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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LHTZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00842

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **5/5/2020** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **36** (L18)
13.Total Certified Beds **36** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	36			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Nicole Osterloh, Supervisor 5/7/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 5/7/2020 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 7, 2020

CMS Certification Number (CCN): 245551

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

Dear Administrator:

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

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

Effective March 31, 2020 the above facility is certified for:

36 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 36 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
May 7, 2020

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

RE: CCN: 245551
Cycle Start Date: January 16, 2020

Dear Administrator:

On May 5, 2020, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LHTZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00842

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(L3) **CLARKFIELD CARE CENTER**
(L4) **805 FIFTH STREET, BOX 458**
(L5) **CLARKFIELD, MN** (L6) **56223**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/16/2020** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	36			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Charity Borresen, HFE NE II 02/24/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 02/28/2020 (L20)

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

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

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3. Both of the Above :
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01/01/1991
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23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

February 12, 2020

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

RE: CCN: 245551
Cycle Start Date: January 16, 2020

Dear Administrator:

On January 16, 2020, 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

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 April 16, 2020 (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 July 16, 2020 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 01/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 1/13/19 through 1/16/19 during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The	E 006		1/22/20

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

Electronically Signed | 02/21/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245551	A. BUILDING _____ B. WING _____	C 01/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 006	Continued From page 1 plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain an emergency preparedness program that was reviewed and updated at least annually. Findings include: Review of the emergency preparedness plan lacked evidence of an annual review and update of policies and procedures. The emergency preparedness policy had dates ranging from October 2018 to November 2018. Interview on 1/15/19 at 3:00 p.m., the administrator identified that no annual review had	E 006	The Emergency Preparedness Plan 1/22/2020 was reviewed and updated on 1/22/2020. The Clarkfield Care Center has determined that all residents have the potential to be affected by the alleged deficiency. Inservice training will be conducted for the safety committee on 2/26/2019. The QA will review and update the policy annually and report updates to QAPI. Minutes of the Safety Committee and QAPI Committee will include documentation of	

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 01/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 006	Continued From page 2 been done on the emergency preparedness program and policy.	E 006	the annual review of the EPP. The administrator or designee will audit minutes of the Safety Committee and QAPI committee monthly to ensure the EPP remains on the agenda to ensure and it is updated as needed and reviewed annually.	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, 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 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	E 039		3/13/20

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 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 3 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 (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	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	Continued From page 4 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 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	E 039		

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E 039	Continued From page 5 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 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	E 039		

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E 039	Continued From page 6 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 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 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	E 039		

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E 039	Continued From page 7 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 (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	E 039		

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E 039	Continued From page 8 maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID'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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a full-scale community exercise to test their emergency preparedness program. This had the potential to affect all 31 residents who currently resided in the facility along with staff who work at the facility. Findings include: Interview and document review on 1/15/19 at 3:00 p.m., with the administrator identified the facility had not completed a full scale exercise for emergency preparedness.	E 039	The Clarkfield care center joined the SW Minnesota Emergency Preparedness Coalition. Joining this group will help educate the leadership team on current practices as well as make critical connections that will help us be prepared for large scale disasters. The coalition conducts multiple tabletop exercises throughout the year and the CCC will participate in them as needed. The Clarkfield Care Center identified that all residents have the potential to be	

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E 039	Continued From page 9	E 039	affected by the alleged deficient practice. The facility administrator and/or designee along with the safety committee will schedule a community base full-scale exercise to be completed annually to test the activation of the emergency management plan followed by a tabletop group exercise led by a facilitator. The Safety committee minutes will show documentation of the emergency drills and will report to the QAPI committee. The facilities Administrator and/or designee are responsible for implementation, oversight, monitoring and evaluation of the exercises to test the emergency plan. The administrator will be meeting with the Ambulance Department Director and the Fire Department Chief the week of February 24th-28th to plan the date and details of the drill. The safety committee will meet quarterly to go over facilities risk, emergency preparedness planning. This will be reported to QAPI for higher scale evaluation and solution planning. The administrator and/or administrative assistant will audit minutes of the Safety Committee and QAPI committee monthly to ensure drills are completed and properly documented. Table top to plan drill will be conducted on 2/27/2020. The drill will be conducted between March 1-15th, 2020.	
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 10 On 1/13/19, through 1/16/19, a standard survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found not to be in compliance with the federal requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5551013C, H5551014C, and H5551015C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609		2/21/20

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F 609	Continued From page 11 serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report to the State Agency allegations of abuse and misappropriation of resident property for 3 of 3 residents (R9, R15, and R80) reviewed. Findings include: Review of the 6/14/19, report to the SA identified the complainant (C) was advised by R80 a staff member was verbally abusive on 5/31/19. R80 was pushing her call light for assistance and staff would not come. Staff continued to be upset with R80. Nursing staff at the facility were informed. C was told by nursing staff the alleged staff person would no longer be allowed to assist R80. Review of the 5/31/19, Record of Grievance/Complaint report identified staff documented a complaint by family on 6/1/19, a	F 609	The Clarkfield Care Center has updated its policies on alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of resident property; which will be reported to State and Federal agencies in accordance with state & Federal law. We reviewed and updated the Grievance policy. Grievances reported will be investigated by the administrator or designee. In situations where alleged violations involving abuse, neglect, exploitation or mistreatment the CCC will follow the updated procedure. All charge nurses were given access to OHFC and have received training on 1/15/2019. Training included how to set up OHFC reports, how to enter in the information, when to report, who to contact if they are unsure,	

