

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: N3L8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00842

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245551		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: <u>7</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2.STATE VENDOR OR MEDICAID NO. (L2) 908340500		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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 IMR 15 ASC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE	
6. DATE OF SURVEY 04/23/2012 (L34)		8. ACCREDITATION STATUS: <u> </u> (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		FISCAL YEAR ENDING DATE: (L35) 09/30	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit Compliance Based On: <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director <u> </u> 1. Acceptable POC <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size <u> </u> 5. Life Safety Code <u> </u> 9. Beds/Room B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A (L12)			
12.Total Facility Beds 52 (L18)		13.Total Certified Beds 52 (L17)		14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IMR 52 (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): See Attached Remarks			
17. SURVEYOR SIGNATURE <u>Marge Meeker, Unit Supervisor</u>		Date : 05/22/2012 (L19)		18. STATE SURVEY AGENCY APPROVAL <u>Nicole Steege, Program Specialist</u> 05/22/2012 (L20)	

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

19. DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Participate <u> </u> 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 : <u> </u>	
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 <u>00</u> INVOLUNTARY 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 03001 (L28) (L31)		30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE 04/19/2012 (L33)		DETERMINATION APPROVAL	

C&T REMARKS - CMS 1539 FORM

CCN: 24-5551

Item 16 Continuation for CMS-1539

At the time of the standard survey completed on March 6, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On April 23, 2012, the Minnesota Department of Health (by review of the plan of correction) and on April 6, 2012, the Minnesota Department of Public Safety completed a Post Certification Revisit and determined that the facility had achieved substantial compliance pursuant to the standard survey completed on March 6, 2012, effective April 10, 2012. Therefore, the remedies outlined in our letter dated March 13, 2012 will not be imposed. See attached CMS-2567B for the results of the April 23, 2012 and April 6, 2012 revisits.



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5551

May 22, 2012

Mr. Paul Luitjens, Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, Minnesota 56223

Dear Mr. Luitjens:

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

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

Effective April 10, 2012 the above facility is recommended for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 skilled nursing facility beds.

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

Please contact me if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Nicole Steege", is located below the word "Sincerely,".

Nicole Steege, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone #: (651) 201-4124 Fax #: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

May 22, 2012

Mr. Paul Luitjens, Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, Minnesota 56223

RE: Project Number S5551022

Dear Mr. Luitjens:

On March 13, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 6, 2012. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 23, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction, and on April 6, 2012 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 29, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 10, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 29, 2012, effective April 10, 2012 and therefore remedies outlined in our letter to you dated March 13, 2012, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Marge Meeker".

Marge Meeker, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7317 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File

5551R12

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245551	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 4/23/2012
Name of Facility CLARKFIELD CARE CENTER		Street Address, City, State, Zip Code 805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0253</u> Reg. # <u>483.15(h)(2)</u> LSC _____	Correction Completed <u>04/10/2012</u>	ID Prefix <u>F0272</u> Reg. # <u>483.20(b)(1)</u> LSC _____	Correction Completed <u>04/10/2012</u>	ID Prefix <u>F0276</u> Reg. # <u>483.20(c)</u> LSC _____	Correction Completed <u>04/10/2012</u>
ID Prefix <u>F0279</u> Reg. # <u>483.20(d), 483.20(k)(1)</u> LSC _____	Correction Completed <u>04/10/2012</u>	ID Prefix <u>F0285</u> Reg. # <u>483.20(m), 483.20(e)</u> LSC _____	Correction Completed <u>03/22/2012</u>	ID Prefix <u>F0309</u> Reg. # <u>483.25</u> LSC _____	Correction Completed <u>04/10/2012</u>
ID Prefix <u>F0314</u> Reg. # <u>483.25(c)</u> LSC _____	Correction Completed <u>04/10/2012</u>	ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC _____	Correction Completed <u>04/10/2012</u>	ID Prefix <u>F0329</u> Reg. # <u>483.25(l)</u> LSC _____	Correction Completed <u>04/10/2012</u>
ID Prefix <u>F0371</u> Reg. # <u>483.35(i)</u> LSC _____	Correction Completed <u>04/10/2012</u>	ID Prefix <u>F0428</u> Reg. # <u>483.60(c)</u> LSC _____	Correction Completed <u>04/10/2012</u>	ID Prefix <u>F0441</u> Reg. # <u>483.65</u> LSC _____	Correction Completed <u>04/10/2012</u>
ID Prefix <u>F0465</u> Reg. # <u>483.70(h)</u> LSC _____	Correction Completed <u>04/10/2012</u>	ID Prefix <u>F0520</u> Reg. # <u>483.75(o)(1)</u> LSC _____	Correction Completed <u>04/10/2012</u>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By _____ MM/NCS	Date: _____ 5/22/12	Signature of Surveyor: _____ 03020	Date: _____ 4/23/12
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Followup to Survey Completed on: 2/29/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245551	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN BUILDING 01	(Y3) Date of Revisit 4/6/2012
Name of Facility CLARKFIELD CARE CENTER		Street Address, City, State, Zip Code 805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0025	Correction Completed 03/07/2012	ID Prefix _____ Reg. # NFPA 101 LSC K0144	Correction Completed 03/13/2012	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By PS/NCS	Date: 5/22/12	Signature of Surveyor: 22373	Date: 4/6/12
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/6/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245551	(Y2) Multiple Construction A. Building B. Wing 02 - BUILDING TWO	(Y3) Date of Revisit 4/6/2012
Name of Facility CLARKFIELD CARE CENTER		Street Address, City, State, Zip Code 805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0144	Correction Completed 03/13/2012	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By PS/NCS	Date: 5/22/12	Signature of Surveyor: 22373	Date: 4/6/12
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/6/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

C&T REMARKS - CMS 1539 FORM

At the time of the standard survey completed on March 6, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8043 8867

March 13, 2012

Mr. Paul Luitjens, Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, Minnesota 56223

RE: Project Number S5551022

Dear Mr. Luitjens:

On March 6, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Marge Meeker
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301-4557

Telephone: (320) 223-7317

Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 10, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 10, 2012 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by June 1, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 1, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

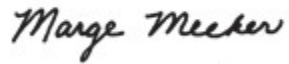
Feel free to contact me if you have questions.

Clarkfield Care Center

March 13, 2012

Page 6

Sincerely,

A handwritten signature in cursive script that reads "Marge Meeker".

Marge Meeker, Unit Supervisor

Licensing and Certification Program

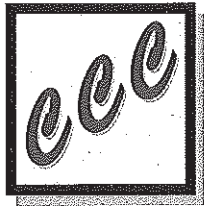
Division of Compliance Monitoring

Telephone: (320) 223-7317 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File

5551s12.rtf



CLARKFIELD CARE CENTER

805 FIFTH STREET, P.O. BOX 458

CLARKFIELD, MN 56223-0458

MAR 26 2012

March 19th, 2012

Marge Meeker
Minnesota Department of Health
3333 West Division Street, Suite 212#
St Cloud, Minnesota, 56301-4557

Dear Ms. Meeker,

Enclosed is our plan of correction for our 2012 survey. If you have any questions, please contact Yvonne Severson or myself at 320-669-7561.

Sincerely,

Paul Luitjens
Executive Director

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

PRINTED: 03/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245551	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2012
NAME OF PROVIDER OR SUPPLIER CLARKFIELD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223	
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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, and interview the facility failed to provide housekeeping and maintenance services for 10 of 53 residents (R14, 4, 36, 24 ,9,37, 5, 7, 12 and 16. observed during the environmental tour. Findings include: During observations of resident rooms the following housekeeping/maintenance concerns were observed: Resident 14's bathroom floor was discolored around the toilet, a bedpan was on the floor. Resident 4 had a dusty bathroom ceiling vent.	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Paul Hutzinger

Executive Dir. 3-20-12

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

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F 253

Continued From page 1

Resident 36's room door had chips/scratches and paint chips off the bathroom door.

Resident 24's bathroom had no baseboard so exposed old glue, discolored floor surrounding toilet and spackling areas not painted by the bathroom sink.

Resident 9's bathroom door had the veneer coming off on the bottom and the closet door was not secured on the bottom.

Resident 37's room had a floor mat with tears in it making it an uncleanable surface.

Resident 5's bathroom floor had a sticky substance, with the odor of urine. The wiring from the wall telephone jack was hanging loose near the room doorframe.

Resident 7's room door had an unsecured sharp plastic piece with some damage to the veneer.

Resident 12's bathroom baseboard was missing on 3 sides of toilet. Wires behind the television were wound in a circular shape, noticeable next to the door frame.

Resident 16's phone jack was hanging loose with wires exposed and visible. Ointment and wipes were on the toilet tank.

At 10:15 a.m. on 2/29/12 during an environmental tour the maintenance/housekeeping director stated he was aware of some of the items, but not all of the above areas were reported to the department. The maintenance/housekeeping

F 253

Maintenance will mount phone jacks on walls in Resident 16's and Resident 5's and Resident 12's room and organize TV wires and cables in a neat and orderly fashion away from doorways and areas of concern to prevent trip hazards. Maintenance director will monitor this.

2. Corrective action as it applied to other residents.

Director of maintenance or his designee will implement policies and procedures to ensure the nursing home is maintained in a safe, clean, functional, comfortable and home like manner. We will strive for ongoing monitoring and record keeping to provide maintenance and housekeeping services to the best of our abilities to ensure a healthy environment for our residents, visitors and staff.

3. Correction will be monitored by maintenance director or designee who will do random audits to ensure cleanliness and structural upkeep and safety.

4. Date of correction: April 10, 2012

4/10/12

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F 253	Continued From page 2	F 253		
F 272 SS=E	director also stated that painting was an ongoing task and all the department employees would be notified of expectations to keep the rooms in good repair and clean. 483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		

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F 272

Continued From page 3

This REQUIREMENT is not met as evidenced by:
Based on interview, document and policy review, the facility failed to perform initial or annual comprehensive assessments related to pressure ulcer care for 1 of 2 residents (R37), oral/dental status for 1 of 3 residents (R21), and for the use of side rail devices for 2 of 4 residents (R43 and R53) in the sample.

Findings include:

Resident 37's (R37) comprehensive assessment for pressure ulcers/skin integrity lacked accurate identification of all significant factors that promoted healing and prevented reoccurrence of the pressure ulcer. R37 had a pressure ulcer at admission that healed, later redeveloped, and still currently received treatment.

R37 had diagnoses that included Parkinsonism, degenerative joint disease, dementia with episodic delirium, non insulin dependent diabetes mellitus, intermittent claudication and chronic leg edema.

The admission minimum data set (MDS) identified R37 with moderately impaired cognitive skills (brief interview mental status BIMS=11), mood and behavioral symptoms present with the behavioral symptoms that placed R37 at risk of

F 272

F272

1. Corrective Action

R37 was transferred to another facility to be closer to home and family on March 1.

R21 oral/dental status done March 2 to accurately assess And record the current factors.

R53 stated did not use grab bar/ Half siderail and it was removed from bed.

R43 informed of risks and benefits of using bedrail/grab bar as aid to mobility. R43 preferred to continue use of this device and consent form obtained/ signed. Physician orders obtained for use of half side rail/grab bar on bed. Half bedrail in use for R43 during survey was removed and different device applied in compliance with regulation guidelines.

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F 272

Continued From page 4
injury. The MDS also noted extensive assistance of 2+ staff for bed mobility, transfers and ambulation, impaired balance and loss of range of motion in both upper extremities and bowel and bladder incontinence. The MDS did not identify the presence of a pressure ulcer at admission but did note a turning and repositioning program and pressure reduction device for bed only. The care area assessment (CAA) was triggered for pressure ulcers. A Braden skin risk assessment completed upon admission on 8/15/11 noted a score of 20; 18 or lower indicated significant risk that required implementation of pressure relieving devices and weekly skin review. R37 had a pressure ulcer at the time the Braden was completed.

