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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8QR7

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 **05/01/2018** (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 **36** (L18)

13.Total Certified Beds **36** (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
	36			
(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 :
Kathleen Lucas, Unit Supervisor 05/17/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 05/17/2018 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/26/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245551

May 17, 2018

Ms. Shari McNamara, Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, MN 56223

Dear Ms. McNamara:

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 April 20, 2018 the above facility is recommended for:

36 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 36 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 17, 2018

Ms. Shari McNamara, Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, MN 56223

RE: Project Number S5551028

Dear Ms. McNamara:

On April 4, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 22, 2018. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On May 17, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 22, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 20, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 22, 2018, effective April 20, 2018 and therefore remedies outlined in our letter to you dated April 4, 2018, 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8QR7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00842

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2.STATE VENDOR OR MEDICAID NO.
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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 **03/22/2018** (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 **36** (L18)

13.Total Certified Beds **36** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	36			
(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 :
Carlene Lange, HFE NE II — 04/10/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Amy Johnson, Enforcement Specialist — 04/25/2018 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 4, 2018

Ms. Shari McNamara, Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, MN 56223

RE: Project Number S5551028

Dear Ms. McNamara:

On March 22, 2018, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (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 1, 2018, 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 June 22, 2018 (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 September 22, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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 _____	03/22/2018

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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 3/19/18 through 3/22/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On March 19,2018, through March 22,2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC 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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580		4/20/18

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

Electronically Signed | 04/09/2018

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 _____	03/22/2018

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
F 580	Continued From page 1 (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations	F 580		

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 _____	03/22/2018

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
F 580	Continued From page 2 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews and document review, the facility failed to notify the resident's physician with a change in condition for 1 of 1 residents (R19) who complained of severe back pain radiating from left side and had increased temperature. Findings include : R19 Diagnosis Record printed 3/22/18, indicated R19 diagnoses included: cerebral infarction, benign prostatic hyperplasia without lower urinary tract symptoms, urinary tract infection, type 2 diabetes, chronic kidney disease-stage 3 moderate, calculus of kidney, essential primary hypertension and muscle weakness. R19's quarterly Minimum Data Set (MDS), dated 2/12/18, indicated R19 was cognitively intact. R19 comprehensive assessment (CAA), dated 5/30/17, identified R19 had episode bladder incontinence, takes a daily diuretic, staff will monitor for signs of infection and report changes to M.D. (medical doctor) R19's care plan, dated 12/21/17, directed staff to monitor R19 for s/sx (signs and symptoms) of urinary tract infection, fever, pain, change in behavior, and notify MD R19's facility progress note, written by licensed practical nurse (LPN)-B, dated 1/4/18, at approximately 6 pm, identified R19 was at supper and began to complain of of back pain radiating to his left side, an aide assisted him back to his room, a nurse asked him about his pain, R19	F 580	1. Corrective Action: a. DON reviewed policy, "Change in Resident Condition or Status", with LPN-B. 2. Corrective Action as it applies to Other Residents: a. The policy, "Change in Resident Condition or Status", was reviewed. b. The policy, "Change in Resident Condition or Status", reviewed with all licensed staff by 4/20/18. 3. Date of Completion: 4/20/18 4. Reoccurrence will be Prevented by: a. DON, or designee, will audit one chart per week for one month, then monthly for six months, to assure proper notification of change in resident condition or status. 5. The Correction will be Monitored by: a. DON, or designee b. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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	245551	A. BUILDING _____ B. WING _____	03/22/2018

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F 580	Continued From page 3	F 580		

stated it was feeling like it felt before when he had gone to the hospital, sharp and very painful rated a 10 , temperature was 100.3, Nurse told R19 she would talk to superiors and get back to him. R19 asked to go to bed to lie down.

R19's physician progress notes and physician orders for 1/4/18, lacked documentation of communication with physician.

R19's physician progress note, dated 12/20/17, indicated R19 had recently been hospitalized and treated for urinary sepsis.

R19's facility progress note, dated 1/5/18, written by a registered nurse, indicated R19 very weak, nail beds cyanotic, face is flushed resident described pain at a level 8, he was not feeling well, temperature 99.3, R19 was sent to hospital for possible sepsis related to kidney stones.

R19's Facility Progress Note, dated 1/9/18, indicated a call was made to Dr. Boelter to update that R19 is in hospital again with sepsis, and would call later this week to on appt. for surgery of removal of kidney stones.

During an interview on 3/21/18, at 12:24 p.m. LPN- B stated she recalled writing progress note on 1/4/18 for R19 having increased back pain that moved to the front, he had started to eat supper but wanted to go to bed, he had a fever. LPN- B stated she had reported that information to the charge nurse. LPN- B was unable to recall who the charge nurse was. LPN- B stated she thought they had called the physician the next day.