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F 609	Continued From page 12 staff member yelled at their mother. The director of nursing (DON) was made aware as well as the registered nurse (RN) case manager. Staff were not interviewed until 6/4/20. Nursing assistant (NA)-B was interviewed. She was asked not to work with R80 related to the complaint. NA-B identified she went into R80's room. R80 asked NA-B for cigarettes. NA-B advised R80 she didn't smoke. R80 called her a liar. NA-B left the room but returned to find R80 up searching in her closet. NA-B reminded R80 she needed to ask for assistance with ambulating in her room and assisted her to bed. Interview with NA-E identified she assisted NA-B with toileting R80 in the middle of the night. NA-E denied NA-B had ever yelled at R80 in her presence. There was no documentation to support R80 was interviewed, or the family member making the complaint tot the facility. There was also no mention a report was made to the SA within 2 hours of the facility being made aware for suspicion of abuse. R80's 4/10/10, admission minimum data set (MDS) identified R80 had a severe cognition problem and needed only supervision with her activities of daily living (ADL's), which included dressing, walking, and bathing. During interview on 01/15/20, at 3:58 p.m. RN-A verified she had investigated the incident. She felt after interviews were conducted she could find no sufficient evidence abuse occurred, so she did not file a report with the SA. RN-A admitted that she had not spoken to the resident about the incident. RN-A did talk with the daughter after the grievance was filed. There was no documentation that she talked with other resident about NA-B. RN-A was aware of the reporting requirements when abuse is suspected that must be completed	F 609	and the updated Abuse & Neglect, & Grievance Policy. The Clarkfield Care Center has identified R9, R15, and R80 as being affected by the deficient practice. Actions taken to identify other potential incidents, The Clarkfield care center took inventory of all personal items of value of current residents. The Abuse/Neglect Reporting and Response Policy & Grievance policy has been reviewed and updated to include that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of resident property will be reported to State & Federal agencies in accordance with state law. All staff have received training regarding timely reporting of potential abuse/neglect on 1/15/2019. The facility staff will notify the administrator immediately in any instance where there is doubt about an allegation of maltreatment or when a resident reports a grievance. To assure ongoing compliance, all alleged violations will be recorded on an Abuse Reporting log indication time of Administrator/Director of Nursing notification. The log will be recorded on for all alleged violations for 3 months and reported at QAPI. At QAPI it will be discussed if the log needs to continue or if desired outcomes have been achieved. Auditing will be conducted weekly for four weeks of staff knowledge of the abuse	

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F 609	Continued From page 13 prior to a full investigation. Interview with director of nursing (DON), on 1/16/20 at 11:00 a.m., identified she was aware of the incident regarding R80's clam of verbal abuse. The DON's expectation was the incident had not needed to be reported until the investigation showed evidence of abuse. Interview on 1/13/20 at 3:12 p.m., FM-A identified R9's wedding ring had been lost. This had been reported to the DON and other staff. The facility informed her they had conducted a search, but had not located the missing wedding ring. Review of the 11/25/19, Lost, Missing, or Damaged Article Report was completed for R9's missing ring. FM-A reported a wedding ring set was last seen on R9's finger on 11/22/19. The wedding ring set was described as a large diamond in the middle with smaller diamonds on the side. Wedding band was soldered together with the engagement band and the band was white gold. Family and staff had completed a search in R9's room. Nursing, dietary and activities had been notified. The ring had not been located. Interview on 1/14/20 at 4:16 p.m., social services designee (SSD) identified all departments searched for the missing ring, but it had not been located. No interviews of staff had been conducted and it had not been reported missing to law enforcement or the state agency. Interview on 1/16/20 at 10:05 a.m., DON identified the facility was not certain R9 had a wedding ring. No investigation had been completed. The missing ring had not been	F 609	policy and procedure and timely reporting. Results of the audits will be reviewed by QA and presented to QAPI. Training Completion Date: 1/15/2019 Completed: 2/21/2020	

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F 609	Continued From page 14 reported to law enforcement or the state agency by her. Her expectation was that it should have been investigated immediately, interviews of staff would have been conducted, law enforcement and state agency would have been notified. Interview on 1/16/20 at 10:17 a.m., the administrator identified his expectation was the police should have been contacted, so that if the ring would show up at pawn shops or was found it can be returned. An investigation should have been conducted including interviews from family members, the resident, and all staff that had worked since the ring had last been seen. The results of the investigation would be given to police. A Report should have been made to the SA. Interview on 1/14/20 at 9:13 a.m., with R15 identified R15 was able to recall an incident with a traveling nurse in October 2019. R15 was unable to recall the nurse's name. R15 used lasix, which caused her to use the bathroom frequently, and she needed staff to help her to the bathroom. When she called to use the bathroom, the nurse was "short" with her. She was upset and reported the issue to the head nurse, and had not seen the nurse since she reported her concern. Interview on 1/14/20, at 11:17 a.m., with family member (FM)-A stated last fall, R15 phoned her to tell her a staff member was rude and yelled at her. R15 had poor health but was coherent enough to know staff were not supposed to yell at her. FM-A was unable to recall further details about the incident. FM-A advised they spoke with	F 609		

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F 609	Continued From page 15	F 609		

a nurse at the facility. The nurse spoke to the NA, and the NA stated she had not meant to come across the way she did. FM-A stated she was not aware of any other concerns since that incident.

R15's 10/6/19, Record of Grievance Complaint form R15's written by licensed practical nurse (LPN)-A identified she received a phone call from family member (FM)-A. FM-A stated R15 called to tell her a staff member yelled at her when she was getting dressed. LPN-A interviewed R15. R15 was alert and aware of her surroundings. R15 stated staff were telling her she needed to eat. There was no indication R15 advised LPN-A of staff verbal abuse. LPN-A then interviewed nursing assistant (NA)-A. NA-A stated she stated she had not yelled at R15. LPN-A interviewed RN-B. RN-B advised LPN-A she went to R15's room that morning. R15 stated NA-A had yelled at her. RN-B had not heard any yelling while she was at the nurses station that day. There was no indication in the report RN-B had notified anyone of R15's claims of alleged verbal abuse, or had made a report to the SA after she had interviewed R15 that morning. LPN-A made no report to the SA upon interviewing RN-A.