The initial admission information sheet body diagram dated 8/15/11 identified R37 had [three/eighths (3/8) inch sore skin missing] noted over the right buttocks area; however, the skin assessment sheet noted, [(R37) was alert and had no evidence of pressure ulcers. Has specialty mattress and was repositioned every two hours. Wheelchair to /from destinations has own recliner he sits in between meals.

The admission assessment did not recognize the presence of the open area present at admission and the care area assessment (CAA) summary was not completed and noted, [See ADL CAA.] The activity of daily living (ADL) CAA noted only that R37 had a potential for skin breakdown and also did not review all the risk factors or detail strategies for interventions that would be included in R37's care plan.

Unit registered nurse-B (RN-B) verified at 11:28

F 272

**2. Corrective Action as it
applies to other residents:**

* Individualized, comprehensive clinical assessments will be done on all residents for:

- A: accurate, thorough, periodic identification of pressure ulcers/ skin integrity and identify significant factors that promote healing and prevent reoccurrence of pressure ulcers;
- B: periodic, thorough, and accurate assessment of oral/dental status and health.
- C: periodic, accurate assessment of siderail/grab bar devices that includes addressing safety factors within regulations and obtaining physician orders if used.
- D. Individualized, comprehensive comprehensive care plans will be done to accurately reflect each person's needs as indicated above.

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F 272	Continued From page 5 a.m. on 2/28/12 she was not sure how to view the CAA on the computer and a medical records licensed practical nurse (LPN) was responsible for entering the data into the CAA summaries. RN-B verified R37 had an open area at admission that should have been addressed in the MDS and CAA and it had healed and then reopened again about 12/8/12 and has remained open since that time until present. RN-B reported it gets smaller and larger, had been up to 1.5cm by .5 cm. and was not stageable, but was currently .5 cm by .5 cm. and was now classified a stage 2 ulcer because the slough was removed. RN-B stated the facility used a wound tracking record flow sheet; however, could only locate tracking that had been completed since 12/29/11. RN-B reported a skin care nurse employed by a dressing supply company vendor made regular visits to advise staff on dressing choices and techniques, but did not chart in the facility interdisciplinary progress notes but had a separate record keeping book. The book was reviewed and noted to primarily contain some data on the size and nature of the wound and information about the dressings selected for use but not collaboration about other treatment and care plan approaches and interventions. The facility skin assessment and care policy updated May 2011 identified tissue tolerance evaluation was to be completed and care plans should include individualized repositioning plan and identification of which pressure-redistributing devices were used with completion of another skin assessment by an RN if a new pressure ulcer developed. R21 failed to have a periodic, comprehensive,	F 272	* Professional and licensed staff will be re-educated on doing initial and periodic comprehensive, accurate standardized assessments to reflect each resident's needs. 3. Reoccurrence will be prevented by: * Periodic audits will be done to ensure assessment conclusions are accurate and complete, including being individualized based on appropriately collected information and accurate analysis. • These periodic audits will be reviewed at quarterly QA meeting for further recommendations. 4. Correction will be monitored by: DoN or designee 5. Date of completion: 6. April 10, 2012		

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F 272	Continued From page 6 and accurate assessment of her oral/dental status conducted. During initial observation and interview with R21 at 5:00 p.m. on 2/27/12 she was noted to have missing teeth on her upper mouth. R21's upper teeth were also noted to be broken and worn. The facility conducted a Functional/Safety assessment on 10/26/11 which had an oral/dental section. The assessment identified R21 with lower partial dentures. The Functional/Safety assessment prior to the 10/26/11 assessment was dated 12/10/10 and the assessment identified R21 with a lower partial and her own upper teeth. The assessment failed to identify the missing, broken, and worn teeth on the upper oral cavity region. R21's annual Minimum Data Set (MDS) assessment, dated 10/28/11 identified her with no oral/dental concerns under Oral Dental Status, section L of the MDS. R21's Care Plan, dated 2/15/12 identified her with a problem with functional balance chewing and mastication difficulty related to edentulous status manifested by signs and symptoms of altered chewing. During interview with R21's Registered Nurse (RN)-B case manager at 10:30 a.m. on 2/29/12 she stated the facility had attempted to have the resident seen by the dentist but R21 would refuse. She stated the facility would make the appointment for R21 and she would refuse to go the day of the appointment. RN-B stated she believed the physician had assessed R21's	F 272			

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F 272	Continued From page 7 oral/dental status during his last check but verified there was no documentation to identify her dental status was assessed. RN-B verified R21's medical record lacked a thorough assessment of her oral/dental status and verified the facility's most recent assessment identified only that she had a lower partial and did not address her upper dental status. The facility failed to conduct an assessment that accurately reflected the oral dental status of R21. The facility assessments failed to identify her missing, broken and worn teeth in her upper oral cavity. The facility lacked any evidence R21's oral cavity had been assessed to identify concerns. The facility failed to assess the safety of a specific bed side rail device for R43. The admission annual minimum data set (MDS) dated 08/24/11 revealed R43 was cognitively intact and was independent with bed mobility and transfers. Review of the Functional Safety Assessment dated 10/9/10, indicated R43 had increased independence for bed rail use. The assessment indicated R43 received education on the risk/benefits of bed rail use and the facility obtained consent to use the bed rails. Review of the plan of care dated 4/29/12 identified R43 had alteration in mobility with potential for injuries due to history of falls and did not always remember safety issues. Interventions included R43 was independent with bed mobility, used grab bars to reposition self, and was independent with transfers. The plan of care included to remind R43 of safety issues and assist as needed. During observation at 6:34 p.m. on 2/27/12, the	F 272			

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F 272	Continued From page 8 right side of R43's bed was noted to be flush with the wall and a silver metal side rail was attached to the left side of the bed, in the upright position. The side rail observed was an older metal design that had five separate openings between the rails (Zone 1) that exceeded standards set forth in the U.S. Health and Human Services, Food and Drug Administration (FDA) publication, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," dated 3/10/06. The openings between the rails in Zone 1 were measured to be at seven and one-half by fourteen (7 1/2 by 14) inches in the center opening. Two openings were six by fourteen (6 by 14) inches and two outer openings were six by nine (6 by 9) inches. The maximum opening between the rails in Zone 1 recommended by the FDA was four and three-quarter (4 and 3/4) inches. R 53, who utilized side rail devices with dimensions not fully in compliance with U.S. Department of Health and Human Services, Food and Drug Administration (FDA) guidance, lacked a comprehensive assessment that included/addressed safety factors related to the use of side rail devices. There was no physician order for the use of a half side rail on the bed and there was no physician order for the use of a grab bar on the bed. R 53 was admitted on 8/19/11, with a diagnosis of congestive heart failure, chronic obstructive pulmonary disease and high blood pressure. The facility form titled, Functional/Safety Assessment, read under bed mobility, extensive assist, and two person physical assist with two assistive devices used.	F 272		
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F 272	Continued From page 9 During the initial tour at 1:00 p.m. on 2/27/12, and throughout the consecutive days of the survey, R 53's bed was observed to have a single half side rail utilized on the outside of the bed in the down position. Interview of R53 at 7:00 p.m. on 2/27/12, revealed the side rail's were not used now, but if there was a need in the future then the rail should stay on "Just in case." Talked to R53 about a least restrictive device such as a grab bar and R53 stated, "That would be fine."	F 272			
F 276 SS=E	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview, document and policy review the facility failed to perform quarterly comprehensive reviews and assessments related to side rail device use for 2 of 4 residents (R7 and R37) and wheelchair positioning for 2 of 3 residents (R37 and R4) in the sample. Findings include: Resident 7 (R7) utilized a single quarter side rail	F 276	F 276 1. Corrective Action: R37 was transferred to another facility to be closer to home and family on March 1. R7 was given risks/benefits of using half rail on bed, prefers to use this, consent form signed, and MD order. received. Half rail devise removed and another half rail applied to bed that is within safety guidelines. R4 was referred to Great Steps		

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NAME OF PROVIDER OR SUPPLIER CLARKFIELD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 FIFTH STREET, BOX 468 CLARKFIELD, MN 56223		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 276	Continued From page 10 device that was not comprehensively assessed for all relevant factors to ensure safe and appropriate use. Additionally, the facility procedures were not followed for obtaining a consent for use of the device. R7 had diagnoses that included schizophrenia, pulmonary disease, hypertension and diabetes mellitus. The most recent quarterly minimum data set (MDS) dated 12/18/11 identified R7 with moderately impaired cognitive skills (brief interview mental status BIMS=12), independence in bed mobility, transfers and ambulation. The MDS noted bed rails were not used. The facility completed a functional /safety assessment tool with the admission MDS and updated with each quarterly re-assessment. The assessment completed 12/18/11 noted use of [top right half rail] and benefits of use of the bed rail were checked for [increased independence/participation.] The safety assessment also noted, [Education on risk benefit provided and consent obtained for use of bed rails.] R7 was observed in bed with an outside metal quarter side rail raised on the bed at 7:30 p.m. on 2/27/12 and 8:50 a.m. on 2/28/12. The side rail observed was an older metal design that had five separate openings between the rails (Zone 1) that exceeded standards set forth in the U.S. Health and Human Services, Food and Drug Administration (FDA) publication, "Hospital Bed System Dimensional and Assessment Guidance	F 276	specialty company dealing with positioning/orthotics regarding foot positioning on March 2. RoM continues to be done B.i.d. Firm foam wedge/cushion placed in 'bucket footrest' of Broda chair to assist to prevent foot-drop. OT referral for improved chair positioning if possible. 2. Corrective Action as it applies to others: a. Professional staff will be re-educated to perform complete, individualized assessments related to safety with side rail use and proper wheelchair positioning done with each routine assessment or more often if needed. b. Nursing staff will be re-educated to to note and then report deviations in safety and positioning to lic. staff.		

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NAME OF PROVIDER OR SUPPLIER

CLARKFIELD CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

805 FIFTH STREET, BOX 458
CLARKFIELD, MN 56223

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F 276

Continued From page 11

to Reduce Entrapment," dated 3/10/06. The openings within the side rails in Zone 1 were measured to be at seven and one-half by fourteen (7 1/2 by 14) inches in the center opening. Two openings were six by fourteen (6 by 14) inches and two outer openings were six by nine (6 by 9) inches. The maximum opening within the side rails in Zone 1 recommended by the FDA was four and three-quarter (4 and 3/4) inches.

The facility assessments did not review all components related to the use of side rails that included individualized functional mobility needs related to the device, medical/safety risk factors, compliance with Federal agency dimensional guidance, potential for restrictiveness with use of the device, possible use of alternative devices to aid in safety or mobility, and a method to implement and monitor use. Additionally, the facility did not recognize the side rail device actually met the technical definition of a quarter side rail that had the potential to be restrictive or that it could potentially pose significant safety risks.

Unit registered nurse-A (RN-A) reported during staff interview at 5:15 p.m. on 2/27/12 R7 did not use quarter or half side rails and there were no side rails utilized in the facility, only grab bar devices were used on the beds.

The director of nursing (DON) reported during interview at 1:30 p.m. on 2/29/12 she was not aware there were any actual side rails in the facility or that there were side rail devices used that were not in compliance with the FDA standards.

F 276

c. Lic. staff will then initiate new assessment process that involves OT, based on reported or observed safety/positioning problems.

d. Lic. staff will be re-educated by reviewing facility's Red Flag Indicators Triggering Referral to Occupational, Physical, or Speech Therapy, including emphasis of poor positioning
Re-occurrence will be prevented by:

a. Lic. staff will perform comprehensive reviews and assessments related to siderail/grab bar device use and wheelchair positioning as per regulation and timelines.

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F 276

Continued From page 12

Unit registered nurse-B (RN-B) verified at 2:30 p.m. on 2/29/12 the facility did not obtain a written consent prior to use of the side rail devices and could not provide any documentation of what was provided to residents for the risk/benefit education noted in the assessment for R7. RN-B also reported the functional/safety assessment tool was the only method used by the facility to evaluate care components related to use of side rail devices.

