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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 3UKG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00842

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245551**
2.STATE VENDOR OR MEDICAID NO.
(L2) **908340500**

3. NAME AND ADDRESS OF FACILITY
(L3) **CLARKFIELD CARE CENTER**
(L4) **805 FIFTH STREET, BOX 458**
(L5) **CLARKFIELD, MN** (L6) **56223**

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 **05/22/2015** (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 **42** (L18)

13.Total Certified Beds **42** (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
	42			
(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 :
Jessica Sellner, Unit Supervisor 05/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 06/05/2015 (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
01/01/1991
(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 06/10/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/27/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245551
June 5, 2015

Mr. Murray Finger, Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, Minnesota 56223

Dear Mr. Finger:

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 May 23, 2015 the above facility is certified for or recommended for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 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
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 5, 2015

Mr. Murray Finger, Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, Minnesota 56223

RE: Project Number S5551025

Dear Mr. Finger:

On April 14, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 1, 2015. 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 May 29, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 29, 2015 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 survey, completed on April 1, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 23, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 1, 2015, effective May 23, 2015 and therefore remedies outlined in our letter to you dated April 14, 2015, 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
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245551	A. Building B. Wing	5/22/2015

Name of Facility	Street Address, City, State, Zip Code
CLARKFIELD CARE CENTER	805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **05/04/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **05/04/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **05/04/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/04/2015**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	06/05/2015	29249	05/22/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/1/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245551	A. Building B. Wing **01 - MAIN BUILDING 01**	5/29/2015

Name of Facility	Street Address, City, State, Zip Code
CLARKFIELD CARE CENTER	805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **04/01/2015**	ID Prefix	Correction Completed **04/02/2015**	ID Prefix	Correction Completed **04/02/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0021		LSC K0050		LSC K0054	
ID Prefix	Correction Completed **05/23/2015**	ID Prefix	Correction Completed **04/01/2015**	ID Prefix	Correction Completed **04/02/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0056		LSC K0072		LSC K0076	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By _____ **State Agency**	**Reviewed By** PS/KJ	**Date:** 06/05/2015	**Signature of Surveyor:** 35842	**Date:** 05/29/2015
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/1/2015	_____	**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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245551	A. Building 02 - BUILDING TWO B. Wing	5/29/2015

Name of Facility	Street Address, City, State, Zip Code
CLARKFIELD CARE CENTER	805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	04/02/2015	ID Prefix Reg. # NFPA 101 LSC K0054	04/02/2015	ID Prefix Reg. # NFPA 101 LSC K0056	05/23/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/KJ	Date: 06/05/2015	Signature of Surveyor: 35482	Date: 05/29/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 4/1/2015		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**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 3UKG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00842

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245551**

2.STATE VENDOR OR MEDICAID NO.
(L2) **908340500**

3. NAME AND ADDRESS OF FACILITY
(L3) **CLARKFIELD CARE CENTER**
(L4) **805 FIFTH STREET, BOX 458**
(L5) **CLARKFIELD, MN** (L6) **56223**

4. TYPE OF ACTION: **2** (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 **04/01/2015** (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 **42** (L18)

13.Total Certified Beds **42** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(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 :
LoAnn DeGagne, HFE NE II 04/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 04/24/2015 (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
01/01/1991
(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 04/27/2015 Co.
DETERMINATION APPROVAL

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 14, 2015

Mr. Murray Finger, Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, Minnesota 56223

RE: Project Number S5551024

Dear Mr. Finger:

On April 1, 2015, 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:

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

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

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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:

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

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 May 11, 2015, 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 July 1, 2015 (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 October 1, 2015 (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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
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
	245551	A. BUILDING _____ B. WING _____	04/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKFIELD CARE CENTER	**805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223**

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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 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		5/4/15