During an interview on 3/22/18, at 12:41 p.m. the

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F 580	Continued From page 4 director of nursing (DON) stated when a resident has change in condition she would expect the physician to be notified immediately. The DON stated for R19 there was no documentation that the physician or acute care nurse was called on 1/4/18 for complaint of pain and fever. Faciltiy policy titled, Change in Resident Condition or Status, dated 12/16, identified "nurse will notify the residents attending physician or physician on call when there has been a significant change in resident physical condition." R19 facility progress notes were requested, but not provided. Message left for R19 attending physician to return call to surveyor. No call back received.	F 580		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		4/20/18

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F 623	Continued From page 5 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and	F 623		

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F 623	Continued From page 6 telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 623	1. Corrective Action: a. DON reviewed	

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F 623	Continued From page 7 failed to send notice of hospital transfers to the Office of the State of Long-Term Care Ombudsman for 3 of 4 residents (R17, R27, R19) who were discharged to the hospital. Findings include: R17's quarterly Minimum Data Set (MDS), dated 2/12/18, identified R17 was cognitively intact and had diagnoses including chronic obstructive pulmonary disease, type 2 diabetes, and chronic pain. R17's MDS history, reviewed from 9/17 to 2/18, identified: -R17 had been discharged with return anticipated on 11/24/17. -R17 had been discharged with return anticipated on 12/19/17. Review of R17's Progress Notes identified the following: -On 11/24/17, at 9:53 a.m. R17 complained of shortness of breath, twitching, lethargy, and had a cough. R17 was transferred to the hospital and was admitted. There was no evidence the Ombudsman had been notified of the transfer. -On 12/19/17, at 9:00 a.m. R17 was transferred to the hospital and admitted for fever, shaking, twitching, and abnormal lung sounds. There was no evidence the Ombudsman had been notified of the transfer. R27's admission record, dated 1/3/18, identified R27 had diagnoses including hepatic failure and muscle weakness. R27's discharge MDS, dated 1/17/18, identified R27 had intact short term memory and was independent with decisions regarding tasks of daily living.	F 623	policy, "Resident Transfer/Discharge Notice", with all licensed staff. 2. Corrective Action as it applies to Other Residents: a. The policy, "Resident Transfer/Discharge Notice", was reviewed. b. The policy, "Resident Transfer/Discharge Notice", reviewed with all licensed staff by 4/20/18. c. Transfer packets made, and put at nursing station, including: Transfer Checklist, Resident Transfer/Discharge Notice Form, Bed Hold Notice Form. 3. Date of Completion: 4/20/18 4. Reoccurrence will be Prevented by: a. DON, or designee, will audit one chart, of a resident transferred/discharged (if any), per week for one month, then monthly for six months, to assure proper notification of transfer/discharge notice. 5. The Correction will be Monitored by: a. DON, or designee b. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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R27's progress notes identified, on 1/7/18, at 11:43 a.m. R27 was short of breath, had abnormal lung sounds, and was cyanotic (blue). R27 was transferred by ambulance to the hospital. R27's family did not wish to hold her bed at that time, however, there was no evidence that the Ombudsman had been notified of the transfer/discharge.

R19 admission record printed 3/22/18 identified R19 diagnoses included: essential hypertension, hyperlipidemia, and chronic atrial fibrillation

Review of R19 Electronic Census Record, identified the following hospitalizations:

A 12/12/18 hospital leave with a 12/19/17 return from hospitalization

A 1/5/18 hospital leave with a 1/10/18 return from hospitalization.

Review of R19 medical record lacked documentation of notification of the Ombudsman for the 12/12/18 and 1/5/18 hospitalizations.

During an interview on 3/20/18, at 10:33 a.m. the director of nursing (DON) stated the Ombudsman had not been notified of R19's hospitalizations on 12/12/17 and 1/5/18

During a subsequent interview on 3/22/18, at 10:58 a.m. the director of nursing (DON) stated she was unable to find documentation that the Office of the State of Long-Term Care Ombudsman was sent notification of R17, R27, and R19's transfers to the hospital. DON stated, "They know to notify the Ombudsman. Right now,

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F 623	Continued From page 9 there's no way to track this. We have learned that we need to keep a copy." Review of the facility's policy, Resident Transfer/Discharge Notice, dated 6/21/17, included, "A notice is to be given to all facility initiated transfers according to CMS [Centers for Medicare and Medicaid Services] guidelines." The policy further directed staff to send a copy of the transfer/discharge notice to the state ombudsman's office by fax, mail, or encrypted email. .	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1)	F 625		4/20/18

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F 625	Continued From page 10 of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident or resident's representative was informed of the bed hold policy at the time of hospitalization for 3 of 4 residents (R17, R6, R19) reviewed for hospitalizations. Findings include: R17's quarterly Minimum Data Set (MDS), dated 2/12/18, identified R17 was cognitively intact and had diagnoses including chronic obstructive pulmonary disease, type 2 diabetes, and chronic pain. R17's MDS history, reviewed from 9/17 to 2/18, identified: -R17 had been discharged with return anticipated on 11/24/17. -R17 had been discharged with return anticipated on 12/19/17. Review of R17's Progress Notes identified the following: -On 11/24/17, at 9:53 a.m. R17 complained of shortness of breath, twitching, lethargy, and had a cough. R17 was transferred to the hospital and was admitted. There was no evidence a bed hold	F 625	1. Corrective Action: a. DON reviewed policy, "Bed Hold Notice", will all licensed staff. 2. Corrective Action as it applies to Other Residents: a. The policy, "Bed Hold Notice", was reviewed. b. The policy, "Bed Hold Notice", reviewed with all licensed staff by 4/20/18. c. Transfer packets made, and put at nursing station, including: Transfer Checklist, Resident Transfer/Discharge Notice Form, Bed Hold Notice Form. 3. Date of Completion: 4/20/18 4. Reoccurrence will be Prevented by: a. DON, or designee, will audit one chart, of a resident transferred/LOA (if any), per week for one month, then monthly for six months, to assure proper Bed Hold Notification. 5. The Correction will be Monitored by: a. DON, or designee b. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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was obtained.
-On 12/19/17, at 9:00 a.m. R17 was transferred to the hospital and admitted for fever, shaking, twitching, and abnormal lung sounds. There was no evidence a bed hold was obtained.