Resident 37 (R37) utilized a single quarter side rail device that was not comprehensively assessed for all relevant factors to ensure safe and appropriate use. Additionally, their procedures were not followed for obtaining a consent for use of the device.

R37 had diagnoses that included Parkinsonism, degenerative joint disease in both shoulders, dementia and episodic delirium.

The most recent quarterly minimum data set (MDS) dated 1/27/12 identified R37 with moderately impaired cognitive skills (BIMS=8), mood and behavioral symptoms present with behavior symptoms that placed R37 at risk of injury. The MDS also noted extensive assistance of 1 staff for bed mobility, extensive assistance of 2 staff for transfers and ambulation, impaired range of motion in both upper extremities, unsteady balance and noted bed rails were not used.

The functional/safety assessment initially completed at admission 8/22/11 with quarterly update 1/27/12 identified R37 required extensive

F 276

b. Visual awareness by nursing and interdepartmental staff for safe, proper, comfortable siderail use and positioning.

c. Report to lic. staff if deviation is noted.

d. Re-education of staff as noted in #2.

e. Random visual audits will be done to always observe for proper positioning, comfort, and safety

4. Correction will be monitored by:

a. Lic. staff and DoN

b..QA committee will review audit results and provide further recommendations as needed.

5. Date of completion:

April 10, 2012

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F 276	Continued From page 13 assistance of staff for bed mobility and assistive devices were used for transfers; however, the section for side rails or transfer bars were not checked for use. Neither the initial safety assessment nor the quarterly updates noted the use of side rails. R37's bed was observed at 9:50 a.m. on 2/28/12 to have a side rail raised on the outside. R37 was not in the bed at the time. The side rail observed was an older metal design that had five separate openings between the rails (Zone 1) that exceeded standards set forth in the U.S. Health and Human Services, Food and Drug Administration (FDA) publication, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," dated 3/10/06. The openings within the side rails in Zone 1 were measured to be at seven and one-half by fourteen (7 1/2 by 14) inches in the center opening. Two openings were six by fourteen (6 by 14) inches and two outer openings were six by nine (6 by 9) inches. The maximum opening within the side rails in Zone 1 recommended by the FDA was four and three-quarter (4 and 3/4) inches. The facility assessment did not review all components related to the use of side rails that included individualized functional mobility needs related to the device, medical/safety risk factors, compliance with Federal agency dimensional guidance, potential for restrictiveness with use of the device, possible use of alternative devices to aide in safety or mobility, and a method to implement and monitor use. Additionally, the facility did not recognize the side rail device	F 276					

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F 276	Continued From page 14 actually met the technical definition of a quarter side rail that had the potential to be restrictive or that it could potentially pose significant safety risks. Unit registered nurse-A (RN-A) reported during staff interview at 5:15 p.m. on 2/27/12 R37 did not use quarter or half side rails and there were no side rails utilized in the facility, only grab bar devices were used on the beds. The director of nursing (DON) reported during interview at 1:30 p.m. on 2/29/12 she was not aware there were any actual side rails in the facility or that there were side rail devices used that were not in compliance with the FDA standards. Unit registered nurse-B (RN-B) verified at 2:30 p.m. on 2/29/12 the facility did not obtain a written consent prior to use of the side rail devices and could not provide any documentation of what was provided to residents for the risk/benefit education noted in the assessment for R37. RN-B also reported the functional/safety assessment tool was the only method used by the facility to evaluate care components related to use of side rail devices and the assessment did not identify the use of the side rail device for R37. RN-B stated R37 was initially resistant to sleeping in the bed and he currently primarily slept in the recliner in the room; however, could potentially still use the bed. R37 also was not reassessed for seating needs that maximized his functional mobility and minimized risk of pressure ulcers while seated.	F 276			

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F 276	Continued From page 15 R37's initial assessment information dated 8/22/11 identified R37 utilized a wheelchair and specialty mattress on the bed, with no mention of any wheelchair cushion utilized. The quarterly update to the functional/safety assessment dated 1/27/12 noted he used a wheelchair and could propel himself short distances. There was also no indication of the type of seat cushion used. R37 was observed at 9:48 a.m. on 2/28/12 seated in a Homecrest Rock and Go geri chair without legrests or wheelchair cushion. R37 complained of the armrests being too high and could not support his arms and he could not reach the front large wheels to propel the chair himself. R37 stated his bottom was always sore. At 9:50 a.m. the maintenance staff was requested by nursing to help locate the legrests for R37's geri chair and they were located and applied. RN-B verified at 11:28 a.m. on 2/28/12 there was no record of a referral to or recommendations by occupational or physical therapy related to proper chair fitting/use or pressure reduction cushion evaluation. RN-B also stated R37 did use a wheelchair at one time and had a gel cushion, but currently had a geri chair with a Roho air cushion but was not sure who changed the seating equipment and when. R37 stated the current care plan still noted the use of a wheelchair and gel cushion. The consultant physical therapist verified at 2:15 p.m. on 2/29/12 the occupational therapist (OT) was the person who did seating evaluations and there was no record the OT received a request for/or performed a seating evaluation of R37 and	F 276			

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F 276	Continued From page 16 nursing must have taken the initiative to change the seating equipment utilized. The facility policy (not dated) reviewed related to referral to specialized therapy identified one possible indicator for referral was resident's poor positioning in bed or chair. R4 's positioning was not comprehensively assessed and addressed to maintain her highest level of well-being. R4 had multiple diagnoses which included Huntington's chorea, depression, and chronic pain syndrome. R4 's quarterly minimum data set (MDS) dated 12/7/11, identified she had a severe cognitive impairment, was totally dependent for wheelchair mobility, and revealed that no occupational or physical therapy services were being provided. The Functional/Safety Assessment revised on 12/7/11 indicated R4 required the use of a Hoyer lift and was totally dependent. During observation at 12:18 p.m. on 2/28/12, R4 was observed in a slightly reclined position and was slouched down in her Broda chair. The bucket foot rest, used to support her legs was approximately six inches longer than her legs. R4 's feet were unsupported; her toes were pointed forward and were touching the base of the foot pad. During interview at 9:15 a.m. on 2/29/12, occupational therapist (OT) confirmed R4 's feet were not supported and with manipulation, identified the presence of contractures in both			F 276			

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F 276

Continued From page 17
feet and stated, "I can't hardly move her feet, they are contracted for sure." OT stated occupational therapy was responsible for head to toe positioning. OT confirmed they worked with R4's wheelchair positioning but had never addressed her foot drop. OT reported occupational therapy sets up the range of motion (ROM) programs and expected nursing staff to complete. OT could not recall ever working on ROM with R4. OT confirmed no referral had been made for addressing wheelchair positioning or foot contractures in the past year.

During interview at 11:00 a.m. on 2/29/12, OT explained that a hard board for foot support would not be appropriate for R4 due to her uncontrollable movements and fear of injury. OT confirmed no other devices had been tried to maintain proper foot positioning and prevent foot drop.

During interview at 12:30 on 2/29/12, director of nursing (DON) indicated R4's slouched position in Broda chair as being typical of how she was always positioned. DON confirmed absence of support for both feet and presence of a foot drop.

Review of facility's Red Flag Indicators Triggering Referral to Occupational, Physical and Speech Therapy document listed poor positioning in bed or chair and decline in available movement or increased difficulty in performing passive range of motion exercises as indicators needing referral.

F 279
SS=D

483.20(d), 483.20(k)(1) DEVELOP
COMPREHENSIVE CARE PLANS

F 276

F 279

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F 279	Continued From page 18 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a plan of care related to dental status and dental care needs for 1 of 3 residents (R4), reviewed in the sample for dental services. R4 's care plan did not address specific oral care needs. R4 's diagnosis include: Huntington's chorea, dysphasia, depression, and chronic pain syndrome. R4 's care area assessment (CAA) dated 12/7/11	F 279	F E F279 1. Corrective Action: R4 oral status/oral health was re-assessed and documented. Oral plan of care changed based on this assessment. Family requests to defer dental visit d/t advanced stage of terminal disease. 2. Corrective action as it applies to others: a. All residents will be assessed for oral health on admission and at least quarterly with individualized plan for oral care developed based on the assessment. b. Nursing staff will be re-educated to follow oral health/oral care policy of the facility.		

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F 279	Continued From page 19 indicated she required total assistance for oral cares. It revealed that her Huntington's movements made oral cares difficult. CAA identified the family requested that no dental referral was to be made for R4. The Physician note dated 4/5/11, identified R4's teeth, "Look to be very poor condition right now." The Physician recommended the nursing staff discuss the plan for dental cares with the family although it would be difficult because of R4 's movements. The Functional/Safety Assessment dated 11/5/10, revealed boxes checked in the oral/dental section included: Obvious or likely cavity or broken natural teeth, and also inflamed or bleeding gums or loose natural teeth. The comments section, revised on 12/7/11, indicated R4 had missing teeth, her gums bled when her teeth were brushed and her remaining teeth were yellow and brown stained. No interventions or plan of care changes were made after this assessment. The care plan revised on 1/4/12 indicated R4 had her own teeth and required assist of two for all personal hygiene. The care plan did not address specific oral care needs that were identified on the oral needs assessment. During observation at approximately 7:30 a.m. on 2/29/12, nursing assistant (NA)-D assisted R4 with brushing her teeth and used a standard yellow, generic toothbrush. NA-D made three passes through R4 's mouth with the toothbrush. Blood was observed on the toothbrush and dripping down the side of R4 's mouth. NA-D	F 279	3. Reoccurrence will be by: a. Re-education of nursing staff regarding following facility policy of individualized oral health assessment and oral care and intervention plan. (as noted in #2) b. Periodic audit of completeness in individualized oral health assessment and specific plan of care. 4. Correction will be monitored by: a. RNs and DoN b. QA committee will review audit results and provide further direction as needed. 5. Date of completion: April 10, 2012		

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F 279	Continued From page 20 gave R4 two small sips of regular water to rinse her mouth and R4 swallowed the water each time. NA-D confirmed that R4 's teeth usually bled with brushing. NA-D also stated R4 was not the best at rinsing and spitting. NA-D explained R4 was supposed to have thickened liquids but there was no way she can rinse and spit with thickened water. Review of the facility's oral care policy revised on 5/11, revealed residents would be assessed for oral health upon admission and at least on a quarterly basis. The oral care policy further indicated an individual care plan for each resident would be developed based on the assessment. The policy was not followed for R4.	F 279		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2) (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and (B) If the individual requires such level of	F 285	During the facility survey The Level 1 screening document for mental illness could not be found in the medical record of R7 and could not be located by Kandiyohi county who did the screening 9/2/08. 1. Correction Action: On 3/22/12 Kandiyohi County did locate the MI level 1 screening document and faxed it to facility social worker. No referral was indicated for Level II. 2. Reoccurrence will be prevented by: The social worker will assure that all appropriate screening documents are in each medical record at admission. 3. Correction will be monitored by: Pat Bakkelund, Licsensed Social worker 4. Date of Completion: 3/22/12.	