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

Electronically Signed | 04/21/2015

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F 329	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor and comprehensively assess medications used for sleep for 1 of 5 residents (R21) reviewed for unnecessary medications. In addition, the facility failed to ensure medical justification for the continued use of an antidepressant for 1 of 5 residents (R23), reviewed for unnecessary medication use. Findings include: R21's quarterly Minimum Data Set (MDS) dated 1/23/15, indicated R21 had moderate cognitive impairment, and had trouble falling or staying asleep, or sleeping too much, 7-11 times during the assessment period. R21's Care Area Assessment (CAA) dated 5/12/14, noted alteration in appropriate behavior with psychotropic drug use and potential for injuries due to falls, uncontrolled pain related to depression, alcohol dependence, COPD, poor social situation, insomnia, personality disorder, and chronic headaches. The facility form Client Diagnosis Report dated 8/13/14, indicated R21 had diagnosis including depression, insomnia, and personality disorder. R21's Care plan dated 3/2/15, indicated R21 was medicated daily with an anti-depressant for his	F 329	POC 329: 1. Corrective Action: a. Resident #21 has been reassessed for sleep pattern and mood. b. Resident #23 has been reassessed for mood, target behaviors, and possible need for reduction of psychotropic medication. 2. Corrective Action as it applies to Other Residents: a. The policy and procedure for both Sleep Disorders and Depression along with the policy for Psychotropic Medications and Unnecessary Medications have been reviewed. b. The policy and procedure for both Sleep Disorders and Depression along with the policy for Psychotropic Medications and Unnecessary Medications reviewed by facility licensed staff and Social Worker 4/21/15. c. All other residents currently receiving or newly prescribed psychotropic or hypnotic medications will receive a comprehensive assessment and appropriate monitoring. d. All residents receiving psychotropic or hypnotic medications will receive gradual dose reductions as recommended and appropriate in coordination with the consultant pharmacist and physician. 3. Date of Completion: 5/4/15 4. Reoccurence will be Prevented by:	

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F 329	Continued From page 2 insomnia, and had a history of insomnia since his original admission to the facility in 2009. The care plan indicated R21 tended to be nocturnal, stayed up late at night watching TV or smoking, liked to sleep late in the morning, and became very angry if staff attempted to wake him. Review of R21's medication administration record (MAR) for 02/15, indicated the resident had an order for Trazodone (an antidepressant medication) 75 milligrams (mg) orally daily before attempting to sleep, with one dose in 24 hours. R21 also had an additional order for Trazodone 25 mg po (by mouth) as needed, which could be given with the 75 mg dose for insomnia. R21's Informed Consent Form for Psychotropic Medications dated 12/23/14, indicated Trazodone was prescribed for insomnia. R21's Mood assessment dated 1/23/15, indicated R21 was diagnosed with depression and recently started Zoloft, and also had diagnoses of insomnia. The assessment indicated the resident usually stayed up through part of or all of the night, and often slept during the day. The assessment indicated R21 had Trazodone at night and as needed (prn). The mood assessment did not include R21's normal sleep pattern,or if the Trazadone had helped with the insomnia. During interview on 4/1/15, at 10:57 a.m. registered nurse (RN)-A stated a resident should be monitored for sleep before starting a medication for insomnia, and also after beginning the medication to ensure the medication is beneficial and at the correct dosage. RN-A stated R21 had no sleep assessment or sleep	F 329	a. DON or designee will audit one record per week for one month, then monthly to assure assessments are comprehensive. b. Consultant Pharmacist will perform monthly reviews of resident medication regimes. 5. The Correction will be Monitored by: a. DON or designee b. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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F 329	Continued From page 3 monitoring completed. During interview on 4/1/15, at 11:44 a.m. director of nursing (DON) stated R21's Trazodone was started for insomnia according to the physician order sheet. DON stated if a resident was started on a sleep medication, or had a change in the dose prescribed, a sleep tracker to monitor sleep and a comprehensive sleep assessment should be completed to ensure the medication is working, however, R21 had no sleep assessment and staff had not been monitoring R21's sleep patterns. The Consultant Pharmacist's Medication Review dated 1/14/15, indicated there was no diagnosis listed on the medication administration record (MAR) for Trazodone, and the MD replied on 1/14/15, indicating the diagnosis was insomnia. During interview on 4/1/15, at 2:32 p.m., consulting pharmacist (CP) stated he would expect a sleep assessment and sleep monitoring would be completed on a resident taking a medication for insomnia to show the effectiveness of the medication. R23's quarterly MDS dated 1/22/15, indicated the resident had severe cognitive impairment, had minimal depression, and had physical and verbal behaviors directed at others 1-3 days per week. R23's behavioral symptoms Care Area Assessment (CAA) dated 5/22/14, indicated R23 exhibited repetitive statements such as calling, "Hey, hey, hey" to people passing by in the hallway, and also yelled out during cares.	F 329		

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F 329	Continued From page 4	F 329		

R23's care plan dated 3/15, indicated R23 exhibited behaviors and staff were to refocus resident's attention on positive things when R23 was being negative, explain why the care was needed, encourage the resident to talk with staff about her family, monitor for changes in behavior, medicate as ordered, and reapproach if needed.