Interview on 1/14/20 at 2:34 p.m., with LPN-A stated she had worked at the facility since 1/14/19. Staff were expected to complete an incident report when a resident reported an allegation of abuse. Staff were to follow up on the allegation and notify the DON. She was unsure of when to report allegation of abuse to the stated agency, but stated it depended on the incident.

An interview on 1/14/20, at 11:40 a.m. with RN-A identified she was the social service designee. Her responsibilities included reviewing all

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F 609	Continued From page 16	F 609		

grievances, and allegations of abuse. Allegations of abuse were expected to be reported to the SA within 2 hours. All charge nurses were able and expected to report allegations of abuse to the SA. LPN-A had documented the DON was contacted of the allegation of verbal abuse. RN-A stated staff completed the handwritten documents "just in case there was an issue, but staff had done a good job investigating the allegation and identified no abuse had occurred". RN-A stated a SA report of the allegation of verbal abuse were not necessary because nursing staff had done a good job investigating the allegation, and found no abuse had occurred. Staff documented their statements in case anything further came of it, and R15 had not submitted a compliant. RN-A was unsure of the facility policy for reporting allegations of abuse.

An interview on 1/14/19, at with the DON at 11:50 a.m., the DON stated there was no allegation of abuse, and staff had completed a thorough investigation to rule out abuse, so no SA report was necessary.

An interview on 1/16/20, at 11:00 a.m. with the administrator (ADM) identified he expected staff to follow the abuse neglect policy when allegations of abuse occurred. He was unaware of the allegations mentioned above. If an alleged abuse event occurs during a weekend or after hours, he expected to be notified immediately to ensure timely reporting of the event. The ADM, DON, NA-A, and charge nurses were responsible to submit any allegations of abuse to the SA. Licensed nursing staff were expected to document allegations of abuse. The interdisciplinacry team (IDT) reviewed incidents documented in Risk Management daily. The

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F 609	Continued From page 17 above incidents were not documented in the electronic medical record system, but were on paper as a grievance, and not an abuse allegation. Review of the December 2016, Abuse Investigation and Reporting policy identified reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulation) and thoroughly investigated by facility management. Suspected abuse will be reported within two hours.	F 609		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		2/14/20

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F 657	Continued From page 18 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R19) care plan contained the necessary revisions previously identified for fall interventions. Findings include: Observation and interview On 1/13/20, at 05:04 p.m., with R19 identified he was sitting in his recliner with his feet elevated. R19's recliner sat in the right corner of the room facing the doorway. R19's wheelchair had anti-lock brakes and was placed between his recliner and bathroom door. His walker was placed at the foot of the recliner's foot rest with a sign instructing him to use the call light to ask for help attached. R19 was unsure why the sign was on the walker and stated he never used a call light because he didn't need it. He was able to get around by himself, and needed little help from staff. R19's 12/8/19, Significant Change, Minimum Data Set (MDS) identified R19 had moderate cognitive impairment. R19 required extensive assistance of 2 staff for all activities of daily living (ADL)s for toileting, bed mobility, transfers and walking. His had an unsteady gait and used a walker and a wheelchair for mobility. He was always incontinent of urine, and frequently	F 657	The Clarkfield Care Center reviewed and updated resident (R19) care plan. The Clarkfield care center created a form to ensure and track that the care plan is updated with immediate interventions. The facility reviewed and updated policies and procedures on Accidents and Incidents Investigating and recording. A new audit form was created to ensure & track that the care plan is updated for immediate interventions and is being reported to nurse and to track if the IDT Root cause analysis is being completed. The Clarkfield Care Center reviewed all care plans for accuracy and found gaps in the process and took corrective steps to make sure all care plans are current. The Clarkfield Care Center updated and reviewed its policy on Accidents and Incidents Investigating and Recording. Inservice training to go over accident and incident reporting and investigation along with care planning will be conducted on 1/15/2020. IDT will review falls and conduct root cause analysis this information will be monitored by QA and reported at QAPI for further discussion. IDT review will include review of the care	

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F 657	Continued From page 19 incontinent of bowel. R19 had fallen since the last assessment. R19's diagnoses included dementia with behavioral disturbance, insomnia, mood disorder, Major Depressive Disorder, urinary incontinence, colitis, and history of recent return form a hospitalization for pneumonia on 12/2/19. R19's 1/14/19, care plan identified R19 had self-care deficits. He required assistance of 1 staff, a transfer belt, and a front wheeled walker to walk to all destinations. He required staff assistance of 1 for bed mobility, toileting, and transfers. Staff encouraged him to use the call light to call for assistance. Caregivers provided positive interaction, and were to stop and talk with him when they pass by his room. R19 had impaired cognitive function, and required staff to cue, reorient, and supervise him needed. R19 used diuretic therapy. He had abdominal discomfort after meals. He was incontinent of bladder and required staff to maintain an unobstructed path to the bathroom; offer assistance with incontinence cares; check the garbage and remove soiled briefs every shift and when needed. R19's care plan made no mention he was at risk for falls, used anti-back brakes on his wheelchair, and made not mention a reminder sign was placed on his walker to remind him to use the call light to call staff for assistance. Review of R19's incident reports identified the following falls: (1) On 12/2/19 at 3:31 p.m., R19 was found on the floor, he had not injuries. R19 identified he was trying to get to his wheelchair. He was forgetful, and was not safety aware. He required assistance to walk. R19 returned to the facility that day following hospitalization for pneumonia. No fall interventions were included on the incident report. (2) On 1/10/20, staff found	F 657	plan to ensure it was updated. Audit checks will be conducted by the DON or Designee two times a week for two weeks followed by one time a week for two weeks or until deficient practice is resolved. Corrected on 2/14/2020	

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R19 lying between his bed and his recliner. R19 stated he was combing his hair by the sink and fell when he tried to walk back to his recliner, and hit his head on the bed frame. He had a quarter sized red mark on the right side of his forehead. He had no additional injuries. He was forgetful, oriented to person and place and was not safety aware. He had gait imbalance, impaired memory, and weakness.