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F 285	Continued From page 21 services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to assure appropriate services for mental retardation/mental illness were provided for 1 of 1 residents (R7) reviewed in the sample. Findings include: Resident 7's (R7) records lacked evidence of completion of screening for both mental	F 285			

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F 285	Continued From page 22 retardation and mental illness. R7 had diagnoses that included schizophrenia, obsessive compulsive disorder, pulmonary disease, hypertension and diabetes mellitus. The most recent quarterly minimum data set (MDS) dated 12/18/11 identified R7 with moderately impaired cognitive skills (brief interview mental status BIMS=12), speech and hearing difficulty with indicators of mood disorder present. The MDS also noted the section for preadmission screening for mental illness/retardation was blank. At survey entrance R7 was included on a list provided of residents who met the requirements for level two services for mental illness. The records reviewed the level one screening for mental retardation and related conditions had been completed dated 9/2/08. The facility social services director was unable to locate the level one screening tool for mental illness and related conditions and a level two screening was not located either. R7's plan of care dated 8/22/08 included visits with psychiatry every three months; however, no specialized rehabilitation or other level two services were provided by the facility. The facility social services director verified at 10:30 a.m. on 2/29/12 she was not able to locate any additional documentation of screening and was not sure which county office would have it. Requests were submitted to the county to fax the reports to the facility; however, by the time of exit at 5:30 p.m. no information had been received.	F 285			

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F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary care and services for 2 of 3 residents (R37 and R4) in the sample who were reviewed for positioning and 2 of 3 residents (R21 and R4) in the sample who were reviewed for oral/ dental care. Findings Include: Resident 37 (R37) did not receive the necessary care and services related to assessment and consistent employment of proper seating devices and equipment that maximized his functional mobility and comfort and minimized the risk of excessive pressure while seated. R37 had diagnoses that included Parkinsonism, degenerative joint disease in both shoulders, dementia and episodic delirium. The most recent quarterly minimum data set (MDS) dated 1/27/12 identified R37 with moderately impaired cognitive skills (BIMS=8), mood and behavioral symptoms present with	F 309	F309 1. Corrective Action: a. R 37 was transferred to another long term care facility to be closer to home and family on March 1. b. R 4 has been referred to OT and orthotics specialist for positioning for comfort and safety, prevention of contractures and foot drop. c. R 21 was re-assessed for oral health status and attempt x2 made to have dental visit, but does not want to go. 2. Corrective action as it applies to others: a. Lic. nursing staff will be re-educated to do complete, individualized positioning and oral health assessments with each routine assessment per policy or more often if needed. b. Nursing staff will be re-educated to note and then report deviations in positioning, range of motion changes, and oral health changes.		

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F 309	Continued From page 24 behavior symptoms that placed R37 at risk of injury. The MDS also noted extensive assistance of 1 staff for bed mobility, extensive assistance of 2 staff for transfers and ambulation, impaired range of motion in both upper extremities, unsteady balance and noted bed rails were not used. R37's initial assessment information dated 8/22/11 identified R37 utilized a wheelchair and specialty mattress on the bed, with no mention of any wheelchair cushion utilized. The quarterly update to the functional/safety assessment dated 1/27/12 noted he used a wheelchair and could propel himself short distances. There was also no indication of the type of seat cushion used. R37's care plan interventions dated 12/4/12 included gel cushion in wheelchair and recliner. The current use of the Roho air cushion and the Homecrest Rock and Go gerichair not included as interventions and a repositioning interval not indicated. The current nursing assistant care sheets did not identify a repositioning time interval for geri chair and recliner or the use of the Homecrest geri chair and Roho cushion or legrests. R37 was observed at 9:48 a.m. on 2/28/12 seated in a Homecrest Rock and Go geri chair without legrests or wheelchair cushion. R37 complained of the armrests being to high and could not support his arms and he could not reach the front large wheels to propel the chair himself. R37 stated his bottom was always sore. At 9:50 a.m. the maintenance staff was requested by nursing to help locate the legrests for R37's geri chair and they were located and applied. R37	F 309	to lic. staff. c. Lic. staff will then initiate new assessment process that involves OT, PT, or another specialized provider based on observed or reported safety/positioning or oral health problems. d. Lic. nursing will be re-educated to review facility's Red Flag Indicators Triggering Referral to OT, PT. and to identify if an individual interventions needed to enhance oral health. 3. Re-occurrence will be prevented by: a. Lic. staff will perform comprehensive reviews and assessments related to positioning, oral health as per regulation and timelines b. visual awareness by nursing and interdepartmental staff for safe, proper, comfortable w/chair positioning and oral health status.		

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F 309	Continued From page 25 had been moved by staff with feet dangling unsupported before the footrests were located. RN-B verified at 11:28 a.m. on 2/28/12 there was no record of a referral to or recommendations by occupational or physical therapy related to proper chair fitting/use or pressure reduction cushion evaluation. RN-B also stated R37 did use a wheelchair at one time and had a gel cushion, but currently had a geri chair with a Roho air cushion but was not sure who changed the seating equipment and when. R37 stated the current care plan still noted the use of a wheelchair and gel cushion. The consultant physical therapist verified at 2:15 p.m. on 2/29/12 the occupational therapist (OT) was the person who did seating evaluations and there was no record the OT received a request for/or performed a seating evaluation of R37 and nursing must have taken the initiative to change the seating equipment utilized. The facility policy (not dated) reviewed related to referral to specialized therapy identified one possible indicator for referral was resident's poor positioning in bed or chair. R21 failed to receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being related to oral/dental need.. During initial observation and interview with R21 at 5:00 p.m. on 2/27/12 she was noted to have missing teeth on her upper mouth. R21's upper teeth were also noted to be broken and worn. The facility conducted a Functional/Safety	F 309	c. Report to lic. staff is diviation is noted. d. Re-education of staff as noted in #2. e. Random visual audits will be done to always observe for proper positioning, comfort, safety, and oral health. 4. Correction will be monitored by: Lic. Staff and DoN 5. Date of completion: April 10, 2012		

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F 309	Continued From page 26 assessment on 10/26/11 which had an oral/dental section. The assessment identified R21 with lower partial dentures. The Functional/Safety assessment prior to the 10/26/11 assessment was dated 12/10/10 and the assessment identified R21 with a lower partial and her own upper teeth. The assessment failed to identify the missing, broken, and worn teeth on the upper oral cavity region. R21's annual Minimum Data Set (MDS) assessment, dated 10/28/11 identified her with no oral/dental concerns under Oral Dental Status, section L of the MDS. R21's Care Plan, dated 2/15/12 identified her with a problem with functional balance chewing and mastication difficulty related to edentulous status manifested by signs and symptoms of altered chewing. During interview with R21's Registered Nurse (RN)-B case manager at 10:30 a.m. on 2/29/12 she stated the facility had attempted to have the resident seen by the dentist but R21 would refuse. She stated the facility would make the appointment for R21 and she would refuse to go the day of the appointment. RN-B stated she believed the physician had assessed R21's oral/dental status during his last check but verified there was no documentation to identify her dental status was assessed. RN-B verified R21's medical record lacked a thorough assessment of her oral/dental status and verified the facility's most recent assessment identified only that she had a lower partial and did not address her upper dental status.	F 309			

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F 309	Continued From page 27 The facility failed to conduct a comprehensive assessment that accurately reflected the oral/dental status to identify if interventions needed to be initiated to enhance oral health for R21. The facility assessments failed to identify her missing, broken and worn teeth in her upper oral cavity and failed to identify if she had any oral cavity anomalies. The facility lacked any evidence R21's oral cavity had been assessed to identify concerns. Resident 4 (R 4) did not receive the necessary care and services to attain or maintain the highest level of well-being related to wheelchair positioning. R4 had multiple diagnoses which included Huntington's chorea, depression, and chronic pain syndrome. R4 ' s quarterly minimum data set (MDS) dated 12/7/11, identified she had a severe cognitive impairment, was totally dependent for wheelchair mobility as well as activities of daily living, and revealed that no occupational or physical therapy services were being provided. The Functional/Safety Assessment revised on 12/7/11 indicated R4 required the use of a Hoyer lift and was totally dependent. Review of R4 ' s Plan of Care indicated an entry dated 2/5/10 which read, " Foot bucket added to Broda chair. Lamb ' s wool lining foot extension. " During observation at 12:18 p.m. on 2/28/12, R4	F 309			

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F 309	Continued From page 28 was observed in a slightly reclined position and was slouched down in her Broda chair. The bucket foot rest, used to support her legs was approximately six inches longer than her legs. R4 's feet were unsupported; her toes were pointed forward and were touching the base of the foot pad. During interview at 9:15 a.m. on 2/29/12, occupational therapist (OT) confirmed R4 's feet were not supported and with manipulation, identified the presence of contractures in both feet and stated, "I can 't hardly move her feet, they are contracted for sure." OT reported the contracture development was likely related to her disease progression but could not say for sure. OT stated occupational therapy was responsible for head to toe positioning. OT confirmed they worked with R4 's wheelchair positioning but had never addressed her foot drop. OT confirmed no referral had been made for addressing wheelchair positioning or foot contracture in the past year. During interview at 11:00 a.m. on 2/29/12, OT explained that a hard board for foot support would not be appropriate for R4 due to her uncontrollable movements and fear of injury. OT confirmed no other devices had been tried to maintain proper foot positioning and prevent foot drop. During interview at 12:30 on 2/29/12, director of nursing (DON) indicated R4 's slouched position in Broda chair as being typical of how she was always positioned. DON confirmed absence of support for both feet and presence of a foot drop.	F 309			

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F 309	Continued From page 29 Review of facility 's Red Flag Indicators Triggering Referral to Occupational, Physical and Speech Therapy document listed poor positioning in bed or chair and decline in available movement or increased difficulty in performing passive range of motion exercises as indicators needing referral. R4 's diagnosis include: Huntington's chorea, dysphasia, depression, and chronic pain syndrome. R4 's care area assessment (CAA) dated 12/7/11 indicated she required total assistance for oral cares. It revealed that her Huntington's movements made oral cares difficult. CAA identified the family requested that no dental referral was to be made for R4. Review of West Station B 's most recent nursing assistant (NA) care sheet reviewed 2/29/12, identified R4 had her own teeth and needed total assistance with oral cares. The Physician note dated 4/5/11, identified R4's teeth, "Look to be very poor condition right now. " The Physician recommended the nursing staff discuss the plan for dental cares with the family although it would be difficult because of R4 's movements. The Functional/Safety Assessment dated 11/5/10, revealed boxes checked in the oral/dental section included: Obvious or likely cavity or broken natural teeth, and also inflamed or bleeding gums or loose natural teeth. The comments section, revised on 12/7/11, indicated	F 309			

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F 309	Continued From page 30 R4 had missing teeth, her gums bled when her teeth were brushed and her remaining teeth were yellow and brown stained. No interventions or plan of care changes were made after this assessment. The care plan revised on 1/4/12 indicated R4 had her own teeth and required assist of two for all personal hygiene. The care plan did not address specific oral care needs that were identified on the oral needs assessment. During observation at approximately 7:30 a.m. on 2/29/12, nursing assistant (NA)-D assisted R4 with brushing her teeth and used a standard yellow, generic toothbrush. NA-D made three passes through R4 's mouth with the toothbrush. Blood was observed on the toothbrush and dripping down the side of R4 's mouth. NA-D gave R4 two small sips of regular water to rinse her mouth and R4 swallowed the water each time. NA-D confirmed that R4 's teeth usually bled with brushing. NA-D also stated R4 was not the best at rinsing and spitting. NA-D explained R4 was supposed to have thickened liquids but there was no way she can rinse and spit with thickened water. Review of the facility's oral care policy revised on 5/11, revealed residents would be assessed for oral health upon admission and at least on a quarterly basis. The oral care policy further indicated an individual care plan for each resident would be developed based on the assessment. The policy was not followed for R4.	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314			

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F 314	Continued From page 31 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure all residents who were at risk of, or had pressure ulcers received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for 1 of 2 residents (R37) reviewed in the sample. Findings Include: R37 had diagnoses that included Parkinsonism, degenerative joint disease, dementia with episodic delirium, non insulin dependent diabetes mellitus, intermittent claudication and chronic leg edema. The admission minimum data set (MDS) identified R37 with moderately impaired cognitive skills (brief interview mental status BIMS=11), mood and behavioral symptoms present with the behavioral symptoms that placed R37 at risk of injury. The MDS also noted extensive assistance of 2+ staff for bed mobility, transfers and ambulation, impaired balance and loss of range of motion in both upper extremities and bowel	F 314	F314 1. Corrective Action: R37 was transferred to another long term care facility to be closer to home and family on March 1. 2. Corrective Action as it applies to other residents: a. Lic. Nursing staff will be re-educated to perform, accurate, comprehensive skin assessment by observation, interview, and documentation of skin condition. b. Re-education for Lic. nursing staff that if resident at risk or has pressure ulcer present is to receive necessary treatment and services to promote healing, prevent infection, and prevent new ulcers to develop. c. Lic. nursing staff will be re-educated on wound tracking documentation to include not only size and nature of wound and dressings, but collaboration about other treatment and plan of care approaches and interventions. d. Lic. nursing staff will be re-educated on use of RoHo cushion including having written guidance with care plan.		