R23's current medication administration record (MAR) dated 4/1/15, indicated medication orders for Zoloft (an antidepressant) 25 milligrams (mg) orally every day for depression. The start date for the Zoloft was 9/4/12.

R23's Behavioral Assessment dated 1/22/15, indicated disruptive behaviors including striking out, refusing to eat, refusing med's, and yelling out. The assessment indicated R23's behaviors increased when she was in a stimulating environment.

R23's Psychotropic Assessment dated 1/22/15, indicated behaviors including repetitive statements and calling out on a daily basis.

Review of R23's physician progress notes for the last 12 months indicated no documentation related to clinical contraindications for a dose reduction or discontinuing of the Zoloft.

During observation on 3/30/15, at 6:00 p.m. R23 was observed being fed supper, was smiling when spoken to, and exhibited no disruptive behaviors.

During observation on 4/01/15, at 7:12 a.m. R23 was resting in bed and exhibited no repetitive verbalizations or disruptive behaviors.

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During observation on 4/01/15, at 8:52 a.m. R23 stated she needed to use the bathroom and was humming a song softly to herself in her room with a flat facial affect. During a follow up observation at 10:40 a.m. R23 was still seated in her wheelchair and was singing to herself.

During interview on 4/01/15, at 8:07 a.m. nursing assistant (NA)-A stated R23 did not exhibit any behaviors when she was assisting her with cares other than making some repetitive statements. NA-A stated R23 did not exhibit any sad or depressed statements and R23's behaviors generally were "Not a problem," for others.

During interview on 4/01/15, at 9:06 a.m. the director of nursing (DON) stated she thought psychoactive drugs should be reviewed for a dose reduction every 6 months, and indicated R23's Zoloft had been recommended by pharmacy for a dose reduction in 8/14, but was unsure of the outcome. The DON stated she would check with the social worker (SW) regarding this information.

During interview on 4/01/15, at 10:25 a.m. licensed practical nurse (LPN)-A stated she had been R23's primary nurse for a long time and had noted no changes in her behavior since being on the Zoloft, she stated R23 had, "Always been this way." LPN-A said R23's behaviors consisted of hitting at staff on occasion with cares or talking about someone coming to take her. R23's behaviors did not appear distressing to herself.

During interview on 4/01/15, at 10:26 a.m. the SW stated R23's Zoloft had not been considered for a dose reduction when recommended in 8/14, because R23's daughter wanted her to continue

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F 329	Continued From page 6 on it. The SW stated the daughter felt, "If it's not broke, don't fix it," and SW was unaware of any other attempts to reduce R23's Zoloft. The SW stated R23's depression scoring had essentially remained unchanged since being on the Zoloft with no improvements nor worsening of her mood. During a follow up interview on 4/01/15, at 11:32 a.m. DON stated R23's Zoloft dosage had not been reduced since 2012, and confirmed the lack of a documented clinical contraindication for doing so. During interview on 4/01/15, at 11:54 a.m. the consulting pharmacist (CP) stated if R23's behaviors had been stable with no improvement or worsening, the provider should have documented the contraindications to further dose reduction. The CP stated Zoloft was not usually used to treat behaviors such as R23 had been exhibiting according to staff documentation. The facility policy titled Depression - Clinical Protocol dated 4/13, indicated the staff and physician will identify situations for tapering or stopping [antidepressant] medications.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		5/4/15

