Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2025

Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, MN 56223

RE: CCN: 245551
Cycle Start Date: March 12, 2025

Dear Administrator:

On March 12, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by June 12, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 12, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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March 14, 2025

Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, MN 56223

Re: State Nursing Home Licensing Orders
Event ID: K94J11

Dear Administrator:

The above facility was surveyed on March 10, 2025 through March 12, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245551	A. BUILDING _____ B. WING _____	C 03/12/2025

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E 000	Initial Comments On 3/10/25 through 3/12/25, a survey for compliance with §483.73 Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is	E 039		3/18/25

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

Electronically Signed | 03/18/2025

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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E 039	Continued From page 1 community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or	E 039		

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E 039	Continued From page 2 (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from	E 039		

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E 039	Continued From page 3 engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the	E 039		

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E 039	Continued From page 4 onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2	E 039		

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E 039	Continued From page 5 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that	E 039		

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E 039	Continued From page 6 may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or	E 039		

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E 039	Continued From page 7 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is	E 039		

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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
E 039	Continued From page 8 led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group	E 039		

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	245551	A. BUILDING _____ B. WING _____	C 03/12/2025

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E 039	Continued From page 9 discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a full-scale community and/or individual facility-based exercise training program to test their emergency preparedness program. This had the potential to affect all 24 residents who currently resided in the facility, along with staff who work in the facility. Findings include: Interview on 3/12/25 at 4:53 p.m., with the administrator identified they had not completed any testing of their emergency preparedness plan since April of 2023. She confirmed she was aware the facility should be testing their emergency plan at least two times a year.	E 039	Plan of Correction for Deficiency E039 1. Deficiency Identification Deficiency Code: E039 Regulation/Standard Not Met: The facility failed to complete a full-scale community and/or individual facility-based exercise training program to test their emergency preparedness program. 2. Corrective Action for Residents Affected " Immediate Action Taken: " Conducted a tabletop exercise involving key staff members to simulate an emergency scenario and discuss response strategies. " Reviewed and updated emergency contact information for all 24 residents to ensure accuracy in case of an emergency. 3. Corrective Action for Other Residents " Identification and Protection Measures: " Conducted a risk assessment to identify any additional residents who may be vulnerable in an emergency situation. " Implemented interim safety measures, such as increased staff	

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E 039	Continued From page 10	E 039	presence during high-risk periods, until full-scale exercises are completed. 4. Systemic Changes " Policy Updates: " Revised the Emergency Preparedness Plan to include mandatory annual full-scale exercises. " Process Changes: " Established a partnership with local emergency services to facilitate joint training exercises. " New Protocols: " Developed a schedule for regular emergency drills, including both announced and unannounced exercises. 5. Monitoring and Quality Assurance " Methods for Monitoring: " Conduct quarterly audits of the emergency preparedness program to ensure compliance with updated protocols. " Collect feedback from staff and residents after each exercise to identify areas for improvement. 6. Responsible Parties " Implementation and Compliance: " Emergency Preparedness Coordinator: Responsible for organizing and overseeing all emergency exercises. " Director of Nursing: Ensures that all nursing staff are trained and participate in emergency drills. 7. Timelines " Deadlines: " Immediate Actions: Completed by	

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E 039	Continued From page 11	E 039	3/18/25. " Full-Scale Exercise: Scheduled for completion by 4/17/25. " Policy and Protocol Updates: Implemented by 3/24/25. 8. Training and Education " Staff Training Plans: " Conduct mandatory training sessions for all staff on the updated emergency preparedness protocols by 3/27/25. " Include emergency preparedness training in the orientation program for new hires. 9. Documentation " Record Maintenance: " Maintain detailed records of all exercises, including participant lists, scenarios, and outcomes. " Document all training sessions and attendance to ensure compliance with training requirements. 10. Follow-Up Plan " Assessment and Compliance: " Results of audits will be brought to QAA on 4/16/25 to determine compliance of the need for further monitoring monthly during QAA until compliance is determined. Results will be reviewed at quarterly QAPI meeting. " Schedule a follow-up review six months post-implementation to assess the effectiveness of corrective actions. " Conduct annual reviews of the emergency preparedness program to ensure ongoing compliance and improvement.	

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E 039	Continued From page 12	E 039	By implementing these corrective actions, the facility aims to enhance its emergency preparedness program and ensure the safety and well-being of all residents and staff.	
F 000	INITIAL COMMENTS On 3/10/25 through 3/12/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55519202C (MN105256) and H55519158C (MN105666). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		3/18/25

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F 580	Continued From page 13 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement	F 580		

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F 580	Continued From page 14 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed notify the provider of a change in condition timely for 1 of 1 resident (R25) reviewed for hospitalization. Findings include: R25's 12/18/24, quarterly Minimum Data Set (MDS) assessment identified R25 with diagnoses of congestive heart failure, hypertension and was cognitively intact. The MDS indicated R25 required substantial assistance with activities of daily ling and did not utilize oxygen. R25's February 2025, medication administration record lacked indication R25 utilized oxygen. The facility Standing Orders dated 7/26/24, included orders for oxygen at 2 liters per minute per nasal canular for complaints of shortness of breath or chest pain and call provider or ER if oxygen's saturation do not improve to 90% or above. The standing orders did not include order for increasing the oxygen higher than 2 liters. Review of R25's progress notes (PN) identified the following information: 1) PN dated 2/13/25 at 12:53 p.m., R25 complained of fatigue as well as coldness in her lower extremities. Her vital signs were blood pressure (BP)109/64, pulse (P) 110, temperature (T) 97.3, respirations (R) 15, and oxygen	F 580	Plan of Correction for Deficiency F580 1. Deficiency Identification Deficiency: The facility failed to notify the provider of a change in condition timely for 1 of 1 resident (R25) reviewed for hospitalization. Regulation/Standard Not Met: F580 - Notification of Changes 2. Corrective Action for Residents Affected " Immediate Action Taken: Upon identification of the deficiency, the facility immediately notified the provider of the change in condition for Resident R25. The resident's care plan was reviewed and updated to reflect the current condition and necessary interventions. 3. Corrective Action for Other Residents " Identification of Other Residents: A comprehensive review of all current residents' records was conducted to identify any other instances where a change in condition may not have been communicated timely. " Protective Measures: For any identified cases, immediate notification to the respective providers was made, and care plans were updated accordingly. 4. Systemic Changes " Policy Update: The facility's policy on	

