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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: I1R4

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

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/26/2014** (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 **66** (L18)

13.Total Certified Beds **66** (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
	66			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor — 08/26/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 09/10/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245573

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

Dear Mr. Stordahl:

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

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

Effective August 11, 2014 the above facility is certified for or recommended for:

66 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 66 skilled nursing facility beds .

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

August 28, 2014

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

RE: Project Number S5573023

Dear Mr. Stordahl:

On July 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 2, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 13, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 26, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 2, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 11, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 2, 2014, effective August 11, 2014 and therefore remedies outlined in our letter to you dated July 18, 2014, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245573	A. Building B. Wing	8/13/2014

Name of Facility	Street Address, City, State, Zip Code
CLARA CITY CARE CENTER	1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **08/11/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **08/11/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **08/11/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/11/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **08/11/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **08/11/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **08/11/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **08/11/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	08/28/2014	10562	08/13/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/2/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245573	A. Building B. Wing 01 - MAIN BUILDING 01	8/26/2014

Name of Facility	Street Address, City, State, Zip Code
CLARA CITY CARE CENTER	1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0017	Correction Completed 07/24/2014	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 07/07/2014	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/KJ	Date: 08/28/2014	Signature of Surveyor: 22373	Date: 08/26/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 7/3/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245573	A. Building 04 - 2010 KITCHEN ADDITION B. Wing	8/26/2014

Name of Facility	Street Address, City, State, Zip Code
CLARA CITY CARE CENTER	1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0144	07/07/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KJ	08/28/2014	22373	08/26/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
7/3/2014	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: I1R4

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

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

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

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

4. TYPE OF ACTION: **2** (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 **07/02/2014** (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 **66** (L18)

13.Total Certified Beds **66** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	66			
(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 :
Karen Aldinger, HFE NE II — 08/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 09/10/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 0440

July 18, 2014

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

RE: Project Number S5573023

Dear Mr. Stordahl:

On July 2, 2014, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
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 August 11, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 11, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 October 2, 2014 (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 January 2, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring

P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Clara City Care Center

1012 North Division Street Po Box 797 Clara City, MN 56222

Phone: 320-847-2221 Fax: 320-847-3553

August 5, 2014 - Addendum to Plan of Correction for MDH QIS 6/29/14-7/2/14:

F 225 and **F 226:** It will be the responsibility of the DON and Social Services to complete audits for required notifications (Administrator (Immediately), the state agency, common entry point, local law enforcement, and responsible party for resident); thorough investigations; and follow up on all investigations as they occur. Results of audits will be reviewed and discussed at staff meetings, IDT meetings, and at quarterly QA meetings.

F 279: It will be the responsibility of the DON or designee to audit 10% of charts weekly for 90 days until Care Plans of all current residents with behavioral health concerns are individualized and include specific behaviors and non-pharmacological interventions. If positive results, audits will be changed to quarterly. Results of audits will be discussed in quarterly QA meetings.

F 323: Audit results will be discussed at quarterly QA meetings.

F 329: It will be the responsibility of the DON or designee to audit medication regimens for 10% of residents weekly for appropriate diagnoses/indications for use, and gradual dose reduction attempts as appropriate for 90 days. If positive results, audits will be changed to quarterly. Results of audits will be discussed at quarterly QA meetings.

F-428: Results of Audits will be discussed at quarterly QA meetings.

F 441: Results of Audits will be discussed at quarterly QA meetings.

Michael Stoddard 8/5/2014

8/13/14 per T.C c Kelly-DON Date on POC to changed to 8/11/14 to reflect 40 days P cert. Alt to chang. BA

8/6/14 BD

Clara City Care Center

Plan of Correction for Minnesota Department of Health QIS 6/29/14-7/2/14

F 225 It is the goal of the Clara City Care Center to ensure that all residents are free from all forms of abuse, including misappropriation of property and any allegations or suspicion of misappropriation of property shall be thoroughly investigated and promptly reported to the state agency, common entry point, and local law enforcement.

Resident #10 and resident #49 were reimbursed by the facility for the amount of money they reported missing due to inconclusive findings during investigation. Resident #10's reimbursed funds were put into her trust account to protect her from future occurrences.

The Clara City Care Center has an Abuse Prevention Policy and Procedure in place, which does include investigation and reporting of all forms of abuse, including alleged or suspected misappropriation of property. To prevent future occurrences of lack of or inadequate investigations and reporting of alleged or suspected misappropriation of resident property, a specific policy for investigation and reporting of missing property has been developed. This includes steps for investigation and both internal and external reporting. Report of Missing/Damaged Items was reviewed and updated. Witness interview tools and incident review guidelines have also been implemented to ensure thorough investigation, reporting, and follow-up. It will be the responsibility of the DON and Social Services or their designees to complete audits and follow up on investigations as they occur. Staff education has been provided through IDT and will again be provided at staff meetings scheduled for 8/7/14 and 8/21/14. Staff education will also be ongoing on an individual basis as needed. Concerns will be addressed at IDT meetings, staff meetings and QA meetings.

Completion date for plan of correction date will be ~~8/21/14~~ 8/11/14

F 226 It is the policy of the Clara City Care Center to ensure that all residents are free from all forms of abuse, including misappropriation of property and that any allegations or suspicion of misappropriation of property shall be thoroughly investigated and promptly and appropriately reported to the state agency, common entry point, and local law enforcement.

Resident #10 and resident #49 were reimbursed by the facility for the amount of money they reported missing due to inconclusive findings during investigation. Resident #10's reimbursed funds were put into her trust account to protect her from future occurrences.

The Clara City Care Center has an Abuse Prevention Policy and Procedure in place, which does include investigation and reporting of all forms of abuse, including alleged or suspected misappropriation of property. To prevent future occurrences of lack of or

8/6/14 See addendum to POC

inadequate investigations and reporting of alleged or suspected misappropriation of resident property, a specific policy for investigation and reporting of missing property has been developed. This includes steps for investigation and both internal and external reporting. Report of Missing/Damaged Items was reviewed and updated. Witness interview tools and incident review guidelines have also been implemented to ensure thorough investigation, reporting, and follow-up. It will be the responsibility of the DON and Social Services or their designees to complete audits and follow up on investigations as they occur. Staff education has been provided through IDT and will again be provided at staff meetings scheduled for 8/7/14 and 8/21/14. Staff education will also be ongoing on an individual basis as needed. Concerns will be addressed at IDT meetings, staff meetings and QA meetings.