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F 428	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility consultant pharmacist failed to ensure 1 of 5 residents (R21) using a medication for sleep was monitored and comprehensively assessed to provide justification for ongoing use. In addition, the consulting pharmacist failed to ensure the facility had medical justification for the continued use of an antidepressant for 1 of 5 residents (R23), reviewed for unnecessary medication use. Findings include: R21's quarterly Minimum Data Set (MDS) dated 1/23/15, indicated R21 had moderate cognitive impairment, and had trouble falling or staying asleep, or sleeping too much, 7-11 times during the assessment period. R21's Care Area Assessment (CAA) dated 5/12/14, noted alteration in appropriate behavior with psychotropic drug use and potential for injuries due to falls, uncontrolled pain related to depression, alcohol dependence, COPD, poor social situation, insomnia, personality disorder, and chronic headaches. The facility form Client Diagnosis Report dated 8/13/14, indicated R21 had diagnosis including depression, insomnia, and personality disorder. R21's Care plan dated 3/2/15, indicated R21 was medicated daily with an anti-depressant for his	F 428	POC 428: 1. Corrective Action: a. Resident #21 has been reassessed for sleep pattern and mood. b. Resident #23 has been reassessed for mood, target behaviors, and possible need for reduction of psychotropic medication. 2. Corrective Action as it applies to Other Resident: a. The policy and procedure for both Sleep Disorders and Depression along with the policy for Psychotropic Medications and Unnecessary Medications have been reviewed. b. The policy and procedure for both Sleep Disorders and Depression along with the policy for Psychotropic Medications and Unnecessary Medications reviewed with facility licensed staff and Social Worker on 4/21/15. c. All other residents currently receiving or newly prescribed psychotropic or hypnotic medications will receive a comprehensive assessment and appropriate monitoring. d. All residents receiving psychotropic or hypnotic medications will receive gradual dose reductions as recommended and appropriate in coordination with the consultant pharmacist and physician. 3. Date of Completion:5/4/15 4. Reoccurence will be Prevented by: a. DON or designee will audit one record	

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F 428	Continued From page 8 insomnia, and had a history of insomnia since his original admission to the facility in 2009. The care plan indicated R21 tended to be nocturnal, stayed up late at night watching TV or smoking, liked to sleep late in the morning, and became very angry if staff attempted to wake him. Review of R21's medication administration record (MAR) for 02/15, indicated the resident had an order for Trazodone (an antidepressant medication) 75 milligrams (mg) orally daily before attempting to sleep, with one dose in 24 hours. R21 also had an additional order for Trazodone 25 mg po (by mouth) as needed, which could be given with the 75 mg dose for insomnia. R21's Informed Consent Form for Psychotropic Medications dated 12/23/14, indicated Trazodone was prescribed for insomnia. R21's Mood assessment dated 1/23/15, indicated R21 was diagnosed with depression and recently started Zoloft, and also had diagnoses of insomnia. The assessment indicated the resident usually stayed up through part of or all of the night, and often slept during the day. The assessment indicated R21 had Trazodone at night and as needed (prn). The mood assessment did not include R21's normal sleep pattern,or if the Trazadone had helped with the insomnia. During interview on 4/1/15, at 10:57 a.m. registered nurse (RN)-A stated a resident should be monitored for sleep before starting a medication for insomnia, and also after beginning the medication to ensure the medication is beneficial and at the correct dosage. RN-A stated R21 had no sleep assessment or sleep	F 428	per week for one month, then monthly to assure assessments are comprehensive. b. Pharmacy consultant will review each resident chart monthly and make appropriate recommendations. 5. The Correction will be Monitored by: a. DON or designee b. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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F 428	Continued From page 9	F 428		

monitoring completed.

During interview on 4/1/15, at 11:44 a.m. director of nursing (DON) stated R21's Trazodone was started for insomnia according to the physician order sheet. DON stated if a resident was started on a sleep medication, or had a change in the dose prescribed, a sleep tracker to monitor sleep and a comprehensive sleep assessment should be completed to ensure the medication is working, however, R21 had no sleep assessment and staff had not been monitoring R21's sleep patterns.

The Consultant Pharmacist's Medication Review dated 1/14/15, indicated there was no diagnosis listed on the medication administration record (MAR) for Trazodone, and the MD replied on 1/14/15, indicating the diagnosis was insomnia.

During interview on 4/1/15, at 2:32 p.m., consulting pharmacist (CP) stated he would expect a sleep assessment and sleep monitoring would be completed on a resident taking a medication for insomnia to show the effectiveness of the medication.
R23's quarterly MDS dated 1/22/15, indicated the resident had severe cognitive impairment, had minimal depression, and had physical and verbal behaviors directed at others 1-3 days per week.

R23's behavioral symptoms Care Area Assessment (CAA) dated 5/22/14, indicated R23 exhibited repetitive statements such as calling, "Hey, hey, hey" to people passing by in the hallway, and also yelled out during cares.

R23's care plan dated 3/15, indicated R23 exhibited behaviors and staff were to refocus

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resident's attention on positive things when R23 was being negative, explain why the care was needed, encourage the resident to talk with staff about her family, monitor for changes in behavior, medicate as ordered, and reapproach if needed.