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F 580	Continued From page 15 saturation (O2) 93%. Nursing staff encouraged R25 to be evaluated in the emergency room as R25's "BP [blood pressure] and HR [heart rate] have not been stable over the last 3-4 days." R25 had been offered to go to the emergency rooms, however, R25 refused. 2) PN dated 2/14/25 at 11:06 a.m., nurse was called to R25's room as R25 was unable to stand with assistance of staff or a sit to stand mechanical device. R25 reported feeling dizzy and light-headed vital signs were identified as BP 30/unknown, P 30, R17, T 97.0 F and O2 was at 86%. The writer contacted the emergency department (ER) and was advised to send resident to ER. 3) PN dated 2/14/25, at 3:29 p.m., a nurse- to-nurse report from the emergency room indicated R25 had been diagnosed with a bladder infection and would be returning to the facility. 4) PN dated 2/14/25 at 5:46 p.m., indicated R25 had returned to the facility at 4:55 p.m. 5) PN dated 2/15/25 at 5:35 p.m. indicated the night nurse had been placed on oxygen during the night. During the day morning hours, R25's oxygen saturation (amount of oxygen in the blood) was noted to be 91%. R25 had been alert and orientated before breakfast, however, began to show increased confusing after lunch. At 4:20 p.m. R25's vital signs were BP 118/77, P 118, R 20, T 97.7, O2 79%. The writer identified they had increased R25's oxygen to 3 LPM/NC (liters per minute per nasal cannula) and oxygen saturation increased to 86%, then increased to 4 LPM/NC and oxygen saturation increase to 89%, then increased to 5 LPM/NC and oxygen saturation increased to 90-91%. Now this afternoon R25 has been noted to have increased shortness of breath, be lethargic, has had no appetite today. Writer informed R25 she was sending her to the	F 580	"Notification of Changes" has been revised to include a mandatory checklist for staff to ensure timely communication with providers. " Process Changes: A new protocol has been established requiring double verification by nursing staff and a supervisor for any change in condition notifications. 5. Monitoring and Quality Assurance " Regular Audits: Weekly audits of resident records will be conducted to ensure compliance with the notification policy. " Data Collection: A log of all notifications made to providers will be maintained and reviewed monthly to identify any patterns or areas for improvement. 6. Responsible Parties " Implementation and Compliance: The Director of Nursing (DON) is responsible for overseeing the implementation of corrective actions and ensuring ongoing compliance with the notification policy. 7. Timelines " Immediate Actions: Completed by 3/18/25. " Systemic Changes: Policy updates and new protocols to be fully implemented by 3/24/25. " Monitoring Initiation: Audits and data collection to begin by 3/31/25. 8. Training and Education " Staff Training: All nursing staff will	

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F 580	Continued From page 16 ER and resident voiced understanding. The progress notes lacked identification of the night nurse's assessment and why or what circumstances lead to R25 being placed on facility standing orders. The progress notes further lacked the identified assessments of the vital signs being monitored throughout the day on 2/15/25 other than the one done at 4:20 p.m. Review of R25's blood pressure records identified on 2/14/25 at 8:10 a.m., R25's BP as 146/95, then on 2/15/25 at 7:08 a.m., BP as 178/149, and the last documented BP was on 2/15/25 at 7:12 a.m., of 113/72. There were no further documented blood pressure readings. During interview on 3/11/25 at 11:38 a.m., registered nurse (RN)-B indicated she had care for R25 on 2/15/25. licensed practical nurse (LPN)-A had placed R25 on oxygen around 5:00 a.m. RN-B stated she could not recall why R25, required oxygen, but R25 did not display any type of concerns during the morning shift. However, at 4:20 p.m. R25 began displaying respiratory distress and was transferred back to the hospital. Upon review of the record, RN-B confirmed the documentation lacked rational as to why R25 required oxygen at 5:00 a.m. and the physician was not notified. The record lacked further assessment of R25 during the day until R25 displayed signs of respiratory distress and was transferred back to the hospital. RN-B confirmed the provider had not been updated until R25 had been sent to the ER later that afternoon. During interview on 3/11/25 at 11:54 a.m., with RN-A identified when a resident was started on oxygen per the facility standing orders the nurse	F 580	undergo mandatory training on the updated "Notification of Changes" policy and procedures by 3/27/25. " Ongoing Education: Quarterly refresher courses will be scheduled to reinforce the importance of timely provider notifications. 9. Documentation " Record Maintenance: All corrective actions, including policy updates, training records, and audit results, will be documented and stored in the facility's compliance binder. " Compliance Demonstration: Documentation will be available for review during any future surveys or audits. 10. Follow-Up Plan " Effectiveness Assessment: A follow-up review will be conducted three months post-implementation to assess the effectiveness of the corrective actions. " Ongoing Compliance: The facility will continue to monitor compliance through regular audits and staff feedback to ensure sustained adherence to the notification policy. " Results of audits will be brought to QAA on 4/16/25 to determine compliance or the need for further monitoring monthly during QAA until compliance is determined. Results will be reviewed at quarterly QAPI meeting. By implementing these corrective actions, the facility aims to ensure timely notification of changes in residents' conditions, thereby enhancing the quality	

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F 580	Continued From page 17 should be updating the provider as that would be a change in condition. During interview on 3/11/25 at 4:05 p.m., with LPN-A identified she had missed documenting her assessment and vitals she obtained on R25 the morning of 2/15/25. She revealed she had placed R25 on oxygen per the facilities standing orders around 5:00 a.m., just before the change of shift. R25 had complained of being short of breath and her oxygen saturations were 88-89% and LPN-A reported she had asked R25 if she had used oxygen while at the hospital and she had said yes and that it had helped so she started her on the oxygen. LPN-A confirmed she had not updated the provider however, had reported the information to the day charge nurse. During interview on 3/11/25 at 2:20 p.m., with the administrator/director of nursing confirmed that if a nurse-initiated oxygen per the facility standing orders the nurse should update the provider of the change in condition. She would expect the provider to be updated and for the nurse to document their assessment of the resident in the resident's medical record. Review of undated, Notification of Changes policy identified times to promptly notify the resident's medical provider and representative of change in condition. The policy identified any time there was clinical complications or circumstances that required a need to alter the resident's treatment.	F 580	of care and maintaining compliance with CMS regulations.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the	F 644		3/18/25