R6's quarterly MDS, dated 1/18/18, identified R6 had moderate cognitive impairment. R6's admission record, dated 7/10/17, identified diagnoses including adult failure to thrive, dementia, and major depression.

R6's MDS history, reviewed from 7/17 to 1/18, identified R6 had been discharged on 1/27/18 with return anticipated.

Review of R6's Progress Notes identified the following:
-On 1/27/18, at 3:38 a.m. R6 complained of severe pain in both sides, had nonproductive cough, and wheezing in both lungs. R6's family transported him to the emergency department and he was admitted to the hospital. There was no evidence a bed hold was obtained.

R19's quarterly Minimum Data Set (MDS), dated 2/12/18 indicated R19 was cognitively intact.

R19's admission record, printed 3/22/18, identified R19 diagnoses included: essential hypertension, hyperlipidemia, chronic atrial fibrillation.

Review of R19 Electronic Census Record, identified the following hospitalizations:
12/12/18, hospital leave with a 12/19/17 return from hospitalization.
1/5/18, hospital leave with a 1/10/18 return from hospitalization.

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F 625	Continued From page 12 Review of R19's medical record lacked documentation of bed hold policy review and forms. During an interview on 3/20/18, at 10:33 a.m. the director of nursing (DON) stated there was not documentation in R19 medical record for hospitalizations on 12/12/17 and 1/5/18 . During a subsequent interview on 3/21/18, at 1:38 p.m. the director of nursing (DON) stated she was unable to find bed hold forms for R17 and R6, but they should have been routed to the business office. On 3/21/18, at 1:59 p.m. the business manager stated she had not seen any bed hold forms. On 3/21/18, at 2:16 p.m. social services designee (SSD) stated a bed hold form should have been signed when a resident was hospitalized. SSD stated the form was put in the resident's medical record and a copy was sent to the business office. SSD stated verbal notification of the resident or family was acceptable, and should be documented in the resident's medical record that the verbal bed hold notification was given. During an interview on 3/22/18, at 10:58 a.m. the DON stated, "The nurse transferring [the resident] should be giving the bed hold notice." The DON further indicated the bed hold policy was updated 2/18, which directed the nurse to give the bed hold notification form to the resident or representative to sign and place in the resident's medical record, and to send a copy to the business office and to the Ombudsman.	F 625		

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F 625	Continued From page 13 Review of the facility's policy, Bed Hold Notice, dated 2/2018, included, "Nursing staff will provide the Bed Hold Policy Notice to the resident or legal representative within 24 hours after leaving the facility for a personal leave or hospital transfer." The policy further directs prior to the resident leaving the facility, nursing staff will complete the form with the date and resident's name, will explain the policy to the resident or representative, give the original copy to the resident or representative, and make a photocopy and route to the business office. In the event of an emergency situation, the policy may be explained by phone but must be given or mailed to the representative on the next business day and the conversation must be documented in the resident chart.	F 625		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure coordination of care and communication between the facility and the dialysis center for 1 of 1 resident (R20) reviewed for hemodialysis. Findings include: R20's admission Minimum Data Set (MDS) dated 12/22/17, indicated R20 was cognitively intact,	F 698	1. Corrective Action: a. DON reviewed Dialysis protocol. b. DON spoke with Administrator, from dialysis center, to inquire what SNF resident monitoring requirements should be. c. DON revised Dialysis protocol to reflect dialysis unit recommendations. d. DON requested dialysis communications to be faxed to Clarkfield Care Center after each dialysis appointment, for Resident 20.	4/20/18