R23's current medication administration record (MAR) dated 4/1/15, indicated medication orders for Zoloft (an antidepressant) 25 milligrams (mg) orally every day for depression. The start date for the Zoloft was 9/4/12.

R23's Behavioral Assessment dated 1/22/15, indicated disruptive behaviors including striking out, refusing to eat, refusing med's, and yelling out. The assessment indicated R23's behaviors increased when she was in a stimulating environment.

R23's Psychotropic Assessment dated 1/22/15, indicated behaviors including repetitive statements and calling out on a daily basis.

Review of R23's physician progress notes for the last 12 months indicated no documentation related to clinical contraindications for a dose reduction or discontinuing of the Zoloft.

During observation on 3/30/15, at 6:00 p.m. R23 was observed being fed supper, was smiling when spoken to, and exhibited no disruptive behaviors.

During observation on 4/01/15, at 7:12 a.m. R23 was resting in bed and exhibited no repetitive verbalizations or disruptive behaviors.

During observation on 4/01/15, at 8:52 a.m. R23 stated she needed to use the bathroom and was

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humming a song softly to herself in her room with a flat facial affect. During a follow up observation at 10:40 a.m. R23 was still seated in her wheelchair and was singing to herself.

During interview on 4/01/15, at 8:07 a.m. nursing assistant (NA)-A stated R23 did not exhibit any behaviors when she was assisting her with cares other than making some repetitive statements. NA-A stated R23 did not exhibit any sad or depressed statements and R23's behaviors generally were "Not a problem," for others.

During interview on 4/01/15, at 9:06 a.m. the director of nursing (DON) stated she thought psychoactive drugs should be reviewed for a dose reduction every 6 months, and indicated R23's Zoloft had been recommended by pharmacy for a dose reduction in 8/14, but was unsure of the outcome. The DON stated she would check with the social worker (SW) regarding this information.

During interview on 4/01/15, at 10:25 a.m. licensed practical nurse (LPN)-A stated she had been R23's primary nurse for a long time and had noted no changes in her behavior since being on the Zoloft, she stated R23 had, "Always been this way." LPN-A said R23's behaviors consisted of hitting at staff on occasion with cares or talking about someone coming to take her. R23's behaviors did not appear distressing to herself.

During interview on 4/01/15, at 10:26 a.m. the SW stated R23's Zoloft had not been considered for a dose reduction when recommended in 8/14, because R23's daughter wanted her to continue on it. The SW stated the daughter felt, "If it's not broke, don't fix it," and SW was unaware of any

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 12 other attempts to reduce R23's Zoloft. The SW stated R23's depression scoring had essentially remained unchanged since being on the Zoloft with no improvements nor worsening of her mood. During a follow up interview on 4/01/15, at 11:32 a.m. DON stated R23's Zoloft dosage had not been reduced since 2012, and confirmed the lack of a documented clinical contraindication for doing so. During interview on 4/01/15, at 11:54 a.m. the consulting pharmacist (CP) stated if R23's behaviors had been stable with no improvement or worsening, the provider should have documented the contraindications to further dose reduction. The CP stated Zoloft was not usually used to treat behaviors such as R23 had been exhibiting according to staff documentation. The facility policy titled Depression - Clinical Protocol dated 4/13, indicated the staff and physician will identify situations for tapering or stopping [antidepressant] medications.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		5/4/15

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	245551	A. BUILDING _____ B. WING _____	04/01/2015

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F 431	Continued From page 13 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide safe and secure medication storage for 1 of 1 medication carts, and 1 of 1 treatment carts observed. This had the potential to affect 19 of 37 residents identified with cognitive impairment and/ or who wandered the facility. Findings include: During observation on 4/1/15, at 7:04 a.m. the medication cart was in the hallway unlocked and out of the view of trained medication aid (TMA)-A.	F 431	POC 431: 1. Corrective Action: a. DON reviewed policy and procedure for Security of Medication Cart and Storage of Medications with TMA-A and LPN-B. 2. Corrective Action as it applies to Other Residents: a. The policy and procedure for both Security of Medication Cart and Storage of Medications were reviewed. b. The policy and procedure for both Security of Medication Cart and Storage of Medications reviewed with facility	