R19's 1/10/20, nurse note documented R19's fall on 1/10/19. The note identified a sign was placed on R19's walker and the care plan was to be updated by checking the edit care plan immediately section in the electronic medical record (EMR).

R19's 1/13/20, nurse notes identified the interdisciplinary team (IDT) reviewed R19's fall on 1/20/19. R19's last fall was on 12/2/19. R19 had dementia and was not safety aware. R19 also had chronic pain. R19 required 1 staff to assist with all ADLs. R19 had no injuries from his falls. Inteventions included a sign was placed on R19's walker to remind him to call for help before getting up.

Interview on 1/15/20, at 9:10 a.m., trained medication aid (TMA)-A identified R19 was resistive with cares, and believed he could take care of himself. Staff frequently reapproached him. He had a history of transferring himself. She was unsure if R19 had and recent falls. She was unsure if he had any recent interventions added to his care plan to prevent falls. She stated staff check on him frequently when they pass by his room.

Observation on 1/15/20, at 9:42 a.m. R19 was

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F 657	Continued From page 21	F 657		

observed sitting in his recliner with eyes closed and his feet elevated. His walker was placed in the middle of the room out of R19's reach, with the sign facing away from R19.

Observation on 1/15/20, at 2:43 p.m., R19 was observed sleeping in his recliner with his feet elevated. R19's walker was placed against the wall across the room and was not in R19's line of sight. R19's wheelchair was parked against the wall by the sink, away from R19's recliner, and his call light was not visible from the drawer. At 3:00 p.m., no staff had passed by his room, and no-one had entered R19's room. R19 continued to sit in his recliner with his eyes closed, feet elevated, and the walker remained against the wall opposite his recliner with the sign facing away the recliner, out of R19's line of sight. His wheelchair was parked against wall by the sink. R19's call light was not visible from the doorway.

An interview on 1/15/20, at 3:10 p.m. TMA-B was familiar with R19's care and worked regularly with him. She stated R19 required 2 staff to assist him to transfer and walk to the bathroom because he had behaviors with toileting. R19 had dementia and was not safety aware. He was sick for a little bit, and had not self-transferred as frequently as he used to, but he was becoming more active and was starting to resume his normal activity. TMA-B was unsure if he had any recent falls.

An interview on 1/15/19, at 3:25 p.m. nursing assistant (NA)-C stated she worked frequently with R19. He required assistance of 1 staff to walk and 2 staff to toilet because one staff distracted him while the other pulled down his pants. He self-transferred frequently because he

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F 657	Continued From page 22 thought he was able to take care of himself. Staff checked on him frequently to try to keep him safe. An observation of R19 on 1/15/19, at At 3:30 p.m., R19 was heard calling for help. Staff approached his room, and a found R19 lying on the floor between the bed and recliner. His call light was not on. NA-B entered the room and addressed R19. NA-C was observed picking up the call light off the floor next to his recliner. His shoes were off and were sitting at the base of the recliner. His walker was against the wall opposite the recliner at the foot of his bed, and the sign was out of his line of sight. Staff asked him what happened, and he stated he was trying to get to the bed to lay down. Registered nurse (RN)-C entered the room to assess R19. His vital signs were within his normal range, he denied hitting his head. No injuries were observed. R19 was asked why he didn't use his call light, and he stated he could not find it. R19 was incontinent of urnie and was assisted to use the bathroom. An interview with NA-C on 1/15/19, at 3:45 p.m. identified R19 was incontinent of urine. She was unsure when R19 was last toileted. He was last observed at 1:45 p.m. She confirmed his walker was against the wall at the foot of the bed, and out of his reach when she entered the room. She was unsure when the walker was placed there and verified the sign was not within his line of site when she entered the room, and was unsure when it was placed there. R19's walker was supposed to be by placed within reach. She confirmed she found R19's call light on the floor next to his recliner when she entered the room. It was supposed hung on the drawer so he could reach it.	F 657		

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F 657	Continued From page 23 An observation and interview on 1/16/20, at 9:35 a.m. identified R19 was sitting in the recliner with his eyes closed and feet elevated. The call light in reach on the table drawer. His walker was placed in the middle of the room with the sign on the walker facing away R19, out of his line of sight. On 1/16/20, at 9:36 a.m. NA-B stated R19's fall interventions included visual checks, and offering the toilet every few hours. R19 frequently refused help, but staff checked his brief and changed him when he allowed them to. R19 had some occasional falls, and staff were instructed to offer to help him to the toilet. NA-C opened the Kardex in R19's EMR to identify additional interventinos. The Kardex identified R19 had a sign in his room and his walker alerting him to use the call light to ask for help and staff were to ensure his call light was in reach. An observation and interview with the director of nursing (DON) on 1/16/20, at 9:45 a.m. identified R19's walker was in the middle of the room. The walker and sign faced away from the resident, out of his line of sight. The DON stated she expected R19's walker to be placed within reach with the sign facing toward R19 so he could see it to remind him to use the call light. No additional signage was visualized in the room. The DON stated another sign should be placed in the room that he could see at all times. The DON provided and updated care plan. She stated after she was alerted of R19's fall on 1/15/20, she reviewed the care plan and identified his fall interventions had been resolved by mistake. She verified fall interventions were not included in the care plan provided on 1/14/19. Fall interventions were	F 657		