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F 698	Continued From page 14 had a diagnosis of end stage renal disease, and received dialysis (procedure for filtering blood.) R20's current care plan, dated 3/8/18, directed to encourage the resident to go to his scheduled dialysis appointments 3 times a week on Tuesdays, Thursdays, and Saturdayeighs, to weigh R20 every morning and when returning from dialysis and obtain vital signs upon return from dialysis. R20's physician orders, included a 12/27/17 order for "Dialysis-Follow Dialysis Protocol." During an interview on 3/21/18, at 12:01 p.m. the director of nursing (DON) stated the dialysis protocol is the facility's dialysis policy. The facility's policy Dialysis, dated 10/17 indicated the "purpose" was to provided services to residents with end stage renal disease by qualified staff. The policy indicated the facility will work in conjunction with the outside dialysis agencies in monitoring and aftercare of dialysis. Procedures included the following: -check dressing daily and change dressing as ordered by dialysis unit. -upon return from dialysis, check vital signs, shunt for bleeding and review dialysis notes. -Communicate with dialysis unit in regard to resident condition and changes. If issues arise, contact dialysis unit for recommendations. -monitor vial signs and notify MD if significant abnormalities. Requested communication documentation between the facility and the dialysis center for March 2018 dialysis dates. 3/1/18. 3/3/18, 3/5/18, 3/6/18, 3/8/18, 3/10/18, 3/13/18, 3/15/18, 3/17/18,	F 698	2. Corrective Action as it applies to Other Residents: a. DON reviewed and revised Dialysis protocol to reflect dialysis unit recommendations. b. DON requested dialysis unit to fax communications to Clarkfield Care Center for all residents, who are seen for a dialysis appointment. 3. Date of Completion: 4/20/18 4. Reoccurrence will be Prevented by: a. DON, or designee, will audit one chart, of a resident receiving dialysis (if any), per week for one month, then monthly for six months, to assure proper protocol implemented in MD orders, proper protocol followed, and proper communications received from dialysis unit, post dialysis appointments. 5. The Correction will be Monitored by: a. DON, or designee b. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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	245551	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 698	Continued From page 15 3/20/18 were requested. The facility did not provide documentation for 3/1/18, 3/3/18, 3/5/18, 3/6/18, 3/6/18, 3/13/18, 3/17/18, or 3/20/18 The documents provided for 3/10/18 and 3/15/18, titled Post Treatment, included information related to the procedures completed while at the dialysis center. The documents lacked communication information from the facility to the dialysis unit and lacked communication for post care instructions from the dialysis center to the facility. Review of R20's medical record lacked documentation of post dialysis vital signs, weights, and dressing site checks. During observations and interview on 3/21/18, at 12:41 p.m. a gauze dressing was observed over the fistula site on R20's left anti-cubital area. The dressing was undated. R20 stated the nurses at the dialysis center check and change the dressing. During an interview on 3/21/18, at 10:31 a.m. licensed practical nurse (LPN)-A stated communication from from the dialysis center does not always get returned. When asked about post dialysis care, LPN-A stated she ensures R20 eats lunch after returning from dialysis. LPN-A stated vital signs are not checked upon returning from dialysis. LPN- stated the dressing at the fistula site is not checked upon returning from dialysis. When asked if R20 was weighed upon returning from dialysis, LPN-A stated no, R20's weight was checked by the dialysis center. When asked if R20's site was monitored for thrill (vibration of blood going through the arm) and bruit (sound of blood flowing though access site) LPN-A stated no.	F 698		

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F 698	Continued From page 16 During an interview on 3/22/18, at 10:34 a.m. registered nurse (RN)-A, from the dialysis center stated she would want the facility to notify the dialysis center for any condition changes. RN-A stated the dressing at the fistula does not need to be checked by facility staff. RN-A stated facility staff do not need to obtain R20's vital signs upon returning from dialysis. RN-A stated facility staff do not need to obtain R20's weight after returning from dialysis, as this is completed at the dialysis center. RN-A went on to say the facility staff should be checking the fistula for bruit and thrill one time daily. RN-A stated she sends a copy of the "run" back with R20 for the facility staff and will write instruction on the run report when needed. RN-A stated she assumed the other nurses at the dialysis center would be sending the run report with instructions back to the facility as well. Review of R20's medical record lacked documentation of monitoring the bruit and thrill. During an interview on 3/22/18, at 11:38 a.m. the director of nursing (DON) stated nurses are to follow the dialysis protocol. The DON stated checking for bruit and thrill were not part of the protocol. The DON stated she did not remember where the protocol originated from, but it did not come from R20's current dialysis center.	F 698		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		4/20/18

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F 757	Continued From page 17 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure accurate monitoring for a blood pressure when administering a high blood pressure medication for 1 of 6 residents (R20) reviewed for unnecessary medication. Findings include: R20's admission Minimum Data Set (MDS), dated 12/29/18, identified R20 was cognitively intact with active diagnoses of hypertension and end stage renal disease. A physician progress note, dated 1/27/18, identified R20 received metoprolol ER (high blood pressure medication) 12.5 mg every day. The note further indicated " [R20] continued to run hypotensive [low blood pressure], but is asymptomatic."	F 757	1. Corrective Action: a. Resident 20 will receive adequate monitoring of blood pressure, per MD order, before giving Metoprolol. 2. Corrective Action as it applies to Other Residents: a. All other residents currently receiving or newly prescribed medications, with specific monitoring ordered, will receive appropriate monitoring. b. Order transcription reviewed will all licensed staff by 4/20/18. 3. Date of Completion: 4/20/18 4. Reoccurrence will be Prevented by: a. DON, or designee, will audit one record per week for one month, then monthly for six months to assure appropriate monitoring is being completed. 5. The Correction will be Monitored by: a. DON, or designee b. The QAPI	

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F 757	Continued From page 18 A pharmacy review dated 2/8/18, indicated "no irregularities identified." However, during an interview on 3/22/18, at 1:44 p.m., licensed practical nurse (LPN)-A stated when consulting pharmacist (CP)-A was at the facility, CP-A recommended to add parameters for monitoring the Metoprolol Succinate ER. R20's Order Summary Report, dated 3/21/18, identified an active order, with a start date of 2/19/18, for Metoprolol Succinate ER tablet. Additional directions were added to give 12.5 mg by mouth one time a day for acute systolic b/p (blood pressure), Hold if BP is less than 60 and notify provider. R20's Electronic Medication Administration Record (EMAR) from 2/19/18 to 3/21/18 (31 days) contained check marks in the administration boxes, indicating R20 received Metoprolol Succinate ER all 31 days. The EMAR contained 31 days of documented pulse (heart rate) readings. The EMAR lacked documentation of blood pressure readings. R20's electronic Weights and Vitals Summary, from 2/19/18 to 3/21/18 (31 days), identified the following blood pressures: 2/22/18 10:29 p.m. 72/50 mmHg. 2/28/18 9:34 p.m. 75/60 mmHg. 3/14/18 9:20 p.m. 95/60 mmHg. 3/18/18 1:02 p.m. 101/61 mmHg. R20's record lacked blood pressure monitoring for 27 out of the 31 days R20 received Metoprolol Succinate. During an interview on 3/21/18, at 1:29 p.m.	F 757	Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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F 757	Continued From page 19 LPN-A reviewed R20's EMAR'S. LPN-A stated the nurses were obtaining R20's pulse instead of a blood pressure. LPN-A stated the administration of the medication without checking R20's blood pressure would be considered a medication error. During an interview on 3/22/18, at 11:38 a.m. the director of nursing (DON) stated the nurses should follow the administration orders on the EMAR. The facility's policy Medication Error Reporting Policy & Procedure, revised June 2017, identified a transcription error as a medication error.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		4/20/18