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F 644	Continued From page 18 pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the designated State Mental Health Authority (SMHA) (Yellow Medicine County) for 1 of 1 resident (R11) with new onset mental illness. Findings include: R11's 12/11/24, annual Minimum Data Set (MDS) assessment indicated R11 had been admitted in October of 2022 and R11's cognition was intact. R11 had the diagnoses including atrial fibrillation, heart failure, hypertension, renal failure, diabetes, arthritis, dementia, depression, and psychotic disorder. R11 required substantial assistance with cares and received, antipsychotic, antidepressant, diuretic, and antiplatelet medications. R11's diagnosis list printed 3/10/25, identified new	F 644	Plan of Correction for Deficiency F644 1. Deficiency Identification Citation: F644 Regulation/Standard Not Met: The facility failed to notify the designated State Mental Health Authority (SMHA) for a resident with new onset mental illness, as required by federal regulations. 2. Corrective Action for Residents Affected " Resident Affected: R11 " Immediate Actions Taken: " The facility immediately notified the designated State Mental Health Authority (Yellow Medicine County) regarding R11's new onset mental illness. " A comprehensive mental health assessment was conducted for R11 to ensure appropriate care and interventions are in place.	

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F 644	Continued From page 19 diagnoses which included unspecified mood affective disorder diagnosed on 5/24/23, unspecified psychosis not due to a substance or known physiological condition diagnosed on 8/6/23, and restlessness and agitation diagnosed on 8/16/23. R11's care plan printed 3/10/25, indicated R11 was dependent on staff for meeting his emotional, intellectual, physical, and social needs related to unspecified psychosis, major depression, and dementia. R11 displayed behaviors of being sexually inappropriate, yelling, arguing with staff, swearing, refusing cares, hallucinations, delusion, wandering, and using abusive language that was initiated on 5/26/23. R11 had delirium or an acute confusional episode related to unspecified psychosis and received an antipsychotic medication that was initiated 12/15/23. R11's 10/25/22, Initial Pre-Admission Screening (PAS) results identified a diagnosis of depression and did not indicate the need for a Level II PASARR to be completed. The record lacked documentation which would indicate the local mental health authority had evaluated R11 for appropriate placement via a level II (Resident Review) following the new diagnoses of unspecified mood disorder, unspecified psychosis, restlessness and agitation. During interview on 3/11/25 at 2:54 p.m., with registered nurse (RN)-A confirmed R11 had received a PAS upon admission to the facility, which indicated he did not require a level II screening. However, confirmed while in residing at the facility, R11 had received new mental health diagnoses. The facility did not notify the	F 644	" R11's care plan was updated to reflect the new diagnosis and interventions. 3. Corrective Action for Other Residents " Identification of Other Residents: " Conducted a review of all current residents to identify any other individuals with new onset mental illness who may not have been reported to the SMHA. " Measures Taken: " Any additional residents identified were promptly reported to the SMHA. " Care plans for these residents were reviewed and updated as necessary. 4. Systemic Changes " Policy Updates: " Revised the facility's policy on mental health reporting to ensure timely notification to the SMHA for any resident with new onset mental illness. " Process Changes: " Implemented a standardized checklist for new diagnoses that includes a step for notifying the SMHA. " New Protocols: " Established a protocol for regular review of residents' mental health status during interdisciplinary team meetings. 5. Monitoring and Quality Assurance " Methods for Monitoring: " Conduct monthly audits of resident records to ensure compliance with SMHA notification requirements. " Utilize a tracking system to document notifications made to the SMHA. " Quality Assurance Activities: " Quarterly review of audit results by	

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F 644	Continued From page 20 local mental health authority to request a resident review to determine if R11 required additional mental health services. RN-A she was unaware residents who received a new diagnosis of a mental health disease were to be re-evaluated by the local mental health authority. During interview on 3/12/25 at 8:01 a.m., with the administrator/director of nursing who confirmed if a resident received a new mental health diagnosis the local authority should be contacted to complete a level II screening. She was unaware that RN-A was not aware she needed to contact the local mental health authority. Review of the undated, Resident Assessment-Coordination with PASARR Program Policy identified the facility would coordinate assessments to ensure individuals with a mental disorder or related condition received care and services in the most integrated setting appropriate to the resident needs. The social service or designee would be responsible for resident PASARR screening and referring to the appropriate authority. The facility would reach out to the appropriate authority for any resident that received a new mental health disorder or condition not previously identified on the initial PAS for a level II screening.	F 644	the Quality Assurance Committee to identify trends and areas for improvement. 6. Responsible Parties " Implementation and Compliance: " Director of Nursing (DON) is responsible for overseeing the implementation of corrective actions. " Social Services Director is responsible for ensuring notifications to the SMHA are completed. 7. Timelines " Immediate Actions: Completed by 3/18/25. " Systemic Changes: Implemented by 3/24/25. " Monitoring and Quality Assurance: Ongoing, with initial review by 3/31/25. 8. Training and Education " Staff Training: " Conducted training sessions for all nursing and social services staff on the updated mental health reporting policy and procedures. " Training to be completed by 3/27/25. " Education Materials: " Distributed educational materials outlining the importance of timely SMHA notifications. 9. Documentation " Record Maintenance: " All corrective actions and notifications to the SMHA will be documented in the residents' medical records. " Maintain a log of all SMHA notifications for audit purposes.	