Completion date for plan of correction date will be ~~8/21/14~~. 8/11/14 BB

F 279 It is the goal of the Clara City Care Center to develop comprehensive, individualized care plans, including non-pharmacological interventions for all residents with behavioral health needs that are receiving psychotropic medications.

Resident #50 was receiving Hospice Care and passed away on 7/18/14.

To prevent future occurrences, comprehensive care plans addressing behaviors and non-pharmacological interventions will be developed and implemented for current and future residents with behavioral health needs. MDS Coordinator, RN Managers, and Social Services were updated on 7/8/14. All nurses will be educated at staff meeting scheduled on 8/21/14. Education will also be provided as needed on an individual basis. It will be the responsibility of the DON or designee to complete care plan audits monthly for 6 months. If positive results, audits will be changed to quarterly. Concerns will be addressed at staff meetings, IDT meetings and QA meetings.

Completion date for plan of correction will be ~~8/31/14~~. 8-11-14 BB

F 309 It is the policy of the Clara City Care Center that a resident will receive Hospice Care when desired and appropriate to promote comfort and dignity and improve quality of life when a physician has diagnosed them with a terminal illness with a life prognosis of six months or less and curative measures have been exhausted.

Resident #50 was receiving Hospice Care and passed away on ~~7/18/14~~. ~~8/11/14 BB~~ emm

To prevent future occurrences, a Hospice Care Policy and Procedure was developed and implemented on 7/8/14, in collaboration with the Hospice RN. All nursing staff members have been educated through IDT and on a shift to shift basis. Re-education of staff will occur at staff meetings scheduled for 8/7/14 and 8/21/14. Annual Hospice Inservice (presented by Hospice) is scheduled for 10/16/14. Communication regarding

Hospice visits has been moved to one central location. The DON or designee will randomly audit staff awareness of Hospice services with direct questions weekly for 60 days. If positive results are found during the audits, audits will continue on an as needed basis.

Completion date for plan of correction is ~~7/31/14~~. 8/11/14 bb

F 323 It is the goal of the Clara City Care Center to ensure that each resident's environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents.

For resident #51, assistive rails were removed due to her advanced dementia. She is independent with transfers and ambulation. She did have one assistive rail reattached to her bed after two falls in the early morning hours of the morning on 7/7/14 and 7/9/14. The assistive rail was assessed and did not have a large gap in zone 2 or any other zone, as identified by the FDA Hospital Bed System Dimensional. For resident #42, the right assistive rail was replaced with one without a large gap in zone 2, as resident #42 does use the rails to participate in bed mobility as able. For resident #54, the left assistive rail has been removed and the right assistive rail does not have any large gaps in zone 2 or any other zone. Resident #54 is independent with bed mobility and transfers and uses the right assistive rail to turn in bed and to get out of bed independently. For resident #1, both assistive rails have been removed, as resident no longer participates in bed mobility. For resident #35, her left assistive rail has been replaced with an assistive rail without large gaps in zone 2 or any other zone. She requires the assistive rail to maintain independence with bed mobility, transfers, and toileting at night.

To prevent future occurrences, the DON audited all assistive rails in the entire facility for large gaps in all zones as identified by the FDA Hospital Bed Dimensional. All residents with assistive rails that have gaps that exceed the recommendations of the FDA Hospital Bed Dimensional were assessed for need of assistive rails and those rails have been replaced with rails that do not have large gaps in any zone. Rails that exceeded the recommendations have been discarded so they will not be utilized in the future. Assistive rails without large gaps in any zone have been ordered for future use. The Clara City Care Center utilizes Safety Risk Data Collection to assist in identification, assessment and development of comprehensive care plans related to potential hazards due to resident condition and/or environmental factors. These are initiated on admission and reviewed and updated quarterly, annually, and as needed. An additional Assistive Rail Utilization Assessment addressing the need for the rails and potential hazards of use has been developed for use on an as needed basis. Education has been provided to staff regarding the FDA recommendations on a shift to shift and on an individual basis and will again be provided on staff meetings scheduled on 8/7/14 and 8/21/14.

The DON or designee will randomly audit Safety Risk Data Collection and care plans weekly for 60 days and if positive results will decrease the audits to quarterly.

Completion date for plan of correction will be ~~8/21/14~~. 8-11-14 HB

F 329 It is the policy of the Clara City Care Center that each resident will have his/her drug regimen reviewed at least monthly and/or upon request by a licensed pharmacist, whether employed directly by the facility or through arrangement. The goal of the Clara City Care Center is that each resident's drug regimen is free from unnecessary drugs.

Resident #50 was receiving Hospice care and passed away on 7/18/14.

To prevent future occurrences, the facility's current Review of Drug Regimen Policy and Procedure was reviewed and updated by the DON to include ensuring that the resident has an appropriate diagnosis for use of the medication prescribed. A policy has been implemented to address use of psychotherapeutic medications. A Psychoactive Medication Audit has also been developed to assist in tracking The Clara City Care Center utilizes a Psychotherapeutic Drug Assessment when a resident is prescribed psychotropic medications. This is initiated upon admission or when a resident is prescribed psychotherapeutic medications. It is reviewed and updated quarterly and as needed. As indicated in the plan of correction for **F 279,** comprehensive care plans addressing behaviors and non-pharmacological interventions will be developed and implemented for current and future residents with behavioral health needs. The consultant pharmacist was updated on 7/2/14. The MDS Coordinator, RN Managers, and Social Services were updated on 7/8/14. All nurses will be educated at staff meeting scheduled on 8/21/14. Education will also be provided as needed on an individual basis. It will be the responsibility of the DON or designee to audit Psychotherapeutic Drug Assessments for appropriate diagnoses and gradual dose reduction attempts monthly for six months. If positive results, audits will be changed to quarterly. Concerns will be addressed at staff meetings, IDT meetings and QA meetings.

Completion date for plan of correction will be ~~8/21/14~~. 8/11/14 HB

F 428 It is the policy of the Clara City Care Center that each resident will have his/her drug regimen reviewed at least monthly and/or upon request by a licensed pharmacist, whether employed directly by the facility or through arrangement.

Resident #50 was receiving Hospice care and passed away on 7/18/14.