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F 758	Continued From page 20 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure an as needed (PRN) antipsychotic medication was not ordered beyond 14 days without the prescribing practitioner evaluating the appropriateness of the medication for 1 of 6 residents (R77) reviewed for unnecessary medication. Findings include. R77's admission Minimum Data Set (MDS), dated 1/5/18, indicated severe cognitive impairment,	F 758	1. Corrective Action: a. Resident 77's prn Haldol will be discontinued. 2. Corrective Action as it applies to Other Residents: a. All other residents currently receiving or newly prescribed antipsychotic medication, ordered on a prn basis, will be assessed by prescribing physician or practitioner, before day 14 of the medication start date. b. All other residents currently receiving or newly prescribed antipsychotic medication, ordered on a prn basis, will have the	

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F 758	Continued From page 21 that R77 had occasional verbal and physical behavior towards others and that R77 was not receiving antipsychotic medication. A Physician Assessment Note, dated 1/30/18, identified R77 was somewhat aggressive and endangering to self and others. R77's physician orders, identified a 2/13/18 faxed initial order for Haldol 5 mg intramuscularly every 2 hours as needed (PRN) for agitation. R77's physician orders identified the 2/13/14 Haldol order was discontinued on 2/14/18. Additional faxed Haldol orders were written as follows: 2/14/18, Haldol 5 mg intramuscularly every 4 hours, PRN, for agitation. 2/14/18, Haldol 5 mg orally every 4 hours, PRN, agitations with directions to attempt oral dose first. R77's physician orders identified the 2/14/18 Haldol orders were discontinued on 2/21/18. A new faxed order for Haldol on 2/21/18, indicated Haldol 5 mg every 8 hours as PRN for aggressive behaviors. A 3/6/18 physicians assessment note identified R77's provider evaluated R77 for the continued use of the PRN Haldol. This was the first face to face physician evaluation since starting the PRN Haldol 21 days earlier. The note indicated R77 had aggressive behaviors with paranoia and had the potential for injuring behavior. The note indicated the Haldol order would remain on R77's order sheet although he has not been needing it. Plan to assess Haldol use on next visit. Review of R77's February 2018 and March 2018 electronic medication administration record	F 758	antipsychotic medication discontinued on day 14, in the absence of a physician evaluation. c. Policy for PRN antipsychotics reviewed with all licensed staff by 4/20/18. 3. Date of Completion: 4/20/18 4. Reoccurrence will be Prevented by: a. DON, or designee, will audit one record per week for one month, then monthly for six months to assure antipsychotics are not ordered as an as needed basis for over 14 days without a physician evaluation. 5. The Correction will be Monitored by: a. DON, or designee b. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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F 758	Continued From page 22	F 758		

(EMAR), indicated R77 received PRN Haldol on the following dates:
2/13/18- 1 time
2/16/18-1 time
2/18/18- 1 time
2/19/18-2 times
2/20/18- 2 times
2/21/18-2 times
2/22/18-1 time
2/23/18-1 time
3/3/18- 2 times
3/8/18- 1 time

The Consultant Pharmacist's Medication Review, dated 3/15/18 indicated "The Haldol PRN was started 2/21/18. Please discontinue this medication unless the resident is seen and medication re-ordered for 14 days (with justification)."

During observations on 03/20/18, at 2:27 p.m. R77 was sleeping in a recliner in his room.

During observations on 3/21/18, at 7:08 a.m. the resident was sitting in a recliner in his room watching TV. Smiled when spoken to.

During an interview on 3/21/18, at 1:29 p.m. licensed practical nurse (LPN)-A stated R77's physician comes every 5 weeks and next scheduled to see R77 on 4/3/18. LPN-A stated R77's PRN Haldol order does not have a stop date. LPN-A stated R77's PRN Haldol was ordered after increased aggression. LPN-A stated antipsychotic PRN medication can only be used for 14 days when it is first started, otherwise it needs to be scheduled.

During an interview on 3/22/18 at 11:38 a.m. the

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F 758	Continued From page 23 director of nursing (DON) stated antipsychotic PRN's are limited to 14 days and not renewed until the attending physician or provider evaluates and assesses a resident. The DON stated the physician would decide how to evaluate and assess the resident. The facility's policy PRN Orders for Psychotropic Medications, undated, indicated "Duration of use for an antipsychotic psychotropic medication will be no greater than 14 days regardless if specified otherwise by the attending physician or other provider." "The PRN antipsychotic psychotropic medication may only be reordered after clinical assessment by attending physician or other prescriber." "if no duration is identified for the PRN antipsychotic psychotropic medication order, facility staff will contact prescriber to obtain a stop date of 14 days."	F 758		

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

F555|027

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	245551	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/21/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY 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 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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. These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. 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. The facility has a capacity of 36 beds and had a census of 27 at time of the survey.	K 000		

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

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.