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F 431	Continued From page 14 There was also a plastic cup sitting on top of the medication cart that was 3/4 full with various pills. During interview on 4/1/15, at 7:08 a.m. TMA-A stated she does not typically leave the cart unlocked or leave medications unattended, and stated she had been in a residents room administering their medication and should have locked the cart and secured all the medications. During observation of medication administration on 4/1/15, at 7:10 a.m. licensed practical nurse (LPN)-A set-up medications for R57 and walked to R57's room without locking and securing the medication cart. On 4/1/15, at 7:14 a.m. LPN-A set -up medications for R16 and walked to R16's room without locking and securing the medication cart. On 4/1/15, at 8:00 a.m. LPN-A entered R40's room to assist R40. After assisting the resident, LPN-A exited the room and walked down the hallway to ask for assistance from the director of nursing (DON) to provide cares to R40. LPN-A and DON went back into R40's room and closed the door to assist the resident. The treatment cart was in the hallway unlocked and not secure. During interview on 4/1/15, at 8:13 a.m. LPN-A stated the medication and treatment cart(s) should be locked and secured any time staff walk away from them. During interview on 4/1/15, at 8:28 a.m. DON stated medication should not be left on top of the carts unattended and verified medications should be secure.	F 431	licensed staff and TMAs on 4/21/15. 3. Date of Completion: 5/4/15 4. Reoccurrence will be Prevented by: a. DON or designee will audit one medication pass per week for one month, then monthly to assure proper medication security and storage. 5. The Correction will be Monitored by: a. DON or designee b. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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F 431	Continued From page 15 The facility policy titled Administering Medications dated 12/12, instructed during administration of medications, the medication cart will be kept closed and locked when out of the sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart, and the cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		5/4/15

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F 441	Continued From page 16 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure hand hygiene was performed for 2 of 6 residents (R46 and R58) observed during medication administration. Findings include: On 3/30/15, at 7:01 p.m. licensed practical nurse (LPN)-B was observed preparing medications for R46. LPN-B touched her glasses and her face, then knocked approximately five paper cups on the floor which she picked up with her bare hands and opened the lid to the trash container on the side of the medication cart with her hand to throw the cups away. LPN-B then placed applesauce in the cup of medications, and approached R46 to administer the resident their medications, LPN-B did not perform any hand hygiene after touching the garage and administering R46 their medications. On 4/1/15, at 8:20 a.m. trained medication aid (TMA)-A was observed preparing medications for	F 441	POC 441: 1. Corrective Action: a. DON reviewed policy and procedure for both Administering Medications and Handwashing/Hand hygiene with LPN-B and TMA-A. 2. Corrective Action as it applies to Other Residents: a. The policy and procedure for both Administering Medications and Handwashing/Hand hygiene was reviewed. b. The policy and procedure for both Administering Medications and Handwashing/Hand hygiene reviewed with facility licensed staff and TMAs on 4/21/15. 3. Date of Completion: 5/4/15 4. Reoccurrence will be Prevented by: a. DON or designee will audit one medication pass per week for one month, then monthly to assure proper hand hygiene during medication pass.	

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F 441	Continued From page 17 R 58. TMA-A touched her glasses, touched her face, coughed into her hand, and proceeded to prepare medications for R58 without first performing hand hygiene. When interviewed on 4/1/15, at 8:25 a.m. TMA-A stated she should have performed hand hygiene after coughing, and prior to touching medications. When interviewed on 4/1/15, at 8:28 a.m. director of nursing (DON) stated hand hygiene should have been performed after coughing into her hand prior to touching the medications. The facility policy titled Handwashing/Hand Hygiene dated 4/12, indicated all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors, and alcohol-based hand rub is to be used before preparing or handling medications. The facility policy titled Administering Medications dated 12/12, indicated staff should follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications.	F 441	5. The Correction will by Monitored by: a. DON or designee b. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Clarkfield 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 444 CEDAR STREET, 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		04/21/2015

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 By email to: Marian.Whitney@state.mn.us and 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. This facility will be surveyed as two separate buildings. 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. This building is partially fire sprinklered because of the missing fire sprinkler heads as cited in K56. 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. The facility has a capacity of 42 beds and had a census of 37 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 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility had a door from a hazardous area which was held open improperly and was not in conformance with NFPA 101 (2000) Chapter 19, Section 19.2.2.2.6 and Chapter 7, Section 7.2.1.8. The deficient practice could affect 10 out 37 residents. FINDINGS INCLUDE: On facility tour between 9:30 AM and 1:30 PM on 04/01/2015, observation revealed that the door	K 021	Maintenance removed the kick down device on the kitchen dishwashing room door on 4/1/15. The Environmental Services Director and/or designee will complete inspections of the facility on a regular basis to ensure that there are no kick down devices or other devices used to hold doors open to assure resident safety.	4/1/15