To prevent future occurrences, the facility's current Review of Drug Regimen Policy and Procedure was reviewed and updated by the DON to include ensuring that the resident has an appropriate diagnosis for use of the medication prescribed. The policy does

include the need for the pharmacist's irregularity reports to be acted upon. The consultant pharmacist was updated on 7/2/14. The MDS Coordinator, RN Managers, and Social Services were updated on 7/8/14. All nurses will be educated at staff meeting scheduled on 8/21/14. Education will also be provided as needed on an individual basis. It will be the responsibility of the DON or designee to audit irregularity reports for appropriate response and action by the physician monthly for 6 months. If inappropriate response or action is received from physician, the DON will request appropriate response/action from the physician. If physician is unwilling to provide this, the DON or designee will contact the Medical Director for assistance. If positive results, audits will be changed to quarterly. Concerns will be addressed at staff meetings, IDT meetings and QA meetings.

Completion date for plan of correction will be ~~8/21/14.~~ 8/11/14 KB

F 441 It is the policy of the Clara City Care Center that glucometers are to be cleaned and disinfected between each resident use.

Policy for cleaning and disinfecting of glucometers was updated and reviewed and staff education was provided through IDT on 6/8/14. Policy was reviewed by DON with RN-B on 7/2/14. Medication administration packet, including policy and procedure for cleaning and disinfecting of glucometers was given to RN-B and was completed on 7/10/14. Re-education of all staff nurses will occur at scheduled staff meeting on 8/21/14. Random audits of medication administration, including glucometer checks and cleaning and disinfecting of glucometers will be completed weekly by DON or designee for 60 days and if positive results, will be done monthly or as needed.

Completion date for plan of correction is ~~8/21/14.~~ 8/11/14 KB

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING _____ B. WING _____	07/02/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	8/6/14 Per addendum to POC BA-approved	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael Stadther
TITLE: Administrator
(X6) DATE: 8-1-2014

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

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure allegations of misappropriation of resident property were reported immediately to the state agency for 2 of 4 residents (R10 and R49), who had reported missing money to staff. R10's quarterly Minimum Data Set (MDS), dated 3/13/2014, identified R10 was cognitively intact. During an interview on 6/29/14, at 3:53 p.m. R10 stated she had some "missing" money, about a "month or two ago," but could not exactly remember when that occurred. R10 stated she had told "three or four" staff members about the missing money: "Twenty-five dollars." R10 stated staff, including the (director of nursing) DON did some kind of investigation, and searched, "High and low" for the money. "I don't know how they did it," R10 stated, "But they gave me a check for that amount."	F 225		

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F 225	Continued From page 2 R10's nursing note dated 5/7/14, indicated R10 reported $25.00 was missing, which was money her niece had given her on 5/6/14. The note also indicated staff assisted searching in R10's room for the missing money. Further, the note indicated other staff members, who routinely assisted R10, were asked about the missing money. A facility "Report of Missing/broken Items", dated 5/7/14, indicated an internal investigation regarding R10's missing money had been completed. The report concluded no money was found, and on 5/14/14, R10 had been reimbursed for the missing money by the facility. During an interview on 7/1/14, at 9:08 a.m. the DON stated an investigation regarding R10's missing money was completed, but had not been reported to the state agency as, "We did not feel [R10's name] money was stolen, and decided to reimburse [R10]." The DON also stated during the investigation, "We looked at our policy in that regard, and maybe it should have been reported." During an interview on 7/1/14, at 10:02 a.m. the administrator stated, at the time of the incident, he did not feel R10's case was reportable, as he did not believe R10's money was stolen. The administrator also stated, that after looking back and considering the questions raised the missing money should have been reported to the state agency.	F 225		

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F 225	Continued From page 3 R49's annual MDS dated 5/15/14, indicated R49 was cognitively intact. R49's care plan dated 5/16/14, indicated, "All s/s [signs and symptoms] of abuse &[and] /or neglect will be reported immediately to the appropriate person(s)." R49's Individual Abuse Prevention Plan Susceptibility To Abuse Checklist, signed 5/14/14, indicated R49 was not easily exploited by others (would give away their money or belongings). During an interview on 6/29/14, at 6:38 p.m. R49 stated he left his wallet in his pants one evening and it had accidentally gone to laundry. R49 stated when returned, $40.00 was missing from his wallet. R49 further stated staff reimbursed him the missing money, but wasn't sure of the date this occurred and thought it was, "Maybe a few months ago." During interview on 6/30/14, at 3:33 p.m. social services designee (SSD)-A stated the facilities formal process was for the initial reporting staff were to complete a, "Report of Missing Items/Broken Items" form, then submit it to either herself, the DON, or the administrator. SSD-A stated the state agency was not notified of the missing money, and an investigation had not occurred. During interview on 6/30/14, at 3:42 p.m. the administrator stated that he was aware of the incident regarding the missing money for R49.	F 225		

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F 225	Continued From page 4 The administrator stated if there was a strong suspicion it had been stolen, that it would have been reported, however this particular incident had not been reported the state agency. The Clara City Care Center Abuse Prevention Plan, dated 1/23/12, indicated "A resident incident report will be completed for each incident." The policy further included, misappropriation of resident property/financial exploitation shall be reported the state agency.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure allegations of misappropriation of resident property were reported to the state agency, according to the facility abuse prevention plan, for 2 of 4 residents (R10 and R49), who reported missing money to staff. Finding include: The facilities Abuse Prevention Plan, updated 1/23/12, included misappropriation of resident property, "Includes... the deliberate misplacement, exploitation or wrongful temporary	F 226		

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F 226	Continued From page 5 or permanent use of a resident's belongings or money without the resident's consent." The plan directed misappropriation of resident property to be reported to the state agency immediately. R10's quarterly Minimum Data Set (MDS), dated 3/13/14, identified R10 was cognitively intact. During an interview on 6/29/14 at 3:53 p.m., R10 stated she had some "missing" money, about a "month or two ago," but could not exactly remember when that occurred. R10 told "three or four" staff members about the missing money: "twenty-five dollars." R10 stated they [staff, including the DON] did some kind of investigation, and searched "high and low" for the money. "I don't how they did it," R10 said, but they gave me a check for that amount." R10's nursing note dated 5/7/14, indicated R10 reported $25.00, money her niece had given her on 5/6/14, was missing. The note included R10's room had been searched and direct care staff interviewed. R10's Report of Missing/broken Items, dated 5/7/14, indicated an internal investigation regarding R10's missing money was done. The report concluded that no money had been, and that on 5/14/14, R10 was reimbursed for the missing money by the facility. When interviewed on 7/1/14, at 10:02 p.m. the administrator stated he was aware R10 had	F 226		

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F 226	Continued From page 6	F 226		

reported money missing, but did not feel it had been stolen, the facility had reimbursed R10, but had not reported to the state agency. The administrator then stated, looking back, the missing money should have been reported to the state agency as directed by the policy.