Electronically delivered
April 4, 2018

Ms. Shari McNamara, Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, MN 56223

Re: State Nursing Home Licensing Orders - Project Number S5551028

Dear Ms. McNamara:

The above facility was surveyed on March 19, 2018 through March 22, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathleen Lucas, Unit Supervisor at (320) 223-7343 or kathleen.lucas@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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
	00842	A. BUILDING: _____ B. WING _____	03/22/2018

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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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 03/19/17 through 03/22/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for	2 265		4/20/18

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2 265	Continued From page 2 example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to notify the resident's physician with a change in condition for 1 of 1 residents (R19) who complained of severe back pain radiating from left side and had increased temperature. Findings include : R19 Diagnosis Record printed 3/22/18, indicated R19 diagnoses included: cerebral infarction, benign prostatic hyperplasia without lower urinary tract symptoms, urinary tract infection, type 2 diabetes, chronic kidney disease-stage 3 moderate, calculus of kidney, essential primary hypertension and muscle weakness. R19's quarterly Minimum Data Set (MDS), dated 2/12/18, indicated R19 was cognitively intact. R19 comprehensive assessment (CAA), dated 5/30/17, identified R19 had episode bladder incontinence, takes a daily diuretic, staff will monitor for signs of infection and report changes	2 265	Corrected	

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2 265	Continued From page 3 to M.D. (medical doctor) R19's care plan, dated 12/21/17, directed staff to monitor R19 for s/sx (signs and symptoms) of urinary tract infection, fever, pain, change in behavior, and notify MD R19's facility progress note, written by licensed practical nurse (LPN)-B, dated 1/4/18, at approximately 6 pm, identified R19 was at supper and began to complain of of back pain radiating to his left side, an aide assisted him back to his room, a nurse asked him about his pain, R19 stated it was feeling like it felt before when he had gone to the hospital, sharp and very painful rated a 10, temperature was 100.3, Nurse told R19 she would talk to superiors and get back to him. R19 asked to go to bed to lie down. R19's physician progress notes and physician orders for 1/4/18, lacked documentation of communication with physician. R19's physician progress note, dated 12/20/17, indicated R19 had recently been hospitalized and treated for urinary sepsis. R19's facility progress note, dated 1/5/18, written by a registered nurse, indicated R19 very weak, nail beds cyanotic, face is flushed resident described pain at a level 8, he was not feeling well, temperature 99.3, R19 was sent to hospital for possible sepsis related to kidney stones. R19's Facility Progress Note, dated 1/9/18, indicated a call was made to Dr. Boelter to update that R19 is in hospital again with sepsis, and would call later this week to on appt. for surgery of removal of kidney stones.	2 265		

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2 265	Continued From page 4 During an interview on 3/21/18, at 12:24 p.m. LPN- B stated she recalled writing progress note on 1/4/18 for R19 having increased back pain that moved to the front, he had started to eat supper but wanted to go to bed, he had a fever. LPN- B stated she had reported that information to the charge nurse. LPN- B was unable to recall who the charge nurse was. LPN- B stated she thought they had called the physician the next day. During an interview on 3/22/18, at 12:41 p.m. the director of nursing (DON) stated when a resident has change in condition she would expect the physician to be notified immediately. The DON stated for R19 there was no documentation that the physician or acute care nurse was called on 1/4/18 for complaint of pain and fever. Faciltiy policy titled, Change in Resident Condition or Status, dated 12/16, identified "nurse will notify the residents attending physician or physician on call when there has been a significant change in resident physical condition." R19 facility progress notes were requested, but not provided. Message left for R19 attending physician to return call to surveyor. No call back received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise policies and procedures for notification to physician for a change in condition. Nursing staff could be educated as necessary on this policy and procedure. The DON or designee could records on a regular basis to ensure compliance.	2 265		

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2 265	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure coordination of care and communication between the facility and the dialysis center for 1 of 1 resident (R20) reviewed for hemodialysis. Findings include: R20's admission Minimum Data Set (MDS) dated 12/22/17, indicated R20 was cognitively intact, had a diagnosis of end stage renal disease, and received dialysis (procedure for filtering blood.) R20's current care plan, dated 3/8/18, directed to	2 830	Corrected	4/20/18

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2 830	Continued From page 6 encourage the resident to go to his scheduled dialysis appointments 3 times a week on Tuesdays, Thursdays, and Saturday, to weigh R20 every morning and when returning from dialysis and obtain vital signs upon return from dialysis. R20's physician orders, included a 12/27/17 order for "Dialysis-Follow Dialysis Protocol." During an interview on 3/21/18, at 12:01 p.m. the director of nursing (DON) stated the dialysis protocol is the facility's dialysis policy. The facility's policy Dialysis, dated 10/17 indicated the "purpose" was to provided services to residents with end stage renal disease by qualified staff. The policy indicated the facility will work in conjunction with the outside dialysis agencies in monitoring and aftercare of dialysis. Procedures included the following: -check dressing daily and change dressing as ordered by dialysis unit. -upon return from dialysis, check vital signs, shunt for bleeding and review dialysis notes. -Communicate with dialysis unit in regard to resident condition and changes. If issues arise, contact dialysis unit for recommendations. -monitor vial signs and notify MD if significant abnormalities. Requested communication documentation between the facility and the dialysis center for March 2018 dialysis dates. 3/1/18. 3/3/18, 3/5/18, 3/6/18, 3/8/18, 3/10/18, 3/13/18, 3/15/18, 3/17/18, 3/20/18 were requested. The facility did not provide documentation for 3/1/18, 3/3/18, 3/5/18, 3/6/18, 3/6/18, 3/13/18, 3/17/18, or 3/20/18 The documents provided for 3/10/18 and 3/15/18,	2 830		