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F 657	Continued From page 24 reviewed daily. Staff used root cause analysis to identifiy causes of falls to implement effective interventions. R19's fall was recent, and the his interventions had not been reviewed for effectiveness. The facility identified falls as an area to improve for their quality assurance and performance improvement (QAPI), and had started a performance improvement project to improve fall investigations and reduce falls. Care plans were expected to be updated when interventions were implemented. Falls were reviewed at IDT meetings. She was unsure if IDT had reviewed the care plan to ensure R19's fall care plan was updated. The September 2010, Fall Prevention policy's purpose was to provide a systematic way for the IDT to prevent, monitor, and assess resident falls occurring in the facility. The policy procedures included to implement fall interventions when a resident was assessed and identified to be at risk for falling. A post fall analysis was to be completed within 24 hours by an RN after each fall and any change in interventions were to be noted on the resident's care plan. An incident communication log was to be completed to alert staff to changes in the care plan.	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.	F 661		2/14/20

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F 661	Continued From page 25 (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a complete discharge summary had been completed for 1 of 1 residents (R30) reviewed for transfer and discharges, who was discharged to an assisted living facility. Findings include: Review of the 10/22/19, Discharge Note identified R30 was discharged to an Assisted Living (AL) facility at approximately 2:00 p.m. on 10/22/19. R30's sister was there to transfer R30 to the AL with current medications. The Ombudsman's office and pharmacy were notified of R30's discharge. An email was sent to the admissions/discharge group. there was no documentation to support a recapitulation of stay	F 661	The Discharge Summary was updated on 1/29/2020 to reflect a signature from the Provider and a statement that he/she has reviewed the Discharge Summary, Medical Dx, Care Plan, Current Orders, and other pertinent information. Updates to the Discharge Checklist and the Death of a resident Checklist have been updated to reflect a signature from the Provider and a statement that he/she has reviewed the Discharge Summary, Medical Dx, Care Plan, Current Orders, and other pertinent information and will sign and date the document and return to CCC Facility. 1/29/2020 All Nursing Staff were trained on regulation of Recapitulation of Resident	

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F 661	Continued From page 26 was created to ensure continuity of care provided to the AL at time of transfer. During interview on 01/15/20, at 10:15 a.m., the director of nursing (DON) and the administrator indicated staff were to use the Discharge Checklist form when discharging a resident. The DON was unaware a recapitulation was required to be sent with the resident to the AL upon discharge. The facility had no policy or procedure informing staff what needed to be included in a discharge summary. Review of a blank Discharge Checklist form identified staff were to complete a discharge summary 1 day prior to discharge.	F 661	Stay Discharge Summary During Mandatory Nursing Meeting on 1/15/2020 F 661 TS All Licensed staff attended and are signed of on education. 1/15/2020 TS The Clarkfield Care Center identified that all residents have the potential to be affected by deficient practice. The Clarkfield Care Center has reviewed and updated (1/29/2020) Discharge Summary forms to include a signature from the provider that the provider has reviewed the Discharge Summary, Medical DX, Care Plan, Current Orders, and other pertinent information. All nursing staff were trained on regulation of recapitulation of Resident Stay Discharge Summary During Mandatory Nursing Meeting on 1//15/2020. Audits will be conducted by DON & SSD (or medical records) once a week for six weeks or until deficient practice is not recurring. Audit will include review of all discharged residents to ensure a recapitulation of stay was completed. Results will be reported to QAPI. Corrected on 2/14/2020	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		2/14/20

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F 677	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure staff assisted 1 of 1 residents (R28) with Activities of Daily Living (ADL) who was dependent upon staff to empty his urinal. Findings include: Observation and interview on 1/13/20 at 1:34 p.m. with R28 in his room identified R28's urinal sat uncovered at the head of his bed full of urine. R28 identified he used the urinal before lunch. Staff had been in and out of the room several times to deliver his tray, remove his tray and pass medications, and they still had had not emptied the urinal. He was unable to walk and required staff to empty the urinal. Usually, when he called staff to empty it, he was told staff were busy and they never returned to empty it. At times, he had to urinate but the urinal was full. Staff would routinely take a long time to empty it, causing him to be incontinent. R28 felt frustrated he had to tell staff to empty the urinal. R28 stated he told the nurses several times, and "nothing ever changed". R28's 1/20/20, quarterly Minimum Data Set (MDS) identified R28's cognition was intact, and required extensive assistance with toileting and personal hygiene. R28's current care plan and Kardex indicated staff were to check and empty R28's urinal as needed. Observation and interview on 1/14/20, at 10:09 a.m., with R28 in his room identified his breakfast	F 677	The corrective action taken for resident R28 was accomplished by a task being implemented in Point Click Care (PCC) to ensure documentation to support that urinal is being emptied on a consistent basis. The staff who primarily work with the resident were educated on the need to empty the urinal. The facility identified that all residents using a urinal have the potential to be affected by alleged deficient practice by not being offered or completed. Residents that have the potential to be affected have had their PCC task sheet updated to ensure the deficient practice does not take place. All residents in the facility will be added to the PCC task list to ensure urinals are being emptied. The facility added all residents on the PCC task list to have urinal emptied. The measures that were put into place were that the SSD or Administrative assistant will conduct random resident interviews and care plan audits, especially with those who require extensive assistance with personal hygiene to verify the residents are receiving care based upon their current plan of care and preferences. Inservice training was conducted on 2/14/2020 The Clarkfield Care Center will monitor its performance by the DON or Designee will complete weekly audits for 2 months or	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 28 tray sat on the bedside table. His urinal sat directly behind his meal tray and was full of urine. R28 stated he used the urinal before breakfast and remained unemptied. Staff had delivered his breakfast tray and placed on the same table as his urinal without removing it or cleaning and disinfecting the surface. "Today was just like any other". He could not understand why staff did not empty it when they saw it when the brought his tray. At 10:24 a.m., staff entered the room to deliver a pitcher of ice without removing his urinal from his tray table, emptying it, and storing it in an appropriate location away from his food. Observation on 1/15/20 at 8:55 a.m., R28's urinal was sitting half full of urine on the bedside table while he was eating breakfast. R28 stated he used before breakfast, the urine was in the urinal when his meal tray was delivered. Interview on 1/15/20, at 9:10 a.m., with trained medication assistant (TMA)-A identified staff were supposed to empty R28's urinal as needed. R28 used the urinal independently, but had not always called for assistance to empty it after he used it. TMA-A was unsure when it was last was emptied. Observation on 1/15/20 at 10:30 a.m., of R28's room identified his urinal remained full sitting on the bedside table. An observation and interview on 1/15/20, at 3:10 p.m., identified R28's urinal was half full of urine. TMA-B stated R28 used the urinal independently. R28 did not call staff to tell them to empty it, and they tried to empty it when they could. She was not sure when it was last emptied, and stated it should be emptied when staff see it is full. Staff did not routinely record when R28's urinal was	F 677	until compliance is achieved. This information will be relayed to the charge nurse or the director of nursing as necessary. Audits will be reviewed by QAPI. Completed on 2/14/2020	