R49's annual MDS dated 5/15/14, indicated R49 was cognitively intact.

During an interview on 6/29/14, at 6:38 p.m., R49 stated he left his wallet in his pants one evening and it had accidentally gone to laundry. When his pants were returned, R49 stated $40.00 was missing from his wallet. R49 further stated staff reimbursed him the missing money, but wasn't sure of the date this occurred and thought it was, "Maybe a few months ago."

During interview on 6/30/14, at 3:33 p.m. social services designee (SSD-A) stated the facilities formal process was for the initial reporting staff to complete a Report of Missing Items/Broken Items form, then submit it to either herself, the director of nursing (DON), or the administrator. SSD-A stated their policy included reporting potential misappropriation of resident property to the state agency immediately, but this had not been done after R49 had reported missing money.

During interview on 6/30/14, at 3:42 p.m. the administrator stated that he had been made aware of the incident regarding the missing money for R49. If the facility had suspected the

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F 226	Continued From page 7 money stolen, they would have reported it to the state agency immediately, they had not considered the money stolen, even though an investigation had not occurred.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan to address behaviors and non-pharmacological interventions for 1 of 5 residents (R50) reviewed for unnecessary medications.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING _____ B. WING _____	07/02/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 8 Findings Include: R50's significant change Minimum Data Set (MDS), dated 5/9/14, included R50 had Alzheimer's disease, dementia, suffered from short and long term memory problems, had an acute change in mental status from her previous baseline, and experienced delusions (misconceptions or beliefs that are firmly held contrary to reality). R50's MDS further indicated she displayed behaviors such as physical symptoms (such as: hitting or scratching self, pacing rummaging, or verbal/vocal symptoms like screaming or other disruptive sounds) for 4-6 of the days in the review week, but less than daily. R50's Antipsychotic Drug Monitor, dated May 2014, indicated R50 had nearly daily episodes of repetitive questions and statements. R50's behavior Care Plan (CP), dated 5/12/14, indicated R50 may have some verbal and other behaviors. R50's CP identified interventions to, "encourage positive behaviors," "explain all cares when providing them," and "offer support by visiting regularly." The CP did not identify specific non-pharmacological interventions that staff could used to help reduce or prevent R50's target behaviors of daily episodes of repetitive questions and statements, that were identified on the Antipsychotic Drug Monitor sheet. During interview on 6/29/14, at 2:52 p.m., R50 was seated in a recliner chair in her room watching television. R50 stated she was waiting for something from the city, but was not sure what	F 279		

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F 279	Continued From page 9	F 279		

it was. During a subsequent observation of R50, on 6/30/14, from 2:41 p.m. until 3:15 p.m. she was seated in the commons area adjacent to the nurses station. R50 was conversing with herself and was heard to say in a distressed voice, "Help me," and "say," to staff, visitors, and other residents as they would pass by. During these times, facility staff made not attempts to redirect or console R50 while she was displaying these agitated behavior.

During interview on 7/1/14, at 2:48 p.m. nursing assistant (NA)-B stated R50 does a lot of praying, and staff will sit and visit with her or rub her back if she appears distressed. NA-B stated the care plan interventions for behavior are typically listed on the, "Care Sheets," the NA staff use. NA-B further stated R50's "Care Sheet" was blank under the identified behavior section.

When interviewed on 7/1/14, at 1:43 p.m. registered nurse (RN)-B stated R50 will frequently call out a lot, "please help me," and that R50 consistently has a legitimate need to be fulfilled when she does call out.

During interview on 7/1/14, at 2:31 p.m., RN-D stated staff will sometimes try to talk to her when she is having behaviors, or attempt to get her involved in an activity. RN-D further stated R50's CP lacked specific interventions for the staff to follow to reduce and prevent behaviors, "I hope it would be in there, but I think it is common sense too."

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F 279	Continued From page 10 When interviewed on 7/2/14, at 9:25 a.m. the director of nursing (DON) stated R50 had significant behaviors that included lots of calling out, not waiting for staff to provide assistance, and swearing, and that R50 had actually improved over the past 3-4 months with those behaviors. The DON further stated in the past R50 was on medications for behavior, which had not helped in the past.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to coordinate hospice services regarding scheduled visits and assigned tasks for 1 of 1 residents (R50) who received hospice services. Findings include: R50's significant change in condition Minimum Data Set (MDS), dated 5/9/14, indicated R50 had diagnoses of Alzheimer's disease, dementia, and heart failure.	F 309		

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F 309	Continued From page 11 R50's care plan (CP), dated 5/16/14, indicated R50 was, "Enrolled in hospice program on 5/9/14 and further decline in condition is expected." R50's CP further indicated to, "Coordinate plan of care with hospice agency reflecting the hospice philosophy," and "ensure the facility and hospice[sic] agency are aware of the other's responsibilities in implementing the plan of care." R50's hospice interdisciplinary team (IDT) care plan, dated 5/12/14, indicates the hospice aide (HA) would complete "Hair Care fluff and fix", skin and fingernail care weekly and the hospice aide was scheduled to visit on Thursdays from 8:45-9:30 a.m.. The care plan identified the skilled nurse would visit weekly and as needed for symptom management, but there was no specific date identified when she would visit, or if she would notify the facility prior to her visits. During observation on 7/1/14, at 8:50 a.m., a hospice registered nurse (HRN)-A was seen completing documentation at the nurses station. When interviewed on at 9:01 a.m., the hospice RN stated she felt hospice and the facility had "wonderful collaboration". HRN further stated that Tuesday was her "Clara City Day" and she tries to call them the day before she comes, so they are aware of her visit. During interview on 7/1/14, at 9:21 a.m., nursing assistant (NA)-C stated she was unaware of when hospice comes. NA-C stated she can look on the "Daily Resident Needs" book located at the nurses station as hospice will sometimes leave a	F 309		