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F 314	Continued From page 32 and bladder incontinence. The MDS did not identify the presence of a pressure ulcer at admission but did note a turning and repositioning program and pressure reduction device for bed only. The care area assessment (CAA) was triggered for pressure ulcers. The initial admission information sheet body diagram dated 8/15/11 identified R37 had [three/eighths (3/8) inch sore skin missing] noted over the right buttocks area; however, the skin assessment sheet noted, [(R37) was alert and has no evidence of pressure ulcers. R37 had a specially mattress and was repositioned every two hours, used a wheelchair to /from destinations and had his own recliner he sat in between meals. A Braden skin risk assessment completed upon admission on 8/15/11 noted a score of 20; 18 or lower indicated significant risk that required implementation of pressure relieving devices and weekly skin review. R37 had a pressure ulcer at the time the Braden was completed. The admission assessment did not recognize the presence of the open area present at admission and the care area assessment (CAA) summary was not completed and noted, [See ADL CAA.] The activity of daily living (ADL) CAA noted only that R37 had a potential for skin breakdown and also did not review all the risk factors, repositioning interval tolerance or detail strategies for interventions that would be included in R37's care plan. R37's care plan dated 11/9/11 identified the initial pressure ulcer at 1X1 (unit of measurement not	F 314	e. Lic. staff will be re-educated to complete individualized plans of care based on appropriately collected information and accurate analysis of skin integrity. f. Lic. nursing staff will be re-educated to document accurately skin condition on MDS and CAA, including reviewing risk factors, repositioning interval tolerance or detailed strategies for interventions. 3. Reoccurrence will be prevented by: a. Use of skin assessment tool-kit to assist in assessment, planning, implementation. b. Re-education of staff as noted above. c. Random audits of clinical records will be done for completeness of skin assessment that includes items as noted in e & f above.		

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F 314	Continued From page 33 indicated) that was crossed off on 11/9/11 and replaced with, [At risk of pressure areas/ulcers. The pressure ulcer that redeveloped on 12/8/12 was not identified on the care plan. Interventions dated 12/4/12 included gel cushion in wheelchair and recliner, monitor skin integrity as needed (PRN), wound nurse visits PRN. The current use of the Roho air cushion and the Homecrest Rock and Go gerichair not included as interventions. The care plan and current nursing assistant care sheets did not identify a repositioning time interval. R37 was observed at 9:48 a.m. on 2/28/12 seated in a Homecrest Rock and Go geri chair without legrests and without a gel or Roho wheelchair cushion. R37 complained of the armrests being too high and could not support his arms and he could not reach the front large wheels to propel the chair himself. R37 stated his bottom was always sore. R37 was also continuously observed from 1:30 p.m. to 4:00 p.m. on 2/28/12. R37 was apparently sleeping in the recliner in his room and no staff was observed to reposition him during the two and one-half hour period. The Roho cushion was noted in use in the recliner. The treatment nurse, licensed practical nurse-A (LPN-A) reported at 9:45 a.m. on 2/29/12 the Roho cushion was on the treatment sheet to check for proper inflation each day. LPN-A stated she just, "Pushed on it to see if it had air. If not, I pump it up until it's full." LPN-A was not sure what the proper inflation level was and could not locate a procedure for correct inflation that was given to nursing. At 11:00 a.m. the dressing change for R37 by	F 314	4. Correction will be monitored By: a. RNs and DoN b. QA committee will review audit results and provide further direction if needed. 5. Date of completion: April 10, 2012		

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F 314	Continued From page 34 LPN-A was observed. LPN-A stated the wound, "comes and goes" and gets "smaller and larger," but was now generally improving. Unit registered nurse-B (RN-B) verified at 11:28 a.m. on 2/28/12 she was not sure how to view the CAA on the computer and a medical records licensed practical nurse (LPN) was responsible for entering the data into the CAA summaries. RN-B verified R37 had an open area at admission that should have been addressed in the MDS and CAA and it had healed and then reopened again about 12/8/12 and has remained open since that time until present. RN-B reported it gets smaller and larger, had been up to 1.5cm by .5 cm. and was not stageable, but was currently .5 cm by .5 cm. and was now classified a stage 2 ulcer because the slough was removed. RN-B stated the facility used a wound tracking record flow sheet; however, could only locate tracking that had been completed since 12/29/11. RN-B reported a skin care nurse employed by a dressing supply company vendor made regular visits to advise staff on dressing choices and techniques, but did not chart in the facility interdisciplinary progress notes but had a separate record keeping book. The book was reviewed and noted to primarily contain some data on the size and nature of the wound and information about the dressings selected for use but not collaboration about other treatment and care plan approaches and interventions. The facility skin assessment and care policy updated May 2011 identified tissue tolerance evaluation was to be completed and care plans should include individualized repositioning plan	F 314			

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F 314	Continued From page 35 and identification of which pressure-redistributing devices were used with completion of another skin assessment by an RN if a new pressure ulcer developed. The facility policy for pressure ulcer care dated May 2011 also identified the need for accurate documentation and timely interventions for problems and outlined details for dressing product selection and wound care.	F 314			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, policy and document review the facility failed to assure the resident environment remained as free of accident hazards as was possible related to an evaluation of safety and appropriate use for 4 of 4 residents (R7, R37, R43 and R53) who were observed to have metal side rails on their bed that did not meet the safety standards as defined by the U.S. Health and Human Services, Food and Drug Administration for dimensions of openings within the side rails (Zone 1.) Findings include: Resident 7 (R7) utilized a single quarter side rail	F 323	F323 Corrective Action: R37 was transferred to another long term care facility to be closer to home and family on March 1. R7 was informed of risks and benefits of using bedrail/grab bar as aid in mobility and prefers to continue use of an assistive device. Consent form signed. Half bedrail that was in use during survey was removed and alternative device applied that meets federal dimensional guidance.		

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F 323	Continued From page 36 device that was not comprehensively assessed for all relevant factors to ensure safe and appropriate use. Additionally, the facility procedures were not followed for obtaining a consent for use of the device and the device was not in compliance with safety audits that were to be completed by the facility according to their policies. Resident 7 (R7) had diagnoses that included schizophrenia, pulmonary disease, hypertension and diabetes mellitus. The most recent quarterly minimum data set (MDS) dated 12/18/11 identified R7 with moderately impaired cognitive skills (brief interview mental status BIMS=12), independence in bed mobility, transfers and ambulation. The MDS noted bed rails were not used. The facility completed a functional /safety assessment tool with the admission MDS and updated with each quarterly re-assessment. The assessment completed 12/18/11 noted use of [top right half rail] and benefits of use of the bed rail were checked for [increased independence/participation.] The safety assessment also noted, [Education on risk benefit provided and consent obtained for use of bed rails.] R7 was observed in bed with an outside metal quarter side rail raised on the bed at 7:30 p.m. on 2/27/12 and 8:50 a.m. on 2/28/12. The side rail observed was an older metal design that had five separate openings between the rails (Zone 1) that exceeded standards set forth in the	F 323	R43 informed of risks and benefits of using bedrail/grab bar as aid in mobility and stated preference to continue use of a device. Consent form obtained/signed. Half bedrail in use during survey was removed and alternative device applied that meets federal dimensional guidance. R53 stated did not use grab bar/ siderail and it was removed from bed. 2. Corrective Action as it applies to other residents: a. Individualized, comprehensive clinical assessments will be done on all residents that include periodic, accurate assessment of siderail/ grab bar devices that includes addressing safety factors within federal guideline and obtaining written, signed consents. b. Lic. staff will be re-educated on doing these assessments accurately to reflect each resident's mobility ability as well as safety device needs.		

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F 323	Continued From page 37 U.S. Health and Human Services, Food and Drug Administration (FDA) publication, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," dated 3/10/06. The openings between the rails in Zone 1 were measured to be at seven and one-half by fourteen (7 1/2 by 14) inches in the center opening. Two openings were six by fourteen (6 by 14) inches and two outer openings were six by nine (6 by 9) inches. The maximum opening between the rails in Zone 1 recommended by the FDA was four and three-quarter (4 and 3/4) inches. The facility assessments did not review all components related to the use of side rails that included individualized functional mobility needs related to the device, medical/safety risk factors, compliance with Federal agency dimensional guidance, potential for restrictiveness with use of the device, possible use of alternative devices to aide in safety or mobility, and a method to implement and monitor use. Additionally, the facility did not recognize the side rail device actually met the technical definition of a quarter side rail that had the potential to be restrictive or that it could potentially pose significant safety risks. Unit registered nurse-A (RN-A) reported during staff interview at 5:15 p.m. on 2/27/12 R7 did not use quarter or half side rails and there were no side rails utilized in the facility, only grab bar devices were used on the beds. The director of nursing (DON) reported during interview at 1:30 p.m. on 2/29/12 she was not aware there were any actual side rails in the	F 323	3. Reoccurrence will be prevented by: a. Periodic audits will be done to ensure assessment conclusions are accurate and complete, including being individualized based on appropriately collected information and accurate analysis. b. These periodic audits will be reviewed with quarterly QA committee meeting for further recommendations if needed. 4. Correction will be monitored by: DoN or designee. 5. Date of Completion: April 10, 2012		

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F 323	Continued From page 38 facility or that there were side rail devices used that were not in compliance with the FDA standards. Unit registered nurse-B (RN-B) verified at 2:30 p.m. on 2/29/12 the facility did not obtain a written consent prior to use of the side rail devices and could not provide any documentation of what was provided to residents for the risk/benefit education noted in the assessment for R7. RN-B also reported the functional/safety assessment tool was the only method used by the facility to evaluate care components related to use of side rail devices. Resident 37 (R37) utilized a single quarter side rail device that was not comprehensively assessed for all relevant factors to ensure safe and appropriate use. Additionally, the facility procedures were not followed for obtaining a consent for use of the device and the device was not in compliance with safety audits that were to be completed by the facility according to their policies. R37 had diagnoses that included Parkinsonism, degenerative joint disease in both shoulders, dementia and episodic delirium. The most recent quarterly minimum data set (MDS) dated 1/27/12 identified R37 with moderately impaired cognitive skills (BIMS=8), mood and behavioral symptoms present with behavior symptoms that placed R37 at risk of injury. The MDS also noted extensive assistance of 1 staff for bed mobility, extensive assistance of 2 staff for transfers and ambulation, impaired range of motion in both upper extremities,	F 323			

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F 323	Continued From page 39 unsteady balance and noted bed rails were not used. The functional/safety assessment initially completed at admission 8/22/11 with quarterly update 1/27/12 identified R37 required extensive assistance of staff for bed mobility and assistive devices were used for transfers; however, the section for side rails or transfer bars were not checked for use. Neither the initial safety assessment nor the quarterly updates noted the use of side rails. R37's bed was observed at 9:50 a.m. on 2/28/12 to have a side rail raised on the outside. R37 was not in the bed at the time. The side rail observed was an older metal design that had five separate openings between the rails (Zone 1) that exceeded standards set forth in the U.S. Health and Human Services, Food and Drug Administration (FDA) publication, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," dated 3/10/06. The openings between the rails in Zone 1 were measured to be at seven and one-half by fourteen (7 1/2 by 14) inches in the center opening. Two openings were six by fourteen (6 by 14) inches and two outer openings were six by nine (6 by 9) inches. The maximum opening between the rails in Zone 1 recommended by the FDA was four and three-quarter (4 and 3/4) inches. The facility assessment did not review all components related to the use of side rails that included individualized functional mobility needs	F 323			