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F 644	Continued From page 21	F 644	10. Follow-Up Plan " Assessment of Effectiveness: " Conduct a follow-up audit three months post-implementation to assess the effectiveness of corrective actions. " Report findings to the Quality Assurance Committee for further action if necessary. " Ongoing Compliance: " Regularly scheduled audits and reviews to ensure continued compliance with SMHA notification requirements. " Results of audits will be brought to QAA on 4/16/25 to determine compliance or the need for further monitoring monthly during QAA until compliance is determined. Results will be reviewed at quarterly QAPI meeting.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to assess, investigate, and document for 1 of 1 resident (R11) who had a newly identified burn. Findings include:	F 689	Plan of Correction for Deficiency F689 1. Deficiency Identification Citation: F689 - The facility failed to assess, investigate, and document a newly identified burn for 1 of 1 resident (R11). This is a violation of the regulation	3/18/25

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F 689	Continued From page 22 R11's 12/11/24, annual Minimum Data Set (MDS) assessment identified R11 had been admitted in October of 2022 and R11's cognition was intact. R11 required substantial assistance with cares and had pain that he rated a 5 on scale of 1-10. R11 took a scheduled pain, antipsychotic, antidepressant, diuretic, and antiplatelet medication. R11 was on oxygen. R11 had the diagnoses of atrial fibrillation, heart failure, hypertension, renal failure, diabetes, arthritis, dementia, depression, and psychotic disorder. Review of R11's Skin Assessments identified: 1) 7/18/24, skin issue identified as other located on left gluteal fold. Area has 2 small open areas each measuring 0.5 cm x 0.5 cm a Mepilex dressing was applied. This was identified as the first observation. 2) 12/18/24, skin issue identified as burn located on upper right side of chest. The area measured 2 cm x 2.5 cm and scabbed. Note of assessment identified that on 12/18/24 residents obtained a burn to right upper chest, redness now surrounds the areas, resident was seen by provider on 12/19/24 and ordered Bacitracin. This was identified as the first observation. 3) 12/25/24, skin issue identified as burn located on upper right side of chest. The area measured 2 cm x 2.3 cm scabbed area, improving. 4) 1/2/25, skin issue identified as burn located on upper right side of chest. The area measured 2 cm x 2.3 cm scabbed area, improving. 5) 1/22/25, skin issue identified as burn located on upper right side of chest. The area measured 0.2 cm x 0.2 cm irregular shaped scab, improving. There were no more skin assessments located in R11's medical record.	F 689	requiring facilities to ensure that residents receive adequate supervision and assistance devices to prevent accidents. 2. Corrective Action for Residents Affected " Immediate Assessment: Resident R11 was immediately assessed by the nursing staff to evaluate the severity of the burn and determine appropriate medical treatment. " Medical Treatment: R11 received necessary medical care, including wound cleaning and dressing, and was monitored for signs of infection or complications. " Documentation: The incident was documented in R11's medical record, including the assessment, treatment provided, and any follow-up care required. 3. Corrective Action for Other Residents " Resident Review: Conducted a review of all residents to identify any other individuals who may have similar unreported injuries. " Preventive Measures: Implemented additional safety checks and supervision for residents at risk of burns or similar injuries. 4. Systemic Changes " Policy Update: Revised the facility's policy on incident reporting to include specific procedures for assessing, investigating, and documenting burns and other injuries. " Process Change: Introduced a new protocol requiring immediate notification of the nursing supervisor and medical director upon identification of any resident	

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F 689	Continued From page 23 Review of R11's progress notes between 12/12/24 through 3/10/25 had no mention of R11 having a burn on his right upper chest. Interview on 3/10/25 at 5:58 p.m., with administrator/director of nursing identified that a nursing assistant had reported to RN-A that there was a area of concern on R11's chest. RN-A had thought that the nurse who was originally told had made a progress note but I guess they did not. She reported that RN-A had investigated how R11 got the burn and that they had discussed it at their interdisciplinary team meeting (IDT). She confirmed that there was no incident report completed for the injury and there should have been. She further confirmed the last skin assessment completed for R11 was done on 1/22/25 and she was unsure why there had been no further skin assessments completed as that one identified the area was still open. Interview on 3/10/25 at 6:47 p.m., with registered nurse (RN)-A identified a nursing assistant that no longer worked at the facility had reported the burn to the nurse that was on duty which she could not recall who that was. She revealed the nurse should have documented the assessment of the burn and made an incident report. She revealed she should have followed up and made sure there had been documentation of the burn and an incident report completed but she had not done that. She further identified she should have documented further on R11's skin assessment that the burn had healed confirming she just stopped the skin assessments. R11's provider did order Bacitracin for the burn but identified that also had not been documented in R11's progress notes.	F 689	injury. 5. Monitoring and Quality Assurance " Regular Audits: Conduct weekly audits of resident records to ensure compliance with the updated incident reporting policy. " Data Collection: Track and analyze data on resident injuries to identify trends and areas for improvement. 6. Responsible Parties " Nursing Supervisor: Responsible for overseeing the implementation of corrective actions and ensuring compliance with the updated policy. " Quality Assurance Committee: Tasked with monitoring the effectiveness of corrective actions and reporting findings to facility leadership. 7. Timelines " Immediate Actions: Completed by 3/18/25. " Systemic Changes: Implemented by 3/24/25. " Monitoring Activities: Ongoing, with initial review by 3/31/25. 8. Training and Education " Staff Training: Conduct mandatory training sessions for all nursing and care staff on the updated incident reporting policy and procedures for assessing and documenting resident injuries. " Education Materials: Distribute educational materials outlining the importance of timely and accurate documentation of resident injuries.	