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F 309	Continued From page 12 note. After reviewing the book, NA-C indicated that no note had been left in the book (today on 7/1/14) that hospice would be in the facility. When interviewed again on 7/1/14, at 1:33 p.m., NA-C stated she has worked in the facility for over a month and had never seen the hospice aide. NA-C further stated she had "no clue" what the hospice aide did for R50 when he/she was here. When interviewed on 7/1/14, at 1:36 p.m., NA-D stated she had "no idea" what hospice does when they are here. NA-D further stated she has never seen a hospice employee with R50. During interview on 7/1/14, at 9:23 a.m., registered nurse (RN)-B stated hospice will frequently "just show up." RN-B further stated a white board, located behind the nurses station in front of the medication room door, will sometimes have a note when the hospice aide is coming next. When interviewed on 7/1/14, at 1:34 p.m., RN-B stated the hospice aides "do not check in with us and that would be nice if they would do that." During interview on 7/1/14, at 9:27 a.m., the director of nursing (DON) stated they (the facility staff) don't always know when the nurse is coming, and she will frequently just stop in. The DON further stated she didn't think the floor staff needed to be aware of that information, regarding	F 309		

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F 309	Continued From page 13 when hospice will be at the facility. During interview on 7/2/14, at 10:47 a.m., the HRN-A stated the hospice aides do not chart in the facility chart and the expectation is that all hospice staff will touch base with facility staff when they are on site, to assist with coordination of services.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assist rails did not have large gaps in zone 2, as identified by the Food and Drug Administration (FDA) Hospital Bed System Dimensional dated 3/10/06, to prevent potential entrapment, for 5 of 5 residents (R51, R42, R54, R1 and R35) reviewed who unitized assist rails on their beds. Findings included: The FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment,	F 323		

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F 323	Continued From page 14 dated 3/10/06, included information for facilities to reduce entrapment risks of patients in side rails/assist rails, which may result in death or serious injury. The guidance identified vulnerable patients as those who have problems with memory, sleeping, incontinence, pain, uncontrolled body movements, or who get out of bed unsafely without assistance. "These patients most often have been frail, elderly or confused." Zone 2 included, the gap, "under the rail, between a mattress compressed by the weight of a patient's head and the bottom edge of the rail at the location between the rail supports, or next to a single rail support." The FDA recommended this space be less than 4 3/4" (inches), a space where a head could become entrapped. R51's significant change Minimum Data Set (MDS) dated 4/21/14, included severe cognitive impairment with a diagnosis of dementia. R51's falls Care Area Assessment (CAA) dated 4/25/14, included, "[R51's name] is at risk for falls and/or injuries due to diagnosis of Lewy Body Dementia with severe cognitive impairment and she has vision impairment. She ambulates without use of assistive device and gait/balance is steady. She receives an antihypertensive, and has intermittent pain and receives a scheduled narcotic medication which increases her risk for falls." R51's left assist rail was observed with the director of nursing (DON) on 6/30/14, at 3:45 p.m. The rail had a gap in zone 2 (between the bottom of the rail and the mattress when compressed) which measured 9.5" (inches) wide by 6" long when the mattress was compressed with moderate pressure.	F 323		

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F 323	Continued From page 15 R51's Clara City Care Center Safety Risk Data Collection dated 4/21/14, identified R51 was at risk for falling and injuries, and utilized grab bars on both sides of her bed. The data collection did not identify if R51 was safe to utilize the grab bars with the large gap in zone 2, to ensure this was not an entrapment hazard for R51. When interviewed on 6/30/14, at 4:00 p.m. the DON stated the facility had not recognized the large gap in zone 2, and had not assessed the safety of R51 while this rail was on her bed. R42's quarterly MDS dated 4/8/14, included severe cognitive impairment with a diagnosis of dementia, required extensive assistance of two persons for bed mobility and her balance was not steady. R42's falls CAA dated 7/12/13, included she was at risk for falling related to needing assistance with transfers and walking, as well as medications that increase risk for falling. R42's assist rails were observed with the DON on 6/30/14, at 3:50 p.m. and the assist rail on right side of the bed had a gap in zone 2 measuring 7.5 inches long by 6 inches when the mattress was compressed. R42's Clara City Care Center Physical Device Assessment dated 4/8/14, included use of assist rails on both sides of the bed. The assessment included R42 was at risk for falling and the mobility devices were being used for comfort and	F 323		

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F 323	Continued From page 16 fall prevention. The data collection did not identify if R42 was safe to utilize the grab bars with the large gap in zone 2, to ensure this was not an entrapment hazard for R42. When interviewed on 6/30/14, at 4:00 p.m. the DON stated the facility had not recognized the large gap in zone 2 and had not assessed if R42 was safe to utilize the rail with the large gap in zone 2. R54's quarterly MDS dated 4/15/14, included severe cognitive impairment with a diagnosis of dementia. The falls CAA dated 7/22/14, included she was at risk for falling due to unsteady gait, arthritis and dementia. R54's assist rails were observed with the DON on 6/30/14, at 3:55 p.m. The rail on the left side of her bed had a gap in zone 2 measuring 7.5" long by 6" deep when the mattress was compressed. R54's Clara City Care Center Safety Risk Data Collection dated 4/14/14, included assist rails on both sides of the bed to maintain independence in bed mobility. However, the data collection failed to address if R54 was safe to utilize the rail with the large gap in zone 2, to ensure this was not an entrapment hazard for R54. When interviewed on 6/30/14, at 4:00 p.m. the DON stated the facility had not recognized the large gap in zone 2 and had not assessed the safety of R54 utilizing this rail.	F 323		

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F 323	Continued From page 17 R1's quarterly MDS dated 5/2/14, included severe cognitive impairment with a diagnosis of dementia, required extensive assistance with bed mobility, and had balance problems. The falls CAA dated 11/5/13, included she was at risk for falls related to inability to ambulate, impaired balance, and severe cognitive impairment. R1's assist rails were observed with the DON on 6/30/14, at 3:55 p.m. The rail on the left side of her bed had a gap in zone 2 measuring 7.5 inches long by 6 inches deep when the mattress was compressed. R1's Clara City Care Center Safety Risk Data Collection dated 5/2/14, included use of assist bars on both sides of the bed and was at risk for falling. The data collection failed to assess if R1 was safe to utilize these assist bars with the large gap in zone 2, to ensure this was not an entrapment hazard for R1. When interviewed on 6/30/14, at 4:00 p.m. the DON stated the facility had not recognized the large gap in zone 2 and had not assessed the safety of R1 utilizing this rail. R35's MDS dated 3/19/14, indicated she was cognitively intact and independent with bed mobility. R35's physician orders dated 6/11/14, included a diagnosis of paroxysmal positional vertigo (dizziness with position changes, such as sitting up, or standing up).	F 323		

