 AM, it was revealed by observation that there was excessive lint covering the sprinkler head in the laundry room above the dryers.</p> <p>2. On 04/07/2026 at 10:51 AM, it was revealed by observation that the sprinklers in the dishwashing room were showing signs of corrosion.</p>	<p>K0353</p>	<p>Summit Fire Protection was called on 4-24-26 and notified. Summit Fire Protection will clean/replace heads that were cited in the survey.</p> <p>A Quarterly Audit/Inspection will be performed by Clarkfield Care Center Maintenance Staff to visually inspect all sprinkler heads. Documentation has been added and posted in the Life Safety Documentation Binder.</p> <p>There were no policy changes</p> <p>The Director of Environmental Services contacted/scheduled and will supervise the cleaning/replacement of the sprinkler heads cited in the survey.</p> <p>Expected Day of Completion: 05/04/2026</p> <p>The Director of Environmental Services will present the findings of the state survey with the Plan of Correction and Audit/Inspection at the next Safety/QAA on 5-20-2026.</p>	<p>05/04/2026</p>

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K0353 SS = E Bldg. 01	Continued from page 3 An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K0353		05/04/2026
K0761 SS = E Bldg. 01	Maintenance, Inspection & Testing - Doors  CFR(s): NFPA 101  Maintenance, Inspection & Testing - Doors  Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.  Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.  Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.  Written records of inspection and testing are maintained and are available for review.  19.7.6, 8.3.3.1 (LSC)  5.2, 5.2.3 (2010 NFPA 80)  This STANDARD is NOT MET as evidenced by:  Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 5.2.1, and 5.2.3. This deficient finding could have a patterned impact on the residents within the facility.  Findings include:  On 04/07/2026 at 10:08 AM, it was revealed by a review of available documentation that the roll up fire doors in the kitchen and business office had not been inspected within the last 12 months.  An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K0761	Summit Fire Protection was called on 4-24-26 and notified. Summit Fire Protection will inspect the two roll up fire doors that were cited in the survey.  Summit Fire Protection has been contracted by the Clarkfield Care Center to perform the Annual Inspections going forward. Quarterly Audits/Inspections will also be completed by Clarkfield Care Center Maintenance Staff. Documentation has been added and posted in the Life Safety Documentation Binder.  There were no policy changes  The Director of Environmental Services contacted/scheduled and will supervise the inspection of the two roll up fire doors.  Expected Day of Completion: 05/04/2026  The Director of Environmental Services will present the findings of the state survey with the Plan of Correction and Audit/Inspection at the next Safety/QAA on 5-20-2026.	05/04/2026
K0911 SS = D Bldg. 01	Electrical Systems - Other  CFR(s): NFPA 101  Electrical Systems - Other	K0911	A local electrician was called and scheduled to install a battery-operated emergency light in the generator transfer switch room.	04/28/2026

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NAME OF PROVIDER OR SUPPLIER  <b>Clarkfield Care Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>805 FIFTH STREET, BOX 458 , CLARKFIELD, Minnesota, 56223</b>	
(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
K0911 SS = D Bldg. 01	<p>Continued from page 4</p> <p>List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p> <p>Chapter 6 (NFPA 99)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to install emergency lighting per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.2.2.3.2(4)(a), and NFPA 110 (2010 edition) Standard for Emergency and Standby Power Systems 7.3.1. This deficient finding could have an isolated impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 04/07/2026 at 10:50 AM, it was revealed by observation at the time of the survey that the facility did not have a battery-operated emergency light in the emergency generator transfer switch room.</p> <p>An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.</p>	K0911	<p>Continued from page 4</p> <p>Monthly and Yearly Audit/Inspections will be performed by Clarkfield Care Center Maintenance Staff. Documentation has been added and posted in Life Safety Documentation Binder.</p> <p>There were no policy changes.</p> <p>The Director of Environmental Services contacted/scheduled and supervised the installation of the battery-operated emergency light.</p> <p>Completed Date: 04/28/2026</p> <p>The Director of Environmental Services will present the findings of the state survey with the Plan of Correction and Audit/Inspection at the next Safety/QAA on 5-20-2026.</p>	04/28/2026