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F 323	Continued From page 40 related to the device, medical/safety risk factors, compliance with Federal agency dimensional guidance, potential for restrictiveness with use of the device, possible use of alternative devices to aide in safety or mobility, and a method to implement and monitor use. Additionally, the facility did not recognize the side rail device actually met the technical definition of a quarter side rail that had the potential to be restrictive or that it could potentially pose significant safety risks. Unit registered nurse-A (RN-A) reported during staff interview at 5:15 p.m. on 2/27/12 R37 did not use quarter or half side rails and there were no side rails utilized in the facility, only grab bar devices were used on the beds. The facility maintenance director verified at 10:00 a.m. on 2/29/12 the dimensions of the four metal side rails that exceeded FDA guidance. Initially, the maintenance director stated he was not aware of the standards, then recalled he had seen some information about the issue. The director reported nursing requested side rails on beds for residents; however, he did not differentiate between the metal side rails for the older beds or the several other types of different and newer beds that utilized a variety of side rail designs and dimensions. He reported the side rails were not removed unless requested to by nursing and were not deactivated if not used. The director of nursing (DON) reported during interview at 1:30 p.m. on 2/29/12 she was not aware there were any actual side rails in the facility or that there were side rail devices used that were not in compliance with the FDA	F 323			

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F 323	Continued From page 41 standards. Unit registered nurse-B (RN-B) verified at 2:30 p.m. on 2/29/12 the facility did not obtain a written consent prior to use of the side rail devices and could not provide any documentation of what was provided to residents for the risk/benefit education noted in the assessment for R37. RN-B also reported the functional/safety assessment tool was the only method used by the facility to evaluate care components related to use of side rail devices and the assessment did not identify the use of the side rail device for R37. RN-B stated R37 was initially resistant to sleeping in the bed and he currently primarily slept in the recliner in the room; however, could potentially still use the bed. Facility policy for the safety program dated May 2011 identified the safety program was acted upon and reported to the quality assurance (QA) for processes to evaluate and implement interventions to reduce hazards and risks. The policy directed safety audits were to be completed and results reported to the QA committee. Included on the audit form was one section that read as follows: [Bed rails applied correctly, fit to mattress, no gaps greater than four and three-quarters (4 3/4") inches.] The facility failed to determine R43's risk for side rail entrapment by evaluating the dimensional limits of the potential zones of entrapment and overall safety of the rails for R43 who utilized side rails. R43 diagnoses included rheumatoid arthritis, hypertension (high blood pressure), osteoarthritis, macular degeneration, cataract, mild cognitive impairment, congestive heart failure and chronic	F 323			

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F 323	Continued From page 42 obstructive pulmonary disease (COPD). The admission annual minimum data set (MDS) dated 08/24/11 revealed R43 was cognitively intact and was independent with bed mobility and transfers. Review of the Functional Safety Assessment dated 10/9/10, indicated R43 had increased independence for bed rail use. The assessment indicated R43 received education on the risk/benefits of bed rail use and the facility obtained consent to use the bed rails. Consent form was not in medial record. Review of the plan of care dated 4/29/12 identified R43 had alteration in mobility with potential for injuries due to history of falls and did not always remember safety issues. Interventions included R43 was independent with bed mobility, used grab bars to reposition self, and was independent with transfers. The plan of care included to remind R43 of safety issues and assist as needed. During observation at 6:34 p.m. on 2/27/12, the right side of R43's bed was noted to be flush with the wall and a silver metal side rail was attached to the left side of the bed, in the upright position. The side rail observed was an older metal design that had five separate openings within the side rails (Zone 1) that exceeded standards set forth in the U.S. Health and Human Services, Food and Drug Administration (FDA) publication, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," dated 3/10/06. The openings between the rails in Zone 1 were measured to be at seven and one-half by fourteen (7 1/2 by 14) inches in the center opening. Two openings were six by fourteen (6 by 14) inches and two outer openings were six by nine (6 by 9) inches. The maximum	F 323			

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F 323	Continued From page 43 opening within the side rails in Zone 1 recommended by the FDA was four and three-quarter (4 and 3/4) inches. R 53, who utilized side rail devices with dimensions not fully in compliance with U.S. Department of Health and Human Services, Food and Drug Administration (FDA) guidance, lacked a comprehensive assessment that included/addressed safety factors related to the use of side rail devices. There was no physician order for the use of a half side rail on the bed. R53 was admitted on 8/19/11, with a diagnosis of congestive heart failure, chronic obstructive pulmonary disease and high blood pressure. The facility form titled, Functional/Safety Assessment, dated 8/26/11, read, under bed mobility, extensive assist, and two person physical assist with two assistive devices used. During the initial tour at 1:00 p.m. on 2/27/12, and throughout the consecutive days of the survey, R 53's bed was observed to have a single half side rail utilized on the outside of the bed in the down position. Interview of R53 at 7:00 p.m. On 2/27/12, revealed the side rail's are not used now, but if there is a need in the future then the rail should stay on "Just in case." Talked to R53 about a least restrictive device such as a grab bar and R53 stated, "That would be fine." . Interviews at 1:00 p.m. on 2/29/12 with nursing assistants (D), (F) and (G) all confirmed that it was a side rail on R53's bed and that R53 does not need a side rail.	F 323			
F 329	483.25(I) DRUG REGIMEN IS FREE FROM	F 329			

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F 329 SS=D	Continued From page 44 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a gradual dose reduction was addressed for an antidepressant medication for 1 of 10 residents (R4) reviewed for unnecessary medication. Findings include: R4 received Zoloft (antidepressant medication)	F 329	F329 1. Corrective Action: a. R4 had medication review by primary physician and pharmacy consultant. Conclusion of review that it is clinically contraindicated to have dose reduction for R4 at this time. b. R4 will have target mood/behavior monitoring to observe for s/s depression/crying behaviors. 2. Corrective action as applies to others: a. Lic. nursing staff re-educated to policy/procedure of addressing GDR or rationale for continued use of medication in effort to be free of unnecessary drugs in accordance with the law. b. Lic. staff re-educated to obtain primary physician follow-up initiated by consulting pharmacist in a timely manner.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245551	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/01/2012
NAME OF PROVIDER OR SUPPLIER CLARKFIELD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page 45 125 milligrams (mg) daily for depression without a gradual dose reduction or an appropriate justification for maintaining current dose since 2009. R4 's diagnoses include Huntington's chorea, depression, and chronic pain syndrome. R4 's quarterly minimum data set (MDS) dated 12/07/11 identified she had a severe cognitive impairment, was nonverbal and had a total severity score of three which indicated minimal depression risk. A nursing home note from the Physician dated 6/7/11 indicated that R4 did not have as many chorea-like movements as usual and was not overly sedated although she was on Zoloft 125 mg per day. The Plan of Care revised 10/11, instructed staff to monitor for mood and effectiveness of R4 's antidepressant. The Behavior Medication Monitoring document dated 1/19/12, identified the consulting pharmacist recommended to address the risk/benefit from the medication as well as the need for the medication to be continued at the current dose related to Zoloft 125 mg daily for depression. The physician 's response (undated) stated " Pt. [patient] seems stable and not overly sedated. " Physician orders dated 2/7/12, instructed staff to administer Zoloft 125 mg every day for depression with and order start date of 2/3/09.	F 329	3. Reoccurrence will be prevented by: a. Random audits of residents noted to have medication irregularities or recommendations from consulting pharmacist will be done to ensure physician has been provided with this information and has addressed it in a timely manner, following regulation guideline. b. Re-education for lic. nursing staff as noted in #2. c. Audits will be reviewed at the quarterly QA meeting for further recommendations. 4. Correction will be monitored by: a. Lic. nurses will collect and monitor data. b. DoN or designee will do random audits. 5. Date of completion: April 10, 2012		

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F 329	Continued From page 46 Nursing home note from the Physician dated 2/7/12, noted R4 was stable and did not appear overly sedated. The document instructed staff to determine R4 's qualification for the awakenings program for help from psychiatry regarding medications. During interview at 2:50 p.m. on 2/28/12, trained medication administration (TMA)-A did not recall R4 had any mood or behavior issues. TMA-A confirmed R4 did not have a target mood/behavior monitoring worksheet in her chart. TMA-A stated R4 had not exhibited signs or symptoms of depression and R4 's shaking movements were under control. During observation at approximately 7:30 a.m. on 2/29/12, R4 was assisted by staff and responded with smiles and laughter to the interactions. At 12:37 p.m. R4 smiled and appeared happy as staff set her up to eat lunch. R4 did not exhibit signs or symptoms of depression. During interview at 8:13 a.m. on 2/29/12, licensed practical nurse (LPN)-A reported R4 had a history of wailing and crying day after day, but had not seen that for a long time. LPN-A attributed these changes to either the drugs or the disease process. At 9:06 a.m. LPN-A confirmed a gradual dose reduction had not been attempted or addressed. During interview at 12:12 p.m. on 2/29/12, director of nursing (DON) confirmed that antipsychotic medications typically were addressed on an annual basis for a gradual dose reduction. DON verified a Worksheet for Interdisciplinary Team (IDT) Review of Resident	F 329			

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F 329	Continued From page 47 Medication Regimen had not been completed for R4. DON stated she believed the physician addressed the medication by noting R4 's condition was stable and was not overly sedated. During interview at 12:21 p.m. on 2/29/12, registered nurse (RN)-B reported R4 did not qualify for the awakenings program because of her terminal prognosis. RN-B stated the facility staff were responsible for addressing a gradual dose reduction because she did not qualify for the program. RN-B confirmed no gradual dose reduction had been attempted or addressed since initiation of the medication in 2009. The facility 's Unnecessary Drugs policy revised on 5/11, indicated an expected outcome as, " Each resident receives only those medications, in doses and for the duration clinically indicated to treat the resident 's assessed condition (s). " The Unnecessary Drugs policy further identified, the IDT reviews residents who receive psychotropic medication to assess for gradual dose reductions and behavioral interventions (unless clinically contraindicated) in an effort to discontinue the medication.	F 329			
F 371 SS=F	483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	Corrective Action will be accomplished: The dietary department will follow the following guidelines in equipment sanitation and food storage procedures that will minimize the possibility of food borne illness.		

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F 371	Continued From page 48 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow equipment sanitation and food storage procedures that would minimize the possibility of food borne illness. This had the potential to affect 48 of 48 residents who ate at the facility. Findings include: The facility did not ensure sanitary conditions related to proper food storage and labeling, maintenance and cleaning of ice machine, up-right freezer, and electric can opener. During the initial kitchen observation at 1:45 p.m. on 2/27/12 the following was observed and confirmed by the dietary manager (DM): A white plastic container with original red lettering read, "Sliced Strawberries," was observed with a hand written label, "sloppy joe hamburger mix," located in the walk-in-freezer. The walk-in cooler located in the kitchen had a cottage cheese container dated 2/11/12 and a clear plastic container with hard boiled eggs dated 2/19/12. DM confirmed this should have been discarded after three days. An open half gallon milk container was also noted as not dated. DM stated the facility did not date the milk containers and verified staff was unable to determine when the milk was opened and when to discard the milk.	F 371	Corrective Action as it applies to others: 1. Correct Containers-All food storage containers will be NSF approved. (No food storage containers from food products will be used). 2. Storage Life-All staff will be trained in the area of shelf life following a three day guideline except for foods determined by DM that may exceed 3 days but not to exceed 7 days. 3. Dating and labeling-Any opened container will be properly labeled with name of product and date opened. 4. Freezer Cleaning Schedule-Freezer cleaning schedule has been re evaluated and put on a monthly cleaning schedule.		