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	245551	A. BUILDING _____ B. WING _____	C 01/16/2020

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F 677	Continued From page 29	F 677		

emptied in their electronic documentation.

Observation and interview on 1/16/20 at 9:49 a.m., with R28 in his room identified R28's urinal was 3/4 full of urine, uncovered sitting directly behind his breakfast tray. R28 was eating breakfast. R28 stated the urine remained at the same fullness level since last night. He had to use it this morning while urine was still in it. He was glad it didn't overflow. The cap was missing because it fell off, and was not replaced. R28 stated staff had not emptied it this morning because they said they were busy.

Interview and document review on 1/16/20, at 9:36 a.m., nursing assistant (NA)-A stated she was assigned to R28's care. NA-A opened R28's Kardex in the EMR. The Kardex indicated staff were to empty his urinal as needed. R28's urinal was full frequently at meal times. NA-A stated R28 had not called for staff to empty the urinal. She was unsure when staff last emptied it. She agreed when staff enter a room and see a urinal full or used, they were to empty the urinal and place in an appropriate location.

Interview on 1/16/19, at 10:45 a.m., registered nurse (RN)-B identified was aware R28 had issues with the urinal in the past, but was not aware he continued to have issues with staff emptying the urinal. Leaving a urinal full sitting at a resident's bedside was unacceptable. In the past, staff were made aware to check R28's urinal and empty it when it was full. There was no documentation to ensure tasks were performed to accommodate R28's needs.

An observation and interview on 1/16/20, at 10:48 a.m., with the director of nursing (DON) saw

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F 677	Continued From page 30 R28's urinal 3/4 full of urine. She stated staff were aware R28 required assistance to empty his urinal, and she expected staff to check it regularly and empty it. Her expectation was staff were to assist R28 in emptying his urinal after being used. There was no policy related to emptying urinals provided by the facility.	F 677		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		2/13/20

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F 880	Continued From page 31 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 880	The Clarkfield Care Center reviewed and	

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F 880	Continued From page 32 facility failed to implement and maintain a comprehensive infection control program that included a thorough collection of data and a comprehensive analysis of developed infections to reduce the risk of infection spread within the facility. This had the potential to affect all 31 residents residing in the facility. Findings include: Review of provided infection control tracking logs lacked evidence of a comprehensive analysis of the data collected. Interview 1/16/20 at 8:34 a.m., with infection preventionist registered nurse (RN)-A identified that she collected data and looked at trends, but failed to complete a comprehensive analysis of the data. She would bring the data and report it to Quality Assurance Performance Improvement (QAPI). This would be important for early recognition to prevent spread of infections. There was no annual review of the infection control program. Interview on 1/16/20 at 10:00 a.m., the director of nursing (DON) identified she was unaware there was no comprehensive analysis of the infection control data was routinely completed. Her expectation was the data would be analyzed. The comprehensive analysis should be brought forward to QAPI not just a collection of data. Interview on 1/16/20 at 10:24 a.m. the administrator (A) identified the A was unaware there was no comprehensive analysis of the data. He confirmed the information was brought to and reported to QAPI, but only collection data was identified.	F 880	updated the infection control policies and procedures. The CCC will continue to use the Active Infection Monitoring forms. The CCC has implemented Infection Summary reports that ask, “Analysis of Data (trends, clusters, etc.), Corrective action taken, preventative measures taken, comment section”. This will be reviewed at infection control meetings and reported to QAPI for further discussion. The Clarkfield Care Center identified that all residents have the potential to be affected by alleged deficient practice. The policies procedures were reviewed and updated. Implemented new form “Infection Summary report: Inservice training on the new Active Infection Monitoring forms will be conducted on 2/13/2020. This information will be reviewed at infection control meetings and reported to QAPI for further discussion. Infection Control Preventionist was educated on how to report the analysis of data to the QAPI committee. The facility will conduct monthly audit checks for 3 months or until alleged deficient practice is corrected. Forms will be reviewed at the infection control meetings and will be reported to QAPI for further discussion. Audit will include interview with the Infection Control Preventionist to determine how data was analyzed. Audit will include review of QAPI minutes to ensure documentation of analysis was completed.	