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F 689	Continued From page 24 Review of 12/19/24, physician order identified provider ordered Bacitracin twice a day to right chest. The order lacked reason for Bacitracin order and an end date. Review of R11's undated, care plan identified the facility had not made revisions follow R11's burn incident to include interventions to prevent further incidents. Interview on 3/10/25 at 7:09 p.m., with R11 who revealed he got a burn on his shoulder area. He reported it was from one of those hand warmers that you stick in your gloves. He revealed he got the hand warmer from another resident and had used it to try to loosen the muscle in his shoulder area. He reported that the nurse did come and look at the burn and told him he could not use that hand warmer. He reported the nurse looked at it about 2 weeks ago, but it has been healed now for a while. Interview on 3/11/25 at 2:20 p.m., with administrator/director of nursing identified she would expect if an injury such as a burn was identified the nurse would assess the burn, investigate how it occurred, document the findings and notify the provider and family. Review of the undated, When to Notify for All Licensed Nurses, protocol identified that the nurse should notify the administrator/director of nursing, the assistant director of nursing immediately when an incident with a serious injury occurred such as burns, major lacerations, head injury, hematoma etc. ...prior to filing a State Agency report as there was only 2 hours to report timely.	F 689	9. Documentation " Record Keeping: Maintain detailed records of all corrective actions taken, including training attendance logs, audit results, and policy updates. " Compliance Evidence: Store documentation in a centralized location for easy access during future surveys or inspections. 10. Follow-Up Plan " Effectiveness Assessment: Conduct a follow-up review within 60 days to evaluate the effectiveness of the corrective actions and make any necessary adjustments. " Results of audits will be brought to QAA on 4/16/25 to determine compliance or the need for further monitoring monthly during QAA until compliance is determined. Results will be reviewed at quarterly QAPI meeting. " Ongoing Compliance: Schedule quarterly reviews to ensure continued compliance with the updated policies and procedures. By implementing these corrective actions, the facility aims to address the identified deficiency and prevent future occurrences, ensuring the safety and well-being of all residents.	

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F 689	Continued From page 25 Review of 2/15/24, Accidents and Incidents Investigating and Recording policy identified regardless of incident or accident, including injuries of an unknown source, staff must report to the department supervisor and fill out an accident or incident report form on the shift the accident or incident occurred. The nurse should assess the resident and notify the provider of the incident or accident. The policy identified the details that were required to be documented under risk management that included that the resident's care plan needed to be updated with immediate interventions.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow physician orders for 1 of 2 residents (R7) reviewed for oxygen therapy. Findings include: R7's significant change Minimum Data Set (MDS) dated 1/15/25, identified R7 was cognitively intact and had diagnoses of chronic respiratory failure	F 695	Plan of Correction for Deficiency F695 1. Deficiency Identification Deficiency: The facility failed to follow physician orders for oxygen therapy for 1 of 2 residents (R7) reviewed. Regulation/Standard: F695 - Respiratory/Tracheostomy Care and Suctioning 2. Corrective Action for Residents Affected	3/18/25

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F 695	Continued From page 26 and pneumonia. R7 used oxygen therapy. R6's undated care plan identified the goal was to have no signs or symptoms of poor oxygen absorption. Interventions were for staff to administer medication as ordered, monitor effectiveness and side effects, elevate head of bed to prevent shortness of breath when lying flat, maintain a clear airway and instruct R7 to clear her own secretions with effective coughing, to use humidified oxygen of 1 to 2 liters (L) as needed, and to keep oxygen (O2) greater than 90%. R7's Order Summary Report printed 3/10/25, identified R7 was to receive oxygen via nasal cannula (flexible tube that enters your nose to deliver oxygen) continuously at 2 LPM (liters per minute) starting 12/16/24. During observation on 3/10/25 at 11:04 a.m., R7 sat in her recliner with nasal cannula in her nose and the tubing was connected to the oxygen concentrator. The oxygen flow meter was set at 2.5 liters. During observation and interview on 3/10/25 at 12:04 p.m., licensed practical nurse (LPN)-B stated R7 was to receive 2 liters of oxygen. LPN-B observed R7's oxygen flow meter, and voiced it was set at 2.5 LPM. LPN-B decreased the flow rate to 2 LPM. She identified staff nurses were to check and identify appropriate oxygen settings on each shift and to follow physician orders for oxygen use. During interview on 3/12/25 at 5:33 p.m., director of nursing stated they expected staff nurses to follow oxygen orders as directed by the primary physician.	F 695	" Immediate Action for R7: " The physician was immediately notified of the oversight in oxygen therapy administration. " R7's oxygen therapy was adjusted to align with the physician's orders. " R7 was monitored closely for any adverse effects due to the deviation from prescribed therapy. 3. Corrective Action for Other Residents " Identification and Protection: " Conducted a review of all residents receiving oxygen therapy to ensure compliance with physician orders. " Adjusted oxygen therapy for any residents found to have discrepancies between physician orders and actual administration. " Implemented additional monitoring for these residents to ensure their safety and well-being. 4. Systemic Changes " Policy Updates: " Revised the oxygen therapy administration policy to include a double-check system for verifying physician orders. " Process Changes: " Introduced a mandatory checklist for nursing staff to confirm oxygen settings at each shift change. " New Protocols: " Established a protocol for immediate physician notification if discrepancies in oxygen therapy are identified. 5. Monitoring and Quality Assurance	

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F 695	Continued From page 27 Review of current, undated Oxygen Administration policy identified staff nurses were responsible for resident's safety with oxygen use. In addition, staff nurses were to administer oxygen therapy under the direction of physician orders. Lastly, staff nurses were to verify and check oxygen equipment to ensure oxygen concentrator equipment and safety checks were completed.	F 695	" Regular Audits: " Conduct weekly audits of oxygen therapy administration records to ensure compliance with physician orders. " Data Collection: " Track and analyze data on oxygen therapy discrepancies to identify trends and areas for improvement. " Ongoing Quality Assurance: " Include oxygen therapy compliance as a standing agenda item in monthly quality assurance meetings. 6. Responsible Parties " Implementation and Compliance: " Director of Nursing (DON) is responsible for overseeing the implementation of corrective actions. " Charge Nurses are responsible for daily compliance checks and reporting any issues to the DON. 7. Timelines " Immediate Actions: " Corrective actions for R7 and other affected residents were completed within 24 hours of identification. " Systemic Changes: " Policy updates and new protocols were implemented within 7 days. " Monitoring: " Regular audits and quality assurance activities commenced immediately and will continue indefinitely. 8. Training and Education " Staff Training: " Conducted mandatory training sessions for all nursing staff on the	