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F 371	Continued From page 49 Ice build-up was noted on the interior ceiling of the small, up-right freezer which contained frozen ice cream products and whipped cream packages. DM pulled large chunks of ice from the cool whip bags located on the top shelf of the freezer and placed the ice chunks in the sink. DM reported freezer was new and had been defrosted approximately one month ago. Review of the Cleaning, Sanitation and Maintenance manual for the facility's ice machine, dated 7/06, indicated the ice machine sanitation process was to use a sanitizer solution after using the scale remover solution. During interview at 11:45 a.m. on 2/29/12, Maintenance-A verified the solution used to clean the ice machine was Scale Remover. Maintenance-A acknowledged the directions identified on the Scale Remover bottle identified the product was not to be used as a sanitizer. Maintenance-A admitted he did not realize the Scale Remover was not a sanitizer and a different solution was needed to sanitize the ice machine was not being done. A blender was noted on top of the counter, DM verified the blender was clean. The lid of blender was removed with water residue noted at the bottom of blender. DM confirmed the blender should be dried after cleaning. A white oblong container with a worn blue ill fitted lid labeled butter, dated 2/24 and a tan container marked margarine dated 12/16 were observed on the kitchen counter. DM stated, "Obviously this is not correct, the staff must not be changing the date because the margarine is used up in a day."	F 371	5.Ice Machine-Procedure has been rewritten to ensure that scale remover is completed first, followed by the sanitizing process. 6.Equipment-Will be allowed to air dry after the washing and sanitizing process before putting into storage. 7.Can Opener-Blade on can opener will be replaced every three months or as needed. Reoccurrence will be prevented by: All of indicated will be written into Dietary P/P and tracked through monthly QA monitoring/auditing. Training of staff completed on 3/21/2012.		

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F 371	Continued From page 50 During follow-up observation at 11:00 a.m. on 2/29/11, the sloppy joe mix stored in the plastic container labeled, "Sliced Strawberries." was again noted in to be in the walk-in-freezer. DM stated, "Oh right that[sloppy joe mix] is still in here." At 11:30 a.m., small metal shavings were observed on the counter in the front and sides of the Edlund electric can opener. During interview at 12:45 p.m. on 2/29/12, Cook-A stated the Edlund electric can opener was purchased last May, and the blades would be changed when there were problems opening the cans. DM verified the date of the can opener purchase and stated blades would be changed when the kitchen staff informed her that the blades were dull. DM added the can opener was cleaned after every use. Review of Edlund Product Manual - M090, undated, manufactures instructions for the facility's can opener, instructed to replace knife blades when excessively dull or when slivers were found on can lids or in food products. Review of the facility's Standard Procedures: Food Preparation on Sanitation and Safety, undated, indicated potentially hazardous foods held for more than 24 hours were to be labeled and discarded within seven days. Review of the facility 's Sanitation Procedure on Food Storage, undated, indicated "Containers will be of a type approved by the National Sanitation Foundation, seamless, tightly covered and constructed of easily cleanable	F 371	Correction will be monitored by: DM, Maintenance or designee. Date of completion: April 10, 2012		

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F 371	Continued From page 51 material. " The procedure went on to indicate, "Food freezers will be defrosted and cleaned at regular intervals [intervals]."	F 371			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to act upon medication irregularities reported by the pharmacist for 1 of 10 residents (R4) reviewed for unnecessary medication. Findings include: The Behavior Medication Monitoring document dated 2/15/11, 10/25/11 and 1/19/12, identified the consulting pharmacist recommended to address the risk/benefit from the medication as well as the need for the medication to be continued at the current dose related to physician ordered Zoloft 125 milligrams (mg) daily for depression. No physician response was provided for the recommendations on 2/15/11 and 10/25/11. The physician 's response for the 1/19/12 recommendation noted " Pt. [patient]	F 428	F428 1. Corrective Action: R4 medication reviewed by primary physician and pharmacy consultant. Conclusion of review: clinically contraindicated at this time to have dose reduction per physician. R4 will have target mood/behavior monitoring to observe for s/s depression/crying behaviors and IDT review of med. regimen. 2. Corrective action as applies to others: a. Lic. nursing staff re-educated to policy/procedure of addressing GDR or rationale for continued use of anti-depressant medication in effort to be free of un-necessary drugs in accordance with the law. b. Lic. staff re-educated to obtain primary physician follow-up		

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F 428	Continued From page 52 seems stable and not overly sedated." R4 received Zoloft 125 mg daily for depression without a gradual dose reduction or an appropriate justification for maintaining current dose since 2009. R4 ' s diagnoses include Huntington's chorea, depression, and chronic pain syndrome. R4 ' s quarterly minimum data set (MDS) dated 12/07/11 identified she had a severe cognitive impairment, was nonverbal and had a total severity score of three which indicated minimal depression risk. A nursing home note from the Physician dated 6/7/11 indicated R4 did not have as many chorea-like movements as usual and was not overly sedated although she was on Zoloft 125 mg per day. Nursing home note from the Physician dated 2/7/12, noted R4 was stable and did not appear overly sedated. The document instructed staff to determine R4 ' s qualification for the awakenings program for help from psychiatry regarding medication management. During observation at approximately 7:30 a.m. on 2/29/12, R4 was assisted by staff and responded with smiles and laughter to the interactions. At 12:37 p.m. R4 smiled and appeared happy as staff set her up to eat lunch. R4 did not exhibit signs or symptoms of depression. During interview at 8:13 a.m. on 2/29/12, licensed practical nurse (LPN)-A reported R4 had a history of wailing and crying day after day, but had not	F 428	initiated by consulting pharmacist in a timely manner. c. IDT review of residents receiving psychotropic medication to address if candidate for GDR and behavioral interventions (unless clinically contradicted) in an effort to discontinue the medication. Each resident should receive only those medications in doses and duration clinically indicated to treat the resident's assessed condition. 3. Reoccurrence will be prevented by: a. Re-education of lic. nursing staff as noted above. b. Random audits of residents receiving psychotropic medications who are noted to have recommendations by consulting pharmacist will be done to ensure physician has been provided the information and has addressed it in a timely manner, following regulation guidelines.		

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F 428	Continued From page 53 seen that for a long time. LPN-A attributed these changes to either the drugs or the disease process. At 9:06 a.m. LPN-A confirmed a gradual dose reduction had not been attempted or addressed for R4's Zoloft. During interview at 12:12 p.m. on 2/29/12, director of nursing (DON) confirmed that antipsychotic medications typically were addressed on an annual basis for a gradual dose reduction. DON verified a Worksheet for Interdisciplinary Team (IDT) Review of Resident Medication Regimen had not been completed for R4 and one should have been to identify if she was a candidate for a gradual dose reduction. DON stated she believed the physician addressed the medication by noting R4's condition was stable and was not overly sedated. During interview at 12:21 p.m. on 2/29/12, registered nurse (RN)-B verified the pharmacist recommended addressing the risk/benefit for the medication as well as the need for the medication to be continued at the current dose. RN-B reported R4 did not qualify for the awakenings program because of her terminal prognosis. RN-B stated the facility staff would be responsible for addressing a gradual dose reduction because she did not qualify for the program. RN-B confirmed no gradual dose reduction had been attempted or addressed since initiation of the medication in 2009. The facility's Unnecessary Drugs policy revised on 5/11, indicated an expected outcome as, "Each resident receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed condition (s)."	F 428	c. IDT reviews as described in #2. d. Audits will be reviewed at quarterly QA committee meeting for further recommendations. 4. Correction will be monitored by: a. RNs, DoN or designee 5. Date of completion: April 10, 2012		

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F 428

Continued From page 54
The Unnecessary Drugs policy further identified, the IDT reviews residents who receive psychotropic medication to assess for gradual dose reductions and behavioral interventions (unless clinically contraindicated) in an effort to discontinue the medication. This policy was not followed for the long-term use of Zoloft for R4.
483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

F 441
SS=F

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted

F 428

F 441

F441

Corrective Action:

Clarkfield Care Center has an organizational commitment to Infection control.

a. Formal infection control program implementation begun to track infections and ensure a system to investigate, control, and prevent infections in the facility.

b. Contaminated urinary drain bag was discarded.
R40 was provided with a new, sterile, single use urinary drain bag/tubing before changing drainage systems.

c. Proper procedure for changing urinary drain bags was reviewed with direct care-givers at once.

d. R4 Proper handwashing/glove use reviewed with the direct care-givers at once.

4-10-12

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F 441	Continued From page 55 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to establish and maintain an infection control program to prevent development and transmission of disease and infection, including handwashing and handling urinary catheter equipment, for the potential to affect 48 of 48 residents. Findings include: At 11:20 a.m. on 2/29/12 the DON was unable to provide a complete infection control program for review. Although no infections were noted from the sample of residents during the survey, the facility failed to have an effective Infection Control Program. The program lacked a system to provide tracking, analysis and ongoing evaluation of infections which might occur with staff and residents. There was no evidence of policies and procedures, logs or tools in place to ensure there was a system to investigate, control and prevent infections in the facility. At 11:20 a.m. on 2/29/12 the director of nursing (DON) provided an infection control manual for long-term care facilities with blank samples for	F 441	2. Corrective Action as it applies to other residents: a. Implementation of Infection Control Coordinator with designated leadership and accountability. b. Infection control coordinator will establish formal staff training and informal coaching regarding infection control. b. IC coordinator will do surveillance and monitoring of resident and staff infections to control, identify, and manage infection. c. Re-education of all nursing staff to basic infection control including hand-washing and glove use. d. Re-educate all nursing staff for prudent and safe use of invasive devices (urinary catheters and urinary drainage systems). e. Re-establish system to track, analyze, and evaluate infections that occur with residents and staff, including use of logs and tools offered by ADMA "American Medical Directors Association". f. Findings will be brought to QA committee to develop and implement plans of action if needed.		

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F 441	Continued From page 56 development of a program. No information specific to the facility was provided, with the exception of an influenza and vaccination policy, dated 6/11. During the survey a handwashing procedure was provided. The DON stated that another registered nurse (RN-A) would be responsible for the infection control program and had not previously developed one. At 11:40 a.m. on 2/29/12 registered nurse-A (RN-A) stated the infection control program coordinator position had not been turned over to her to date. She had not presented infection control data to the quality assurance meeting. During the initial tour at 5:30 p.m. on 2/27/12, a urinary Foley catheter drainage bag and tubing was hung on the resident grab bar in the bathroom of R40 and the tubing to the urinary catheter drainage bag was on the floor in the bathroom. There was no cap on the end of the urinary Foley catheter drainage bag tubing and the floor of the bathroom was sticky to the step and there were yellow stained areas in the floor tile with a strong urine odor present. Interview at 6:30 p.m. on 2/27/12, with nursing assistant NA-A and NA-B who generally care for R40, confirmed the urinary drainage Foley catheter tubing should not have been on the floor and there should be a cap on the end of the tubing to protect against contamination. R 40 uses a urinary drainage leg bag during the day when up and the urinary Foley catheter drainage bag when in bed. NA-A and NA-B said the urinary drainage leg bag and urinary drainage catheter bag are to be rinsed with half and half vinegar and water but they have not seen a policy and procedure for this. NA-F stated "Someone	F 441	F441 3. Reoccurrence will be prevented by: a. See all items in #2. b. Will establish IDT infection control team with designated leadership (IC coordinator), accountability and regular meetings. c. Implementing and using <i>Quality Improvement Tools for Infection Control: Clinical Practice Guidelines</i> from AMDA. d. Ensure a system in place that will investigate, control, and prevent infections in facility. e. Random audits will be done to monitor for proper hand-washing, safe glove use, and safe catheter drain system care. f. Audit results and analysis of infections for both residents and staff will be presented to QA committee, including Medical Director for further recommendations.		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245551	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/01/2012
NAME OF PROVIDER OR SUPPLIER CLARKFIELD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 57 told us to use half and half (vinegar and water), and drain it out" "I have not seen a policy they just kind of tell you what to do." A policy and procedure was requested for changing and cleaning of the urinary drainage leg bag, and urinary Foley catheter bag and tubing from the director of nursing at 10:00 a.m. on 2/29/12. The undated policy received at 1:00 p.m. on 2/29/12 was for a leg bag used for a Suprapubic Catheter care and read, "Clean drainage bags with warm water and soap every day or two. Place one teaspoon of vinegar in rinse water to reduce odor." Resident 4 (R4) was observed to receive incontinence care without full compliance with accepted infection control procedures. R4 's diagnoses include Huntington's chorea, depression, and chronic pain syndrome. R4 's quarterly minimum data set (MDS) dated 12/07/11 identified she had a severe cognitive impairment, and was totally dependent on staff for cares. During observation at approximately 7:30 a.m. on 2/29/12, nursing assistant (NA)-D assisted R4 with morning cares including washing face, combing hair and brushing teeth. NA-D removed her gloves after cares were complete, NA-D turned the water on, briefly wet her hands, applied one pump of soap to both hands, rubbed her hands together for a couple of seconds and finally rinsed her hands under running water for a total handwashing time of less than five seconds.	F 441	4. Correction will be monitored by: Infection control Coordinator DoN Medical Director		