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F 880	Continued From page 33 Review of the 2017, Infection Prevention and Control Program Manual Surveillance, identified the infection preventionist would utilize the information collected to analyze the data to identify opportunities for improved care and process and identify an action plan for follow up and corrective action and reporting.	F 880	Corrected on 2/13/2020.	
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a comprehensive antibiotic stewardship program with established protocols and monitoring to help reduce unnecessary antibiotic use and potential drug resistance. The lack of a program had potential to affect all 31 residents residing in the facility. Findings include: Review of the monthly 2019 and 2020, Infection Control Logs lacked evidence identifying antibiotic use was screened for appropriateness prior to starting the medications, documented infection cultures, nor any evidence to demonstrate the	F 881	It is the policy of the Clarkfield Care Center to prevent and treat infections according to the industry standards. Infection Control logs will show evidence that the use of the antibiotic was appropriate, there will be documentation of cultures and the use of the antibiotic will be reviewed for effectiveness. The Clarkfield Care Center has determined that all residents have potential to be affected by the alleged deficient practice. The policy for antibiotic stewardship was reviewed and is current. Inservice training	2/20/20

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F 881	Continued From page 34 prescribed antibiotics were monitored to ensure effectiveness through to resolution. Interview on 1/16/20 at 8:34 a.m., with the infection preventionist (IP) identified they did not utilize any standardized infection forms. The IP instructed staff to complete and use the McGeer's criteria (professional standard) but it was not consistently being done. There was no annual review of the antibiotic stewardship program. Interview on 1/16/20 at 10:00 a.m., with the director of nursing (DON) stated she was unaware McGeer's criteria was not being completed and expected staff to complete prior to physician notification of suspected infection. All policies should have been followed. Interview on 1/16/20 at 10:24 a.m., with the administrator (A) identified he was unaware the antibiotic stewardship program was not being implemented and expected policies related to antibiotic stewardship to be followed. Review of the facility's 2017, Infection Prevention and Control Manual Antibiotic Stewardship policy, identified the program was to promote appropriate use of antibiotics and a system for monitoring to improve resident outcomes and reduce antibiotic resistance. Antibiotics were to be prescribed for the correct indication, dose, and duration to appropriately treat the resident while attempting to reduce the development of antibiotic resistance and other adverse outcomes.	F 881	was provided to Infection preventionist on the policy for antibiotic stewardship using Loeb and McGreer Criteria – a practical guide for use in long-term care found on the Minnesota Department of Health Website. The Infection Preventionist will review forms weekly to ensure they are completed as per policy. The Infection Control Logs will be reviewed weekly for 4 weeks to determine real-time entry, completeness, and if Loeb's Criteria has been met. Results of the audits will be reviewed at QA and reported to QAPI. Corrected on 2/20/2019	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal	F 883		1/17/20

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F 883	Continued From page 35 immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 883		

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F 883	Continued From page 36 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to obtain and administer the influenza vaccine to 1 of 5 residents (R13) reviewed for immunizations. Findings include: R13's 11/11/9, admission face sheet identified diagnoses of compression fractures, pneumonia, Alzheimer's, and chronic obstructive pulmonary disease (COPD). R13's 1/13/19, Immunization report lacked evidence she had been offered or received the influenza vaccine for the current influenza season. Interview on 1/14/20 at 12:26 p.m., the director of nursing (DON) identified she was responsible for the influenza vaccinations of the residents. The facility had used their supply of influenza vaccine. She reordered the vaccine but had not received additional doses because it had been on backorder. R13 had not received the vaccination	F 883	The Clarkfield Care Center has reviewed and updated its current influenza policy. The Administrator and DON educated themselves on external sources to obtain influenza shots if contracted supplier has a delay or back order such as; clinics, hospitals, pharmacy flu clinics, etc. The influenza vaccine was delivered during the state survey and administered on 1/15/20. The Clarkfield Care Center has audited all the residents in the facility to make sure no other residents were impacted on this alleged deficiency. No other residents were affected. The Charge Nurse will continue to administer Influenza shots during flu season. Inservice training was conducted for the DON and for the Administer on alternative sources for Influenza Vaccine on 2/18/2020. The DON and Administrator have contacted and identified two other providers who can provide vaccine if	

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F 883	Continued From page 37 as a result of the backorder. The DON had not attempted to obtain influenza vaccines from any other source. Interview on 1/16/20 at 9:33 a.m., with the pharmacy consultant (PC) identified initially there had been a problem obtaining the influenza vaccinations. To her knowledge this had been resolved quickly and she was unaware of any problems obtaining the vaccine. Her expectation was that the faciilty would have contacted her to assist in obtaining the vaccines, or sent R13 to the clinic to assure she had been vaccinated. There is identified influenza activity in the community. Immunization is most effective when given prior to the emergence of influenza outbreaks to assure protection from the disease. Interveiw on 1/16/20 at 9:35 a.m., with the licensed pharmacist (RPh) identified the pharmacy had no difficulty obtaining the influenza vaccine. The local pharmacy could have set up a flu clinic and administer the vaccines at the pharmacy or go to the nursing home and administer the vaccine there. Interview on 1/16/20 at 10:24 a.m., the administrator (A) identified Awas unaware not all of the residents had received influenza vaccinations. R13 should have been sent to clinic or other options should have been explored to assure all residents were vaccinated timely. The facilities August 2016, Influenza Vaccine policy identified that all residents admitted between October 1st and March 31st would be offered the vaccine within 5 working days of their admission. Administration of the vaccine will be made in accordance with current Centers for	F 883	another shortage occurs. During Influenza season the CCC will conduct Audit checks by the infection control team and to be reviewed at QA and reported at QAPI. Corrected 1/15/2020	

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F 883	Continued From page 38 Disease Control (CDC) recommendations at the time of the vaccination.	F 883		

Electronically delivered

February 12, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: LHTZ11

Dear Administrator:

The above facility was surveyed on January 13, 2020 through January 16, 2020 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 Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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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 1/13/19 through 1/16/19, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00842	A. BUILDING: _____ B. WING _____	C 01/16/2020

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2 000	Continued From page 1 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 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota 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. 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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2 685	Continued From page 2	2 685		
2 685	MN Rule 4658.0465 Subp. 2 Transfer, Discharge, and Death Subp. 2. Other discharge. When a resident is transferred or discharged for any reason other than death, the nursing home must compile a discharge summary that includes the date and time of transfer or discharge, reason for transfer or discharge, transfer or discharge diagnoses, and condition. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a complete discharge summary had been completed for 1 of 1 residents (R30) reviewed for transfer and discharges, who was discharged to an assisted living facility. Findings include: Review of the 10/22/19, Discharge Note identified R30 was discharged to an Assisted Living (AL) facility at approximately 2:00 p.m. on 10/22/19. R30's sister was there to transfer R30 to the AL with current medications. The Ombudsman's office and pharmacy were notified of R30's discharge. An email was sent to the admissions/discharge group. there was no documentation to support a recapitulation of stay was created to ensure continuity of care provided to the AL at time of transfer. During interview on 01/15/20, at 10:15 a.m., the director of nursing (DON) and the administrator indicated staff were to use the Discharge Checklist form when discharging a resident. The DON was unaware a recapitulation was required to be sent with the resident to the AL upon discharge. The facility had no policy or procedure	2 685	Corrected	2/21/20

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2 685	Continued From page 3 informing staff what needed to be included in a discharge summary. Review of a blank Discharge Checklist form identified staff were to complete a discharge summary 1 day prior to discharge. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff regarding how to compelte a comprehensive discharge summary with a recapitulation osf stay to ensure continuity of care when a resident is discharged. TIME PERIOD FOR CORRECTION: 21 days	2 685		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to implement and maintain a comprehensive infection control program that included a thorough collection of data and a comprehensive analysis of developed infections to reduce the risk of infection spread within the facility. This had the potential to affect all 31 residents residing in the facility. Findings include: Review of provided infection control tracking logs	21375	Corrected	2/21/20

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21375	Continued From page 4 lacked evidence of a comprehensive analysis of the data collected. Interview 1/16/20 at 8:34 a.m., with infection preventionist registered nurse (RN)-A identified that she collected data and looked at trends, but failed to complete a comprehensive analysis of the data. She would bring the data and report it to Quality Assurance Performance Improvement (QAPI). This would be important for early recognition to prevent spread of infections. There was no annual review of the infection control program. Interview on 1/16/20 at 10:00 a.m., the director of nursing (DON) identified she was unaware there was no comprehensive analysis of the infection control data was routinely completed. Her expectation was the data would be analyzed. The comprehensive analysis should be brought forward to QAPI not just a collection of data. Interview on 1/16/20 at 10:24 a.m. the administrator (A) identified the A was unaware there was no comprehensive analysis of the data. He confirmed the information was brought to and reported to QAPI, but only collection data was identified. Review of the 2017, Infection Prevention and Control Program Manual Surveillance, identified the infection preventionist would utilize the information collected to analyze the data to identify opportunities for improved care and process and identify an action plan for follow up and corrective action and reporting. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to	21375		

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21375	Continued From page 5 ensure the ongoing, routine collection of infection data and subsequent analysis of the data to reduce the risk of spread within the facility; then educate applicable staff and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		

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	245551	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/15/2020**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Clarkfield Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/21/2020

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 "IF OPTING TO USE EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED" 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 description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Clarkfield Care Center is a 1-story building with partial basement. The building was constructed at 4 different times. The original building was constructed in 1955 and was determined to be of Type II(111) construction. In 1958 an addition was constructed and was determined to be of Type II(111) construction. In 1970, an addition was constructed and determined to be of Type II(111) construction. The most recent addition was constructed in 2004 and determined to be of Type II(111) construction. These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.	K 000		

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K 000	Continued From page 2 The building is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is monitored for automatic fire department notification. The facility has a capacity of 36 beds and had a census of 31 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code.This deficient practice could affect 31 of the 31 residents. Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily	K 345	The fire alarm system was tested and approved on 1/14/2020 The Clarkfield Care Center identified that all residents had the potential to be affected by the alleged practice. The system was checked 6 days late due to scheduling error on behalf of the facility. In the future the facility will schedule to have the systems checked sooner so there is no potential for reoccurrence. The environmental director will be responsible for monitoring the fire alarm	1/17/20

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K 345	Continued From page 3 available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25. FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 01/15/2020, during documentation review, it was revealed that the Annual Fire Alarm Inspection was not completed within the required time frame. The last inspection was conducted on 01/09/2019. This deficient practice was verified by the Facility Maintenence Director.	K 345	system and will report all discrepancies in the safety committee, which will report to the Administrator & QAPI. The deficient practice was corrected on 1/14/2020	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		3/6/20

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K 353	Continued From page 4 by: Based on observation and interview, the Facility failed to maintain the automatic sprinkler system in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could affect 31 out of 31 residents. Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 01/15/2020, during the inspection, it was observed that the gauge on the fire sprinkler system was last changed in March 2014. This deficient practice was verified by the Facility Maintenance Director.	K 353	The Sprinkler system was checked in April of 2019. The worker that checked the Sprinkler system and forgot to switch out the gage that needs to be changed out every 5 years. The facility called the organization and has put in an order to have a new gage put in ASAP. The Clarkfield Care Center has identified that all residents had the potential to be affected by the alleged deficient practice. Policies and Procedures were reviewed and determined to be current. The Environmental Director will be responsible for oversight of the sprinkler system and will report any discrepancies to the safety committee and to the Administrator. The Deficient Practice Will be corrected 3/06/2020.	