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F 695	Continued From page 28	F 695	updated oxygen therapy policy and procedures. " Provided additional education on the importance of adhering to physician orders and the potential risks of non-compliance. 9. Documentation " Record Keeping: " Maintained detailed records of all corrective actions taken, including training attendance logs and audit results. " Documentation is stored securely and is readily available for review by regulatory bodies. 10. Follow-Up Plan " Effectiveness Assessment: " Results of audits will be brought to QAA on 4/16/25 to determine compliance or the need for further monitoring monthly during QAA until compliance is determined. Results will be reviewed at quarterly QAPI meeting. " Conduct a follow-up review in 30 days to assess the effectiveness of the corrective actions and make adjustments as necessary. " Ongoing Compliance: " Schedule quarterly reviews to ensure sustained compliance with physician orders for oxygen therapy.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755		3/18/25

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F 755	Continued From page 29 them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to coordinate with the provider and pharmacy to ensure a prescribed medication was available and administered for 1 of 1 residents (R10) reviewed who did not receive ordered medication. Findings include:	F 755	Plan of Correction for Deficiency F755 1. Deficiency Identification Deficiency Code: F755 Regulation/Standard Not Met: The facility failed to coordinate with the provider and pharmacy to ensure a prescribed medication was available and administered for 1 of 1 residents (R10) reviewed who did not receive ordered	

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F 755	Continued From page 30 R10's 2/26/25, quarterly Minimum Data Set (MDS) assessment identified R10's cognition was intact. R10 had no behaviors and required assistance with cares. R10 was frequently incontinent of urine. R10 was on a scheduled pain medication and rated her pain a 4 on scale of 1-10. She had no skin concerns and took a daily antidepressant, blood thinner, and diuretic (water pill). R10 was on oxygen therapy and planned to remain in the facility. Interview on 3/10/25 at 12:34 p.m., with R10 identified she had a yeast infection that was not resolved yet. She reported she was to be getting Monistat but had not received that for the last 2 weeks as staff told her they had to get a new order. In the meantime, she reported she itched, and it hurt when she voided. Review of progress notes identified: 2/19/25, communication with provider, R10 continues to complain of burning and itching in vaginal area. Question if she would benefit from Monistat cream. 2/20/25, received order for Monistat care instant itch relief external cream 1%, apply to vaginal area topically two times a day for vaginal itching and change to as needed when clear. 2/21/25, Monistat 1% cream no prescription. 2/28/25, Monistat 1% cream no prescription. 3/1/25, Monistat 1% cream no prescription. 3/2/25, Monistat 1% cream no prescription. 3/3/25, Monistat 1% cream no prescription. 3/4/25, Monistat 1% cream no prescription. 3/5/25, Monistat 1% cream no prescription. 3/6/25, Monistat 1% cream no prescription. 3/7/25, Monistat 1% cream no prescription. 3/8/25, Monistat 1% cream unavailable, pharmacy was awaiting new prescription from	F 755	medication. 2. Corrective Action for Residents Affected • Immediate Action Taken for Resident R10: • Contacted the prescribing provider and pharmacy to expedite the delivery of the missing medication. • Administered the medication to Resident R10 as soon as it was available. • Conducted a health assessment of Resident R10 to ensure no adverse effects occurred due to the missed dose. 3. Corrective Action for Other Residents • Identification and Protection Measures: • Conducted a review of all current residents' medication orders to identify any other potential discrepancies or delays in medication administration. • Ensured all identified residents received their medications promptly. • Established a temporary protocol for daily checks of medication availability for all residents until systemic changes are fully implemented. 4. Systemic Changes • Policy and Process Updates: • Revised the medication management policy to include a mandatory verification step for medication availability upon receipt of new orders. • Implemented a new protocol for immediate communication with the pharmacy and provider if a medication is not available within 24 hours of the order. • Introduced a checklist for nursing staff	

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F 755	Continued From page 31 provider and will send when received. 3/9/25, Monistat 1% cream no prescription. 3/10/25, Monistat 1% cream no prescription. 3/11/25, provider communication that R10 had complained of itching in her vaginal area and had pain when voiding. Provider ordered Monistat for 10 days. 3/11/25, resident seen by provider during routine rounds. Resident continues to complain of burning and itching. Resident reported that the Monistat did not help but then asked the provider for Monistat. R10 reported that she had never complained of burning and itching since she had been a resident there. The provider discontinued the order for Monistat and ordered Estradiol gel nightly for 2 weeks. Review of R10's February 2025, Administration Record identified Monistat Care Instant Itch Relief external cream 1%, apply to vaginal area typically two times a day for vaginal itching and change to as needed when clear. Charted administered 2/21/25, through 2/27/25, then charted as other 'see progress note' on 2/28/25. R10's March 2025, Administration Record identified Monistat Care Instant Itch Relief external cream 1% was charted as 'other see progress note' 3/1/25 through 3/11/25. During interview on 3/11/25 at 2:13 p.m., trained medication assistant (TMA)-A identified that the facility had the Monistat for R10 but then ran out and they could not get any more. She reported they were to fax the pharmacy a week before a resident runs out of a medication, and if they did not get that medication in from the pharmacy, they were to notify the charge nurse who then contacted the pharmacy.	F 755	to confirm medication availability during each shift change. 5. Monitoring and Quality Assurance • Monitoring Methods: • Conduct weekly audits of medication administration records to ensure compliance with the updated policy. • Collect and analyze data on medication availability and administration timeliness. • Report findings to the Quality Assurance and Performance Improvement (QAPI) committee monthly. 6. Responsible Parties • Implementation and Compliance: • Director of Nursing (DON) is responsible for overseeing the implementation of corrective actions and ensuring ongoing compliance. • Nursing staff are responsible for adhering to the updated medication management protocols. 7. Timelines • Deadlines for Completion: • Immediate corrective actions for Resident R10 were completed on 3/11/25. • Systemic changes to be fully implemented by 3/24/25. • Initial staff training to be completed by 3/20/25. 8. Training and Education • Staff Training Plans: • Conducted training sessions for all nursing staff on the revised medication management policy and new protocols.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245551	A. BUILDING _____ B. WING _____	C 03/12/2025