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K 021	Continued From page 3 from the Kitchen/ Dish Wash Room from an area deemed hazardous was improperly held-open with a kick down hold open device. This finding was confirmed with the Facility Maintenance Director (JB) at the time of discovery.	K 021		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation and a staff interview, it was confirmed the facility failed to sufficiently vary the times of the fire drills. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.7.1.2, and CMS policy. This deficient practice could affect all 37 residents. FINDINGS INCLUDE: On facility tour between 9:30 AM and 1:30 PM on 04/01/2015, while reviewing fire drill reports for calendar year 2015/2014, it was confirmed that not all fire drills had been sufficiently varied by time. Specifically, fire drills conducted on the	K 050	Environmental Service Director will monitor fire drill times to ensure that fire drills are conducted quarterly and no less than 90 minutes apart on all shifts.	4/2/15

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K 050	Continued From page 4 Night-shift during the 2nd and 3rd quarter were not greater than thirty (30) minutes and on the Afternoon shift during the 2nd and 4th quarter were commenced not greater than eight (8) minutes apart. This finding was confirmed with the Facility Maintenance Director (JB) at the time of discovery.	K 050		
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirement 1999 NFPA 72, Sections 7-3.2 and 7-3.2.1. This deficient practice could affect all 37 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on 04/01/2015, the review of available records provided by facility staff, no documentation could be provided verifying that the bi-annual sensitivity testing has been done. The last documented test was conducted on 01/14/2013.	K 054	Environmental Service Director notified Building Sprinkler Inc. regarding the lack of documentation of sensitivity testing performed. Building Sprinkler Inc. made a visit to the facility on 4/2/15 and performed a sensitivity test for the fire safety system. Environmental Service Director will work with Building Sprikler Inc. to ensure that sensitivity testing for the fire safety system is completed in accordance with the Life Safety Code. Environmental Service Director will also work with Building Sprinkler Inc. to ensure that all proper documentation of sensitivity testing is complete and available to the facility for review.	4/2/15

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K 054	Continued From page 5 This finding was confirmed with the Facility Maintenance Director (JB) at the time of discovery.	K 054		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide proper coverage of the fire sprinkler system as per 2000 NFPA 101 Chapter 19.3.5 and 9.7. This deficient practice could affect all 37 residents. FINDINGS INCLUDE: On facility tour between 9:30 AM and 1:30 PM on 04/01/2015, observation revealed that: #1: The Kitchen Walk-in Freezer does not have fire sprinkler protection;	K 056	Environmental Service Director has contacted Building Sprinkler Inc. regarding the need for installation of sprinkler heads in the kitchen walk-in freezer, two kitchen walk-in coolers, and chapel storage/altar room. Environmental Service Director has obtained a quote from Building Sprinkler Inc. for the installation of the sprinkler heads in the above noted areas. The quote from Building Sprinkler Inc. has been accepted by the Clarkfield Care Center. The work will be completed by 5/23/15 by Building Sprinkler Inc. The	5/23/15

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K 056	Continued From page 6 #2: The two (2) Kitchen Walk-in Coolers do not have fire sprinkler protection This deficient practice was confirmed by the Facility Maintenance Director (JB) at the time of discovery.	K 056	installation of the sprinkler heads to appropriate areas as noted above will be monitored by the Environmental Service Director.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain a stairwell free from impediments to full instant use in the case of fire or other emergency, in accordance with NFPA 101 (2000), Chapter 7, Sections 7.1.10.1 and 7.1.10.2.1, and, the 2007 edition of Minnesota State Fire Code (MSFC) Chapter 10, Section 1028. The deficient practice could affect 10 out 37 residents. FINDINGS INCLUDE: On facility tour between 9:30 AM and 1:30 PM on 04/01/2015, observation revealed that crates of drinking water are being stored on the top landing in West Basement Stairwell.	K 072	On 4/1/15 maintenance staff removed water jugs from the west basement stairwell landing. Environmental Service Director will monitor areas of egress for obstructions or impediments to ensure safe exiting in the event of a fire.	4/1/15

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	245551	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/01/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKFIELD CARE CENTER	**805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223**