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2 830	Continued From page 7 titled Post Treatment, included information related to the procedures completed while at the dialysis center. The documents lacked communication information from the facility to the dialysis unit and lacked communication for post care instructions from the dialysis center to the facility. Review of R20's medical record lacked documentation of post dialysis vital signs, weights, and dressing site checks. During observations and interview on 3/21/18, at 12:41 p.m. a gauze dressing was observed over the fistula site on R20's left anti-cubital area. The dressing was undated. R20 stated the nurses at the dialysis center check and change the dressing. During an interview on 3/21/18, at 10:31 a.m. licensed practical nurse (LPN)-A stated communication from from the dialysis center does not always get returned. When asked about post dialysis care, LPN-A stated she ensures R20 eats lunch after returning from dialysis. LPN-A stated vital signs are not checked upon returning from dialysis. LPN- stated the dressing at the fistula site is not checked upon returning from dialysis. When asked if R20 was weighed upon returning from dialysis, LPN-A stated no, R20's weight was checked by the dialysis center. When asked if R20's site was monitored for thrill (vibration of blood going through the arm) and bruit (sound of blood flowing though access site) LPN-A stated no. During an interview on 3/22/18, at 10:34 a.m. registered nurse (RN)-A, from the dialysis center stated she would want the facility to notify the dialysis center for any condition changes. RN-A stated the dressing at the fistula does not need to	2 830		

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2 830	Continued From page 8 be checked by facility staff. RN-A stated facility staff do not need to obtain R20's vital signs upon returning from dialysis. RN-A stated facility staff do not need to obtain R20's weight after returning from dialysis, as this is completed at the dialysis center. RN-A went on to say the facility staff should be checking the fistula for bruit and thrill one time daily. RN-A stated she sends a copy of the "run" back with R20 for the facility staff and will write instruction on the run report when needed. RN-A stated she assumed the other nurses at the dialysis center would be sending the run report with instructions back to the facility as well. Review of R20's medical record lacked documentation of monitoring the bruit and thrill. During an interview on 3/22/18, at 11:38 a.m. the director of nursing (DON) stated nurses are to follow the dialysis protocol. The DON stated checking for bruit and thrill were not part of the protocol. The DON stated she did not remember where the protocol originated from, but it did not come from R20's current dialysis center. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could communicate with the dialysis center to develop policies and procedures related to dialysis communication and care. The director of nursing or designee could educate staff regarding these polices, and audit resident records for compliance to these policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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21535	Continued From page 9	21535		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure an as needed (PRN) antipsychotic medication was not ordered beyond 14 days without the prescribing practitioner evaluating the appropriateness of the medication for 1 of 6 residents (R77) reviewed for unnecessary medication. Findings include.	21535	Corrected	4/20/18

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21535	Continued From page 10 R77's admission Minimum Data Set (MDS), dated 1/5/18, indicated severe cognitive impairment, that R77 had occasional verbal and physical behavior towards others and that R77 was not receiving antipsychotic medication. A Physician Assessment Note, dated 1/30/18, identified R77 was somewhat aggressive and endangering to self and others. R77's physician orders, identified a 2/13/18 faxed initial order for Haldol 5 mg intramuscularly every 2 hours as needed (PRN) for agitation. R77's physician orders identified the 2/13/14 Haldol order was discontinued on 2/14/18. Additional faxed Haldol orders were written as follows: 2/14/18, Haldol 5 mg intramuscularly every 4 hours, PRN, for agitation. 2/14/18, Haldol 5 mg orally every 4 hours, PRN, agitations with directions to attempt oral dose first. R77's physician orders identified the 2/14/18 Haldol orders were discontinued on 2/21/18. A new faxed order for Haldol on 2/21/18, indicated Haldol 5 mg every 8 hours as PRN for aggressive behaviors. A 3/6/18 physicians assessment note identified R77's provider evaluated R77 for the continued use of the PRN Haldol. This was the first face to face physician evaluation since starting the PRN Haldol 21 days earlier. The note indicated R77 had aggressive behaviors with paranoia and had the potential for injuring behavior. The note indicated the Haldol order would remain on R77's order sheet although he has not been needing it. Plan to assess Haldol use on next visit.	21535		