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

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F 755	Continued From page 32 During interview on 3/11/25 at 2:20 p.m., administrator/director of nursing identified that licensed practical nurse (LPN)-B had been dealing with the pharmacy related to getting R10's Monistat. The pharmacy had sent a very small tube, and it ran out right away. The pharmacy kept saying they needed a new prescription. During interview on 3/11/25 at 2:41 p.m., LPN-B reported R10 had an order for Monistat, and according to the pharmacy, they only had an order for as needed (PRN) and the pharmacy was waiting on a new prescription from the clinic before they sent out another tube of Monistat. She revealed she did not know if anyone from the facility had reached out to R10's provider for a new prescription. She identified if the facility did not have a medication supply, they were to reach out to pharmacy first and then the pharmacy usually reached out to the clinic. If the facility still did not receive the ordered medication the facility was to reach out to the provider. A policy related to what staff were to do if a medication supply was not available was requested however, the administrator/director of nursing reported the facility did not have one.	F 755	• Provided additional education on the importance of timely medication administration and coordination with providers and pharmacies. 9. Documentation • Record Maintenance: • Documented all corrective actions taken in Resident R10's medical record. • Maintained records of staff training sessions, including attendance and training materials. • Kept detailed logs of audits and quality assurance activities related to medication management. 10. Follow-Up Plan • Assessment and Compliance Assurance: • Schedule follow-up audits every three months to assess the effectiveness of the corrective actions. • Review and update the medication management policy annually or as needed based on audit findings. • Report ongoing compliance and any issues to the QAPI committee for further action.	

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	00842	A. BUILDING: _____ B. WING _____	C 03/12/2025

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/10/25 through 3/12/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/18/25

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H55519202C (MN105256), H55519158C (MN105666). NO citations were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		

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	245551	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/11/2025**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/11/2025. At the time of this survey, Clarkfield Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/18/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Clarkfield Care Center is a 1-story building with partial basement. The building was constructed at 4 different times. The original building was constructed in 1955 and was determined to be of Type II(111) construction. In 1958 an addition was constructed and was determined to be of Type II(111) construction. In 1970, an addition was constructed and determined to be of Type II(111) construction. The most recent addition was constructed in 2004 and determined to be of Type II(111) construction.	K 000		

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K 000	Continued From page 2 This facility was surveyed as one building under the 2012 Life Safety Code. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is monitored for automatic fire department notification. The facility has a capacity of 30 beds and had a census of 25 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire alarm out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 346	Plan of Correction for Deficiency K346 1. Deficiency Identification Deficiency: The facility failed to implement a fire alarm out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. Tag Identifier: K346 2. Corrective Action for Residents Affected	3/18/25

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K 346	Continued From page 3 On 03/11/2025 between 09:30 AM and 12:00 PM, it was revealed by review of available documentation that the fire alarm system out-of-service policy was incomplete and did not list the appropriate safety measures to follow. An interview with the Environmental Service Director verified this deficient finding at the time of discovery.	K 346	• Immediate Action Taken: Upon identification of the deficiency, the facility immediately conducted a manual fire watch to ensure resident safety until the fire alarm system was fully operational. • Notification: All affected residents and their families were informed of the situation and the measures being taken to ensure their safety. 3. Corrective Action for Other Residents • Assessment: A comprehensive assessment was conducted to identify any other residents who might be affected by the fire alarm system's out-of-service status. • Protection Measures: Additional fire safety measures, including increased staff presence and manual fire watches, were implemented throughout the facility to protect all residents. 4. Systemic Changes • Policy Update: The facility's fire safety policy was updated to include a detailed fire alarm out-of-service protocol in compliance with NFPA 101, section 9.6.1.6. • Process Changes: A new process was established for immediate notification and implementation of fire watches whenever the fire alarm system is out of service. • Protocol Development: Developed a checklist for staff to follow in the event of a fire alarm system failure. 5. Monitoring and Quality Assurance • Regular Audits: Monthly audits will be	

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K 346	Continued From page 4	K 346	conducted to ensure compliance with the updated fire safety policy. • Data Collection: Incident reports and fire watch logs will be reviewed weekly to monitor adherence to the new protocols. • Quality Assurance Meetings: Quarterly quality assurance meetings will include a review of fire safety compliance. 6. Responsible Parties • Fire Safety Officer: Responsible for implementing corrective actions and ensuring compliance with fire safety protocols. • Maintenance Supervisor: Ensures the fire alarm system is regularly tested and maintained. • Facility Administrator: Oversees the overall compliance and effectiveness of the corrective actions. 7. Timelines • Immediate Actions: Completed by 3/12/25. • Policy and Process Updates: Completed by 3/24/25. • Staff Training: Completed by 3/27/25. • First Audit: Scheduled for 4/1/25. 8. Training and Education • Staff Training Sessions: Conducted for all staff on the updated fire safety policy and procedures, including fire alarm out-of-service protocols. • Ongoing Education: Regular refresher courses will be scheduled bi-annually to ensure continued compliance and awareness.	

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K 346	Continued From page 5	K 346	9. Documentation • Record Keeping: All corrective actions, training sessions, and audits will be documented and maintained in the facility's compliance records. • Compliance Binder: A dedicated compliance binder will be created to store all relevant documentation related to fire safety protocols. 10. Follow-Up Plan • Effectiveness Assessment: A follow-up assessment will be conducted six months post-implementation to evaluate the effectiveness of the corrective actions. • Continuous Improvement: Feedback from audits and assessments will be used to make continuous improvements to the fire safety protocols. • Annual Review: An annual review of the fire safety policy and procedures will be conducted to ensure ongoing compliance with NFPA 101 standards.	
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion	K 354		3/18/25

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K 354	Continued From page 6 of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire sprinkler out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, and 9.7.5, and NFPA 25 (2010 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/11/2025 between 09:30 AM and 12:00 PM, it was revealed by review of available documentation that the sprinkler system out-of-service policy was incomplete and did not list the appropriate safety measures to follow. An interview with the Environmental Service Director verified this deficient finding at the time of discovery.	K 354	Plan of Correction for Deficiency K354 1. Deficiency Identification The facility failed to implement a fire sprinkler out-of-service policy as required by NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, and 9.7.5, and NFPA 25 (2010 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2. This deficiency could potentially have a widespread impact on the residents within the facility. 2. Corrective Action for Residents Affected • Immediate Actions Taken: • Conducted a thorough inspection of the fire sprinkler system to ensure it is fully operational. • Implemented temporary fire watch measures to ensure resident safety until the sprinkler system was confirmed to be in service. • Notified all residents and staff of the temporary fire watch and the measures being taken to ensure safety. 3. Corrective Action for Other Residents • Identification and Protection Measures: • Reviewed the fire safety status of all facility areas to identify any other potential risks. • Extended the temporary fire watch to	