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F 323	Continued From page 18 R35's falls CAA dated 12/26/13, included, "[R35's name] is at risk for falls related to history of falls, frequent urinary incontinence, and administration of a diuretic, an antidepressant, an antihistamine, and cardiac medications...She has had 3 falls in the past year. She uses a left grab bar to maintain independence with bed mobility. [R35's name] is at risk for further decline in ADL's [activities of daily living] increased pain, and injuries related to falls." R35's bed was observed with the DON on 6/30/14, at 3:40 p.m. An assist rail on the left side of the bed had a gap in zone 2 which measured as 7.25 inches wide, by 5.25 inches from the bottom of the rail to the top of the compressed mattress. R35's Clara City Care Center Safety Risk Data Collection dated 6/12/14, included use of a grab bar on the left side of her bed. However, the data collection failed to assess if R35 was safe to utilize this assist rail with the large gap in zone 2, to ensure this was not an entrapment hazard for R35. When interviewed on 6/30/14, at 4:00 p.m. the DON stated the facility had not recognized the large gap in zone 2's assist rail, and had not assessed the safety of R35 utilizing this device. A policy was requested, but not provided by the facility.	F 323		

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to administer psychotropic medications for an appropriate medical diagnosis or attempt non-pharmacological interventions prior to starting antipsychotic or antianxiety medications for 1 of 5 residents (R50) reviewed for unnecessary medication use.	F 329		

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F 329	Continued From page 20 Findings Include: R50's significant change Minimum Data Set (MDS), dated 5/9/14, included R50 had Alzheimer's disease, dementia, suffered from short and long term memory problems, had an acute change in mental status from her previous baseline, and experienced delusions (misconceptions or beliefs that are firmly held contrary to reality). R50's MDS further indicated she displayed behaviors such as physical symptoms (such as: hitting or scratching self, pacing rummaging, or verbal/vocal symptoms like screaming or other disruptive sounds) for 4-6 of the days in the review week, but less than daily. During observation on 6/30/14, at 2:41 p.m., R50 was seated in the commons area adjacent to the nurses station conversing with herself, at times having non-sensical speech. She stated in a distressed voice, to other residents, visitors and facility staff, "help me," but they continued to walk past R50. During interview on 7/1/14, at 2:48 p.m. nursing assistant (NA)-B stated R50 does a lot of praying, and staff will sit and visit with her or rub her back if she appears distressed. NA-B stated the care plan interventions for behavior are typically listed on the, "Care Sheets," the NA staff all use. Review of the care sheet with NA-B, identified the behavior section was blank for R50. During interview on 7/1/14, at 1:43 p.m., registered nurse (RN) - B stated R50 will frequently call out a lot and typically has an actual need that needs to be met. R50's psychoactive medication Care Plan, dated	F 329		

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F 329	Continued From page 21 5/16/14, indicated R50 had target behaviors of repetitive questions, restlessness with frequent self transfer attempts, impaired sleep at night, sad and worried facial expressions, and statements of being sad or angry about being here. The interventions included staff to track mood and behavior each shift, do a psychotropic drug assessment each quarter, report any changes to the nurse and monitor for side effects or lack of effectiveness. The behavior care plan identified R50 had verbal and other behaviors, removing tabs alarms, and yelling at staff. The approach directed staff to come back at later time to provide cares if upset or combative, encourage visits from family and friends, explain all cares and staff to offer support by visiting regularly. The care plan interventions were not individualized fro R50. They did not identify specific non pharmacological interventions that could be implemented to help reduce or prevent R50's identified target behaviors. Even though RN-B, NA-B stated they pray with her, rub her back if she is distress and when she calls out she typically has a need that needs to be met. They were not identified as interventions on the care plan. Review of the monthly Antipsychotic Drug Monitor sheets for Risperdal .75mg (milligrams) morning and evening from March through May 2014 identified, "description of behaviors to be managed" as "repetitive questions, self transfers and wondering with no purpose." The March 2014 sheet identified R50 had 4 out of 31 days of repetitive questions during 11-7 shift, 29 of 31 days during the 7-3 shift and 28 of 31 days during the 3-11 shift. R50 had one day of self transfers during 11-7 shift, 21 of 31 days	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING _____ B. WING _____	07/02/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 22 during the 7-3 and 3-11 shifts. R50 was also monitored for wandering without purpose which occurred zero time during 11-7 shift, 11 of 31 days during 7-3 shift and 21 of 31 days during 3-11 shift. The April 2014 sheet identified R50 had zero of 30 days of repetitive questions during the 11-7 shift, 24 of 30 days during 7-3 shift and 26 of 30 days during 3-11 shift. R50 had zero days of self transfer during 11-7 shift, 4 out 30 days during 7-3 shift and 2 of 30 days during 3-11 shift. R50 was monitored for wandering without purpose which occurred zero days during 11-7 and 7-3 shift, and 7 days during the 3-11 shift. The May 2014 sheet identified R50 had repetitive questions/statement zero days of occurrence during the 11-7 shift, 27 out of 31 days during 7-3 shift and 30 out of 31 days during 3-11 shift. R50 had no self transfers or wandering without purpose for 7-3 and 3-11 shifts. The antipsychotic drug monitor form identified if the behavior occurred and what shift, but it does not identify the time of day, the number of times the occurrence happened during the shift, the extent of the occurrence, or what non pharmacological intervention were implemented if any and the results of those interventions prior to asking the physician for psychotropic medications. Review of R50's signed Physician Order Report, dated 5/29/14, indicated R50 had diagnoses of anxiety, depressive disorder, and dementia. The Physician Order Report further included orders for: Risperdal (an anti-psychotic medication) 0.75 mg	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING _____ B. WING _____	07/02/2014

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F 329	Continued From page 23 (milligrams) BID (twice a day) for diagnosis of "Anxiety state NOS [not otherwise specified]", started 2/20/14. R50 also had an order for risperidone (generic for Risperdal) 0.5 mg every 4 hours as needed for anxiety (start date of 1/20/14), and; Buspirone (an anti-anxiety medication) 15 mg BID with a listed diagnosis of depressive disorder, major, unspecified, which started 11/26/13. Vistaril (an anti-histamine medication) 50 mg Q (every) 4 hrs (4 hours) PRN (as needed) with a listed diagnosis of "Anxiety state NOS [not specified]", which started 2/25/14. Celexa (anti-depressant / anxiety medication) 30 mg once a day for a diagnosis of "Depression disorder, major reoccurring, unspecified", started 5/30/13. (This was not listed before) A fax communication to the physician, dated 11/11/13, indicated R50 continued with agitation and restlessness at times. The physician provided an order for Buspar (an anti-anxiety medication) 7.5 mg daily for 7 days, then increased it to BID for 7 days, then increased it to 15 mg BID. On 1/13/14 the facility, after discussion with R50's family, faxed a request to the physician for a psychiatric consultation, with subsequent orders being received. There was no indication in the consultation notes, progress notes from 1/13/14 through 7/2/14 that R50 had the psychiatric consultation completed. There was a fax to the physician on 1/17/14, requesting "Do you think we could try Risperdal (an anti-psychotic medication) 0.25 mg BID to help with behaviors. I don't see that this has been tried.", and requested an order for Risperdal	F 329		