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21535	Continued From page 11 Review of R77's February 2018 and March 2018 electronic medication administration record (EMAR), indicated R77 received PRN Haldol on the following dates: 2/13/18- 1 time 2/16/18-1 time 2/18/18- 1 time 2/19/18-2 times 2/20/18- 2 times 2/21/18-2 times 2/22/18-1 time 2/23/18-1 time 3/3/18- 2 times 3/8/18- 1 time The Consultant Pharmacist's Medication Review, dated 3/15/18 indicated "The Haldol PRN was started 2/21/18. Please discontinue this medication unless the resident is seen and medication re-ordered for 14 days (with justification)." During observations on 03/20/18, at 2:27 p.m. R77 was sleeping in a recliner in his room. During observations on 3/21/18, at 7:08 a.m. the resident was sitting in a recliner in his room watching TV. Smiled when spoken to. During an interview on 3/21/18, at 1:29 p.m. licensed practical nurse (LPN)-A stated R77's physician comes every 5 weeks and next scheduled to see R77 on 4/3/18. LPN-A stated R77's PRN Haldol order does not have a stop date. LPN-A stated R77's PRN Haldol was ordered after increased aggression. LPN-A stated antipsychotic PRN medication can only be used for 14 days when it is first started, otherwise it needs to be scheduled.	21535		

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21535	Continued From page 12 During an interview on 3/22/18 at 11:38 a.m. the director of nursing (DON) stated antipsychotic PRN's are limited to 14 days and not renewed until the attending physician or provider evaluates and assesses a resident. The DON stated the physician would decide how to evaluate and assess the resident. The facility's policy PRN Orders for Psychotropic Medications, undated, indicated "Duration of use for an antipsychotic psychotropic medication will be no greater than 14 days regardless if specified otherwise by the attending physician or other provider." "The PRN antipsychotic psychotropic medication may only be reordered after clinical assessment by attending physician or other prescriber." "if no duration is identified for the PRN antipsychotic psychotropic medication order, facility staff will contact prescriber to obtain a stop date of 14 days." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise policies and procedures for PRN antipsychotic medications. Nursing staff could be educated as necessary. The DON or designee could audit PRN antipsychotic medication orders a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21580	MN Rule 4658.1325 Subp. 7 Administration of Medications; Requirements Subp. 7. Administration requirements. The	21580		4/20/18

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21580	Continued From page 13 administration of medications must include the complete procedure of checking the resident's record, transferring individual doses of the medication from the resident's prescription container, and distributing the medication to the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure accurate monitoring for a blood pressure when administering a high blood pressure medication for 1 of 6 residents (R20) reviewed for unnecessary medication. Findings include: R20's admission Minimum Data Set (MDS), dated 12/29/18, identified R20 was cognitively intact with active diagnoses of hypertension and end stage renal disease. A physician progress note, dated 1/27/18, identified R20 received metoprolol ER (high blood pressure medication) 12.5 mg every day. The note further indicated " [R20] continued to run hypotensive [low blood pressure], but is asymptomatic." A pharmacy review dated 2/8/18, indicated "no irregularities identified." However, during an interview on 3/22/18, at 1:44 p.m., licensed practical nurse (LPN)-A stated when consulting pharmacist (CP)-A was at the facility, CP-A recommended to add parameters for monitoring the Metoprolol Succinate ER. R20's Order Summary Report, dated 3/21/18, identified an active order, with a start date of	21580	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00842	A. BUILDING: _____ B. WING _____	03/22/2018

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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21580	Continued From page 14	21580		

2/19/18, for Metoprolol Succinate ER tablet. Additional directions were added to give 12.5 mg by mouth one time a day for acute systolic b/p (blood pressure), Hold if BP is less than 60 and notify provider.

R20's Electronic Medication Administration Record (EMAR) from 2/19/18 to 3/21/18 (31 days) contained check marks in the administration boxes, indicating R20 received Metoprolol Succinate ER all 31 days. The EMAR contained 31 days of documented pulse (heart rate) readings. The EMAR lacked documentation of blood pressure readings.

R20's electronic Weights and Vitals Summary, from 2/19/18 to 3/21/18 (31 days), identified the following blood pressures:
2/22/18 10:29 p.m. 72/50 mmHg.
2/28/18 9:34 p.m. 75/60 mmHg.
3/14/18 9:20 p.m. 95/60 mmHg.
3/18/18 1:02 p.m. 101/61 mmHg.

R20's record lacked blood pressure monitoring for 27 out of the 31 days R20 received Metoprolol Succinate.

During an interview on 3/21/18, at 1:29 p.m. LPN-A reviewed R20's EMAR'S. LPN-A stated the nurses were obtaining R20's pulse instead of a blood pressure. LPN-A stated the administration of the medication without checking R20's blood pressure would be considered a medication error.

During an interview on 3/22/18, at 11:38 a.m. the director of nursing (DON) stated the nurses should follow the administration orders on the EMAR.

The facility's policy Medication Error Reporting

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21580	Continued From page 15 Policy & Procedure, revised June 2017, identified a transcription error as a medication error. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise policies and procedures for medication transcription. Nursing staff could be educated as necessary. The DON or designee could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21580		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to form a family council within the past calendar year as required. This	21942	Corrected	4/20/18

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21942	Continued From page 16 had the potential to affect all 27 residents and their families who resided in the facility. Findings include: During an interview on 3/20/18, at 10:44 a.m. the social services designee stated she was unaware if the facility had an active family council. On 3/22/18, at 10:58 a.m. the facility's director of nursing stated there had been a change in the director of social services position and there was no evidence in the previous director's paperwork that there had been an attempt to form a family council since 12/29/16. When interviewed on 3/22/18, at 11:58 a.m. the facility's administrator stated she was aware of the requirement to form a family council, however, she stated, "We are such a small facility and we talk to these families all the time. Families really aren't interested in family council." The administrator stated two family members attended the last attempted family council on 12/29/16. A facility policy was requested, however, was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could develop policies, provide education for staff regarding formulation of a Family Council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942		