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K 354	Continued From page 7	K 354	cover all areas of the facility until the sprinkler system was verified to be fully functional. • Communicated with residents and families about the steps being taken to ensure safety. 4. Systemic Changes • Policy and Process Updates: • Developed and implemented a comprehensive fire sprinkler out-of-service policy in accordance with NFPA 101 and NFPA 25 standards. • Established a protocol for immediate notification and implementation of fire watch procedures in the event of sprinkler system issues. • Updated the facility's emergency preparedness plan to include detailed procedures for handling fire protection system outages. 5. Monitoring and Quality Assurance • Monitoring Methods: • Conduct regular audits of the fire sprinkler system to ensure compliance with NFPA standards. • Implement a monthly review of fire safety protocols and equipment functionality. • Utilize a checklist to document compliance with the new fire sprinkler out-of-service policy. 6. Responsible Parties • Implementation and Compliance: • The Maintenance Director is responsible for ensuring the fire sprinkler system is operational and compliant.	

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CLARKFIELD CARE CENTER	**805 FIFTH STREET, BOX 458** **CLARKFIELD, MN 56223**

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K 354	Continued From page 8	K 354	• The Safety Officer will oversee the implementation of the new policy and conduct regular audits. • The Administrator will ensure all corrective actions are completed and documented. 7. Timelines • Deadlines for Completion: • Immediate corrective actions were completed by 3/12/25. • Systemic changes and policy updates will be fully implemented by 3/24/25. • Regular audits and monitoring will commence by 4/1/25. 8. Training and Education • Staff Training Plans: • Conduct training sessions for all staff on the new fire sprinkler out-of-service policy by 3/27/25. • Provide ongoing education on fire safety protocols and emergency preparedness. • Ensure all new hires receive training on fire safety and the updated policies during orientation. 9. Documentation • Record Keeping: • Maintain detailed records of all inspections, audits, and corrective actions taken. • Document staff training sessions and attendance. • Keep a log of any fire watch activities and notifications to residents and families. 10. Follow-Up Plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245551	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/11/2025**

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K 354	Continued From page 9	K 354	• Assessment and Compliance: • Schedule follow-up audits to assess the effectiveness of the corrective actions by 4/15/25. • Review and update the fire safety plan annually or as needed based on audit findings. • Report findings and any further actions required to the facility's Quality Assurance Committee. By implementing these corrective actions and systemic changes, the facility aims to ensure compliance with NFPA standards and enhance the safety and well-being of all residents.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.2.5.3.8 and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.1.2. This deficient finding could have a isolated impact on the residents within the facility. Findings include:	K 355	Plan of Correction for Deficiency K355 1. Deficiency Identification Deficiency: The facility failed to inspect fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.2.5.3.8 and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.1.2. Tag Identifier: K355 2. Corrective Action for Residents Affected	3/18/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245551	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/11/2025**

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K 355	Continued From page 10 On 03/11/2025 between 09:30 AM and 12:00 PM, it was revealed by observation that the class K extinguisher in the kitchen had not been inspected monthly. An interview with the Environmental Service Director verified this deficient finding at the time of discovery.	K 355	• Immediate Inspection: All fire extinguishers within the facility were immediately inspected by a certified fire safety technician to ensure they are in proper working order. • Replacement and Servicing: Any fire extinguishers found to be non-compliant or expired were replaced or serviced immediately. 3. Corrective Action for Other Residents • Facility-Wide Inspection: A comprehensive inspection of all fire extinguishers throughout the facility was conducted to ensure compliance with NFPA standards. • Resident Safety Assurance: Residents were informed of the corrective actions taken to ensure their safety and the facility's compliance with fire safety standards. 4. Systemic Changes • Policy Update: The facility's fire safety policy was updated to include a detailed schedule for monthly inspections of all fire extinguishers. • Inspection Log: A new inspection log was created to document the date, time, and results of each fire extinguisher inspection. 5. Monitoring and Quality Assurance • Regular Audits: Monthly audits will be conducted by the maintenance supervisor to ensure all fire extinguishers are inspected and compliant. • Quarterly Reviews: The safety committee will review inspection logs	

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K 355	Continued From page 11	K 355	quarterly to ensure ongoing compliance and address any issues promptly. 6. Responsible Parties • Maintenance Supervisor: Responsible for conducting monthly inspections and maintaining the inspection log. • Safety Committee Chair: Oversees the quarterly review of inspection logs and ensures compliance with fire safety standards. 7. Timelines • Immediate Actions: Completed by 3/12/25. • Systemic Changes Implementation: Completed by 3/24/25. • Ongoing Monitoring: Monthly audits to begin by 3/31/25. 8. Training and Education • Staff Training: All maintenance staff will receive training on the updated fire safety policy and proper inspection procedures by 3/24/25. • Annual Refresher Course: An annual refresher course on fire safety and extinguisher inspection will be conducted for all relevant staff. 9. Documentation • Inspection Records: All inspection logs and maintenance records will be maintained in a centralized location for easy access and review. • Training Records: Documentation of staff training sessions, including attendance and materials covered, will be kept on file.	

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K 355	Continued From page 12	K 355	10. Follow-Up Plan • Effectiveness Assessment: The safety committee will conduct a follow-up assessment six months after implementation to evaluate the effectiveness of the corrective actions. • Continuous Improvement: Feedback from the follow-up assessment will be used to make any necessary adjustments to the fire safety program.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 1, 2025

Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, MN 56223

RE: CCN: 245551
Cycle Start Date: March 12, 2025

Dear Administrator:

On May 1, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 1, 2025

Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, MN 56223

Re: Reinspection Results
Event ID: K94J12

Dear Administrator:

On May 1, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 12, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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