(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 072	Continued From page 7 This finding was confirmed with the Facility's Maintenance Director (JB) at the time of discovery.	K 072		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility was storing medical gas cylinders in a manner not in conformance with NFPA 99 (1999 edition) Chapter 4, Section 4-3.1.1.1. The deficient practice could affect 10 out 37 residents. FINDINGS INCLUDE: On facility tour between 9:30 AM and 1:30 PM on 04/01/2015, observation revealed oxygen cylinders stored inside of the Central Storage Room. These cylinders were stored on the floor surface, in an upright position, and had combustible material stored within five feet of the oxygen cylinders.	K 076	Environmental Service Director removed oxygen tanks from the central storage room on 4/2/15. Environmental Service Director will monitor oxygen storage and maintain compliance with Life Safety Codes.	4/2/15

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	245551	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/01/2015**

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K 076	Continued From page 8 This finding was confirmed with the Facility Maintenance Director (JB) at the time of discovery.	K 076		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245551	A. BUILDING **02 - BUILDING TWO** B. WING _____	**04/01/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Clarkfield 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 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, 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		04/21/2015

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
	245551	A. BUILDING **02 - BUILDING TWO** B. WING _____	**04/01/2015**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and 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. This facility will be surveyed as two separate buildings. In 2004, a one story addition, with no basement was constructed and was determined to be of Type II(111) construction. This building is partially fire sprinklered because of the missing fire sprinkler head as cited in K56. 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. The facility has a capacity of 42 beds and had a census of 37 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.	K 050		4/2/15

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K 050	Continued From page 2 The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on observation and a staff interview, it was confirmed the facility failed to sufficiently vary the times of the fire drills. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.7.1.2, and CMS policy. The deficient practice could affect all 37 residents. FINDINGS INCLUDE: On facility tour between 9:30 AM and 1:30 PM on 04/01/2015, while reviewing fire drill reports for calendar year 2015/2014, it was confirmed that not all fire drills had been sufficiently varied by time. Specifically, fire drills conducted on the Night-shift during the 2nd and 3rd quarter were not greater than thirty (30) minutes and on the Afternoon shift during the 2nd and 4th quarter were commenced not greater than eight (8) minutes apart. This finding was confirmed with the Facility Maintenance Director (JB) at the time of discovery.	K 050	Environmental Service Director wil monitor fire drill times to ensure that fire drills are conducted quarterly and no less than 90 minutes apart on all shifts.	
K 054	NFPA 101 LIFE SAFETY CODE STANDARD	K 054		4/2/15

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K 054 SS=D	Continued From page 3 All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirement 1999 NFPA 72, Sections 7-3.2 and 7-3.2.1. This deficient practice could affect all 37 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on 04/01/2015, the review of available records provided by facility staff, no documentation could be provided verifying that the bi-annual sensitivity testing has been done. The last documented test was conducted on 01/14/2013. This finding was confirmed with the Facility Maintenance Director (JB) at the time of discovery.	K 054	Environmental Service Director notified Building Sprinkler Inc. regarding the lack of documentation of sensitivity testing performed. Building Sprinkler Inc. made a visit to the facility on 4/2/15 and performed a sensitivity test for the fire safety system. Environmental Service Director will work with Building Sprinkler Inc. to ensure that sensitivity testing for the fire safety system is completed in accordance with the Life Safety Code. Environmental Service Director will also work with Building Sprinkler Inc. to ensure that all proper documentation of sensitivity testing is complete and available to the facility for review.	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with	K 056		5/23/15

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K 056	Continued From page 4 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide proper coverage of the fire sprinkler system as per 2000 NFPA 101 Chapter 19.3.5 and 9.7. This deficient practice could affect all 37 residents. FINDINGS INCLUDE: On facility tour between 9:30 AM and 1:30 PM on 04/01/2015, observation revealed that the Chapel Storage/Altar Room does not have fire sprinkler protection. This finding was confirmed with the Facility Maintenance Director (JB)at the time of discovery.	K 056	Environmental Service Director has contacted Building Sprinkler Inc. regarding the need for installation of sprinkler heads in the kitchen walk-in freezer, two kitchen walk-in coolers, and chapel storage/altar room. Environmental Service Director has obtained a quote from Building Sprinkler Inc. for the installation of the sprinkler heads in the above noted areas. The quote from Building Sprinkler Inc. has been accepted by the Clarkfield Care Center. The work will be completed by 5/23/15 by Building Sprinkler Inc. The installation of the sprinkler heads to appropriate areas as noted above will be monitored by the Environmental Service Director.	