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F 329	Continued From page 24 to given as an "as needed" medication. The physician provided orders to start Risperdal 0.25 mg PO (by mouth) BID for significant anxiety. A subsequent fax communication, dated 2/20/14, indicated R50 continued to display repetitive statements, anxiety, and anger. The physician increased the Risperdal dose to 0.75 mg BID on 2/20/14. Review of the Psychotherapeutic Drug Assessment, dated 5/9/14, indicated a reduction was contraindicated with a 'X' placed in a field labeled "Other" stating "Risperdal initially ordered 1/17/14. Klonopin (clonazepam) D/C'd (discontinued) 2/1/14. Haldol D/C'd 6/24/13. She has had many psychotropic medication changes." Although R50 had multiple medication and dosage changes based on nursing request, there was no indication that R50's behaviors were analyzed to identify a specific pattern of behaviors, or what time of day these patterns occurred. There was no analysis to determine if any non-pharmacological interventions implemented to change the resident behavior were effective and if so which ones were effective for R50. There was no indication that R50's current psychoactive medications were effective at the current dose. During interview on 7/2/14, at 9:25 a.m., the director of nursing (DON) stated R50 had a long history of behavior. The DON stated she had orders for a psychiatric consultation in January 2014, but was never completed due to a lack of transportation and R50's primary medical doctor agreed to help manage her medication regimen. The DON stated anxiety is not an acceptable medical diagnosis for use of antipsychotic	F 329		

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F 329	Continued From page 25 medication. The DON further stated an assessment should be completed before requesting psychotropic medications from the physician, "I'm sure one wasn't done."	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow-up on pharmacist consultant recommendations for 1 of 5 residents (R50) reviewed for unnecessary medication use. Findings Include: R50's signed Physician Order Report, dated 5/29/14, indicated R50 had diagnoses of anxiety, depressive disorder, and dementia. The Physician Order Report further included orders for: Risperdal (an anti-psychotic medication) 0.75 mg (milligrams) BID (twice a day) with a listed	F 428		

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F 428	Continued From page 26 diagnosis of "Anxiety state NOS [not otherwise specified]", started 2/20/14, and; Celexa (an anti-depressant medication) 30 mg once a day with a listed diagnosis of "Dprsv dsord, major rcr, unspec [depressive disorder, major reoccurring, unspecified]", which started 5/30/13, and; Buspirone (an anti-anxiety medication) 15 mg BID with a listed diagnosis of "Dprsv dsord, major rcr, unspec", started 11/26/13. Vistaril (an anti-histamine medication) 50 mg Q (every) 4 hrs (4 hours) PRN (as needed) with a listed diagnosis of "Anxiety state NOS", which started 2/25/14. A Behavior-Medication Monitoring communication form, dated 6/10/14, indicated R50 was currently prescribed Celexa 20 mg QD (everyday), Risperdal 0.75 mg BID, Vistaril 50 mg PRN (per request), and Buspirone 15 mg BID. The form requested a "review and comment on Risk/Benefit from each medication," and "Is the Risperdal at the lowest effective dose/necessary to be continued or could dosage reduction be attempted?" under an area labeled "Pharmacist monthly drug review comment on psychoactive medication." A response from the physician, dated 6/11/14, indicated "OK to continue current medications @ [at] current doses." The response from the physician was signed by facility nursing staff on 6/12/14. Although the pharmacist requested a "Risk/Benefit from each medication" and "Is Risperdal at the lowest effective dose?" The physician had not provided a justified rational to continue the same medication at the current dose.	F 428		

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F 428	Continued From page 27 When interviewed on 7/1/14, at 1:43 p.m., registered nurse (RN)-B stated she didn't feel R50 needed several psychoactive medications anymore, "maybe at one time." RN-B further stated R50 typically has a motive or need when she is calling out, that needs to be addressed. During interview on 7/2/14, at 9:25 a.m., the director of nursing (DON) stated the response from the physician would be considered follow-up completed to the pharmacists requests, and it was not adequate rational for the use use of the medications at that specific dose. The DON stated we (staff) need to review the process for addressing these identified pharmacist concerns. The DON further stated R50 never completed the psychiatric consultation due to a lack of transportation and the primary medical doctor agreed to help manage R50's medication regimen. Further, the DON stated the Buspar had not been addressed for reduction by the pharmacist, "I guess I don't know." The pharmacist was contacted several time for an interview, but did not respond to the request. An untitled note was received from the pharmacist on 7/7/14. The note was dated 7/2/14, and identified R50 had a psychiatric consultation completed in January 2014 with "noted nice improvement in mood, affect, behavior - continue same doses." The pharmacist further identified the psychiatric consultation, "felt include the medication Buspar and that her level of anxiety warranted continued use." R50, did not have a psychiatric evaluation completed in January 2014, due to lack of transportation.	F 428		

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F 428	Continued From page 28 Although the pharmacist requested a "Risk/Benefit from each medication" and if the "Risperdal at the lowest effective dose?" in June 10, 2014. The physician had not provided a justified rational to continue the medication at the current dose to ensure R50 was only receiving medications that were needed for her behaviors as the pharmacist requested.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 29 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow a disinfecting and cleaning regimen for a facility or "house" blood glucose monitor (glucometer), for 1 of 4 residents (R11), who utilized the glucometer on the east wing of the nursing home. Findings include: During observation on the east wing on 7/1/14, at 8:20 a.m., registered nurse (RN)-B measured R10's blood sugar in her room. RN-B removed the test strip from the glucometer, removed her gloves with used test strip folded inside, sanitized her hands, and then placed the glucometer, without cleansing it, on the medication cart. RN-B stated another resident needed blood sugar testing before breakfast, and pushed the medication cart next to R11's room. RN-B inserted a new test strip into the glucometer, donned gloves, and proceeded to enter the room to test R11's blood sugar without first disinfecting the glucometer. RN-B was stopped by the surveyor prior to measuring R11's blood sugar.	F 441		

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F 441	Continued From page 30 During an interview on 7/1/14, at 8:26 a.m., RN-B stated she should have cleaned it [the glucometer]. RN-B said "It's something I normally do, I just didn't bring the wipes with me." RN-B stated the blood glucometer was a "house" unit, and was currently utilized by four residents on the east wing who required daily blood sugar checks. RN-B returned from the supply storage area with disinfecting wipes, cleansed the glucometer, and allowed it to air dry. RN-B then proceeded to use the disinfected glucometer to check R11's blood sugar. In an interview on 7/1/14, at 11:19 a.m., the director of nursing (DON) said the policy regarding the cleaning of the glucometer between resident use had, "just been updated and reviewed with the nurses." The DON stated the glucometer "should have been cleaned" before using it on another resident. Review of the facility policy for cleaning and disinfecting of glucometer's, updated 6/8/2014, indicated "glucometer's...are to be cleaned and disinfected between each resident use..." The policy further indicated to "disinfect entire glucometer" with a bleach wipe, and allow to air dry before next use.	F 441		

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

F5573022

PRINTED: 08/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE FORM CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 3, 2014. At the time of this survey, Building 01 of Clara City Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	POC ok JB 8-13-14 RECEIVED AUG 12 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael Goodstar

TITLE: Administrator

(X6) DATE: 8/7/2014

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/03/2014**

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Clara City Care Center is one-story in height, with a partial basement. The original building was constructed in 1966 and was determined to be of Type II(111) construction. In 1970, an addition was constructed and was determined to be of Type II(111) construction. In 1989, an addition was constructed and was determined to be of Type II (111) construction. In 1997 an addition was constructed and was determined to be of Type II(111) construction. The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a licensed capacity of 66 beds and had a census of 59 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 017	NFPA 101 LIFE SAFETY CODE STANDARD	K 017		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 017 SS=D	Continued From page 2 Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility had a use area which was not separated from the corridor in accordance with NFPA 101 (2000 edition), Chapter 19, Section 19.3.6.1. In a fire emergency, this deficient practice could adversely affect 12 of 66 residents. FINDINGS INCLUDE: On 07/03/2014 at 2:10 PM, observation revealed The East Dining Room was a space open to the corridor system, and was not equipped with electrically supervised automatic smoke detection. This arrangement was not in accordance with the requirements at NFPA 101 (2000), Chapter 19, Section 19.3.6.1.	K 017		

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K 017	Continued From page 3 This finding was confirmed with the chief building engineer at the time of discovery.	K 017		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain the emergency generator in accordance with the requirements at NFPA 101 (2000) Chapter 9, Section 9.1.3 and NFPA 110 (1999) Chapter 6, Section 6-4. In a fire or other emergency, this deficient practice could adversely affect 66 of 66 residents. FINDINGS INCLUDE: On 07/03/2014 at 12:50 PM, during a review of the emergency generator monthly inspection and testing logs for the previous year, the percent of load (KW) had not been recorded. As such, it could not be documented that the genset had been either: 1). Exercised at not less than 30% of the EPS nameplate rating, or; 2). Loaded to maintain the minimum exhaust gas temperature as recommended by the	K 144		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	*245573	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/03/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 4 manufacturer, or; 3). Had a 2-hour load bank test performed within the previous year. This finding was confirmed with the chief building engineer.	K 144		

Clara City Care Center Plan of Correction for LSC Survey that took place on 07/03/2014
"Amended Version to include K017"

K 017 On 7/24/2014 Willmar Electric Service installed two new electrically supervised automatic smoke detectors. The Maintenance Supervisor arranged for the new detectors to be installed and checked prior to the electricians leaving that they were in proper working order. The Maintenance Supervisor or designee will ensure that proper testing is completed in accordance with our fire protection testing policies.

Completion date for plan of correction is 7/24/2014.

K 144 A form from the Minnesota Department of Public Safety website related to generator testing was downloaded and adopted for use on 07/07/2014. This form has an area where the KW load is to be recorded for each monthly test. The Maintenance Supervisor will ensure that the generator is exercised at 30% or more of the EPS nameplate rating during each monthly test. The Administrator or Designee will audit the generator inspection forms for the next three months to ensure the KW load is recorded and that it was run at 30% or more of the EPS nameplate rating. If the results are found to be in compliance then the audit will be conducted quarterly.

Completion date for plan of correction will be 07/07/2014.

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

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PRINTED: 07/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING 04 - 2010 KITCHEN ADDITION B. WING _____	07/03/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE FORM CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 3, 2014. At the time of this survey, Building 02 of Clara City Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	POC ok TB 8-13-14 RECEIVED AUG - 1 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 7-3-14 DC: 8-11-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Stadstad	Administrator	8-1-2014

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING 04 - 2010 KITCHEN ADDITION B. WING _____	07/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 02 of Clara City Care Center consists of a kitchen addition, constructed in 2010. Building 02 is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a licensed capacity of 66 beds and had a census of 59 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 144	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain the emergency generator in accordance with the requirements at NFPA 101 (2000) Chapter 9, Section 9.1.3 and NFPA 110 (1999) Chapter 6, Section 6-4. In a fire or other emergency, this deficient practice could adversely affect 66 of 66 residents. FINDINGS INCLUDE: On 07/03/2014 at 12:50 PM, during a review of the emergency generator monthly inspection and testing logs for the previous year, the percent of load (KW) had not been recorded. As such, it could not be documented that the genset had been either: 1). Exercised at not less than 30% of the EPS nameplate rating, or; 2). Loaded to maintain the minimum exhaust gas temperature as recommended by the manufacturer, or; 3). Had a 2-hour load bank test performed within the previous year. This finding was confirmed with the chief building engineer.	K 144		

Clara City Care Center Plan of Correction for LSC Survey that took place on 07/03/2014

K 144 A form from the Minnesota Department of Public Safety website related to generator testing was downloaded and adopted for use on 07/07/2014. This form has an area where the KW load is to be recorded for each monthly test. The Maintenance Supervisor will ensure that the generator is exercised at 30% or more of the EPS nameplate rating during each monthly test. The Administrator or Designee will audit the generator inspection forms for the next three months to ensure the KW load is recorded and that it was run at 30% or more of the EPS nameplate rating. If the results are found to be in compliance then the audit will be conducted quarterly.

Completion date for plan of correction will be 07/07/2014.