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NAME OF PROVIDER OR SUPPLIER

CLARKFIELD CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

805 FIFTH STREET, BOX 458

CLARKFIELD, MN 56223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 58 During observation at approximately 7:30 a.m. on 2/29/12, NA-C donned gloves and used Prevail wipes to provide incontinence care for R4 who was incontinent of urine. NA-C put the soiled brief and wipes into the garbage can and removed her gloves. NA-C assisted NA-D with application of the clean brief and pulled up R4's pants. NA-C then touched the door handle, opened the door and left the room to obtain a lift sling from the clean supply area. NA-C returned within a minute and continued to assist NA-D in transferring R4 from bed into a Broda chair. NA-C gathered garbage bag out of garbage can, touched the door handle, opened the door and left the room. NA-C then entered the utility room, threw garbage bag into garbage can, turned the water on, briefly wet her hands, applied one pump of soap to both hands, rubbed her hands together for a couple of seconds and rinsed under running water for less than five seconds. During interview at 12:38 p.m. on 2/29/12, NA-C confirmed she had failed to wash her hands after removing gloves and prior to leaving R4's room during observation that morning. NA-C verified that training had been provided by the facility on hand washing via the computer. NA-C reported that proper hand washing should be completed when removing gloves, before leaving a resident's room and should last for 15-20 seconds. NA-C was unable to recall the last time an in-service had been provided. Review of the facility's Basic Infection Control policy (undated) identified, hand washing was the most important thing you can do to prevent transmission of infections including 20 seconds of hand washing (using friction) before and after	F 441		

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F 441	Continued From page 59 visiting each resident. The Infection Control policy further indicated when staff were to wash their hands and included before and after resident contact, before and after removing gloves and after contact with a source of microorganisms. The policy was not followed to prevent the transmission of infection disease for R4.	F 441			
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure cleanable surfaces for a sanitary environment related to the kitchen floor, with the potential to affect 48 of 48 residents in the facility. Findings include: During the initial kitchen observation at 1:45 p.m. on 2/27/12, floor grout was noted to be black in color throughout the main areas of the kitchen floor compared to the whitish color of grout in areas of the kitchen where less foot traffic occurred (i.e., under the sinks and outer perimeters). During follow-up kitchen observation at 11:00 a.m. on 2/29/12, the floor grout remained black in color and was not flush with kitchen floor tile, leaving a small groove between the tiles. Dietary	F 465	1. Corrective Action The dietary department will follow the following guidelines in equipment sanitation procedures that will minimize the possibility of food borne illness. 2. Corrective Action as it applies to other residents: The floor will be professionally cleaned and resealed on 3/28/2012.		

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F 465	Continued From page 60 Manager (DM) verified the grout looked dirty and acknowledged there were many products on the market to clean grout. DM stated their initial plans were to use a darker color grout but this was not available at the time kitchen floor tile was laid. During this observation Cook-B stated staff would get down on their hands and knees to scrub with a brush, but nothing worked. Cook-A added maintenance brought a machine in a couple of months ago to clean the grout with Uric Acid, admitting it helped some, but the smell was so bad they discontinued using it. During interview at 2:35 p.m. on 2/29/12, Maintenance-A verified cleaning the kitchen floor three months ago with Bromic Acid on an area of 4 x 4 feet, but discontinued using the Bromic Acid even though it "brightened it up some, [because] it smelled really bad." Maintenance-A reported the facility currently used Tuff Green which he verified was effective. Maintenance-A added, "I feel if they just get down on their hands and knees and scrubbed it [kitchen floor], it would brighten it [grout] up." During follow-up interview at 2:45 p.m. on 2/29/12, DM reported every night the staff cleaned the kitchen floor with a small scrub brush, attached to a handle, with either Oasis or bleach, and then mopped the kitchen floor. Review of the facility policy Standard Procedure, Attachment 6034A: Procedure for washing walls, floors and ceilings, undated, indicated floors were to be swept well, washed with hot water and non-sudsing cleaning solution, rinsed well with mop, wiped with sanitizer and air dried. The policy/procedure did not address how to clean	F 465	Floor will be thoroughly swept and mopped every night with disinfectant. Random audits will be done at least weekly to ensure surfaces are clean. Implement P/P for floor cleaning. 3.Reoccurrence will be prevented by: This has been developed into P/P and will be tracked accordingly. Correction will be monitored by: DM, Maintenance or designee. Completion date; April 10, 2012		

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F 465	Continued From page 61	F 465			
F 520	floor grout or how to ensure cleanable surfaces.	F 520			
SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS				
	A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.				
	The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.				
	A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.				
	Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.				
	This REQUIREMENT is not met as evidenced by: Based on interview, document and policy review, the facility failed to conduct quality assessment and assurance (QAA) activities that developed and implemented appropriate plans of action to correct identified quality deficiencies. The practice had the potential to affect all 48 residents in the				
			F 520 1. Corrective Action: a. QA meeting dates are set at least 3 months in advance, including notification of medical director. b. Specialized rehab. service will be notified of meeting dates and will be asked to participate or report information to the committee. c. Formal implementation of Infection Control program and IDT infection control team with designated leadership, accountability, and regular meetings. d. Infection Control Coordinator will establish and ensure that a system is in place to identify, track, investigate, and manage surveillance of infections and will be reviewed at each QA meeting. e. Safety issues involving side-rails/grab bars that meet regulations will be addressed at QA meetings. f. Informal coaching and formal training for hand-washing is on-going, including new colored and laminated pictorial posters recently placed in strategic locations. See PoC for F441.		

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NAME OF PROVIDER OR SUPPLIER CLARKFIELD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 FIFTH STREET, BOX 45B CLARKFIELD, MN 56223		
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F 520	Continued From page 62 facility. Findings include: The facility quality assessment and assurance committee did not identify significant deficient quality practices evident during the survey process that would have required appropriate plans of action be in process and/or policy revisions to demonstrate an effective oversight function. The 2012 licensing and certification survey identified deficient practices related to the following areas: -Infection control processes and resident care policies, nosocomial infection reporting and monitoring. -Medication administration and pharmacy practices and consulting services. -Safety practices and audit oversight by QAA. -Kitchen/dietary sanitation/storage issues that were cited for the past three years. -Oral/dental care practices. -Pressure ulcer prevention and treatment processes that included comprehensive assessments, care plan development and preventative interventions. -Adaptive seating assessments and necessary care and services. -Housekeeping and maintenance process and functions. -Medical director oversight of data reported, policy revision and monitoring of compliance with recommendations. The director of nursing (DON), who was responsible for direction of the QAA committee,	F 520	f. Medication errors will be reviewed at each QA meeting. 2. Corrective Action as it applies to others: a. Implementation of formal infection control program with designated leadership and accountable to QA committee to ensure a system is in place to identify, control and prevent infections in the facility b. Review and audits of infection control processes and resident care policies and practices. c. Report and monitor nosocomial infection d. Review and report safety/regulation regarding side-rails and grab bars use at QA meetings for over-sight by committee. e. Re-education of staff in infection control including handwashing. f. Review of medication errors at every QA meeting.		

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F 520	Continued From page 63 verified during interview at 1:45 p.m. on 2/29/12 the committee met quarterly and the medical director had attended three of the last four meetings. The pharmacy consultant attended, on average, half of the meetings. The DON also verified that contracted services such as specialized rehabilitation did not participate or report information to the QAA committee. The DON verified she had been the primary infection control nurse/director, but had not monitored or reported specific objective data related to nosocomial infections acquired at the facility and reviewed and discussed infection trends in, "general terms" the QAA meetings. In addition, RN-B had recently been appointed as the new infection control nurse, but had not received specific training on the duties or expectations and she had not attended a QAA meeting. The DON reported that safety information from audits had not identified the safety issues with the side rails that exceeded dimensional safety standards from the Food and Drug Administration. The medical director reported telephonically at 11:48 a.m. on 3/1/12, she would like to have seen additional staff education for infection control concerns such as hand washing, but was not sure if the facility had followed through with the recommendations she made. The medical director had also asked for data related to medication errors that had not yet been provided in the QAA meetings.	F 520	3. Reoccurrence will be prevented by: a. Implementing <i>Quality Improvement Tools for Infection Control: Clinical Practice Guidelines</i> from ADMA b. Monitoring infections and reporting specific objective data relating nosocomial infections acquired at the facility in order to investigate, control, manage, and prevent infections. c. See #2. 4. Correction will be monitored by: Administrator Medical Director DoN or designee 5. Date of completion: April 10, 2012		

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NAME OF PROVIDER OR SUPPLIER CLARKFIELD CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223
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K 000

INITIAL COMMENTS

K 000

FIRE SAFETY

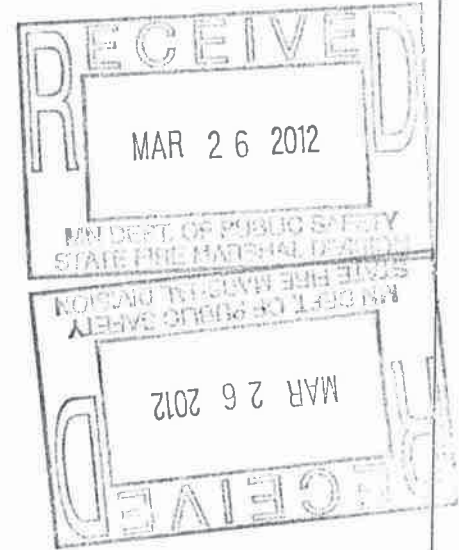
THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

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 on March 6, 2012. At the time of this survey, Building 01 of Clarkfield Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar St., Suite 145
ST. Paul, MN 55101-5145



POC OK
FB 3-27-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>Paul Luthers</i>	Executive Dir	3-20-12

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
Pat.Sheehan@state.mn.us
Facsimile: 651-215-0525

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.

Building 01 consists of the original 1955 building and the 1958 and 1970 Additions. These buildings were surveyed at NFPA 101 (00) Chapter 19 Existing Health Care Occupancies. Building 02 consists of the 2004 building Addition, and was surveyed at NFPA 101 (00) Chapter 18 New Health Care Occupancies. Two (2) Form CMS-2786R booklets were completed.

The building is fully sprinklered. The facility has a

K 000

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K 000	Continued From page 2 fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 52 beds and had a census of 47 at time of the survey.	K 000			
K 025 SS=B	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025	3/7/12 Environmental Service Director used the fire wall sealer rated for fires, smoke, and draft with a two hour fire resistance. The penetrations were sealed. Environmental service Director Jeffrey Bailey will monitor fire walls to ensure future penetrations are filled in. Work completed on 3/7/12 by Jeffrey Bailey Environmental Services Director		3/7/12

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NAME OF PROVIDER OR SUPPLIER CLARKFIELD CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223
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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
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K 025 Continued From page 3

This STANDARD is not met as evidenced by:

Based on observation, the facility had penetrations through a smoke barrier wall which was not in conformance with NFPA 101 (2000), Chapter 19, Sections 19.1.6.3. and 19.3.7.3 and Chapter 8, Section 8.2.4. In a fire emergency, smoke and/or fire could migrate between smoke compartments, adversely affecting 18 of 52 residents, staff and visitors.

FINDINGS INCLUDE:

On 3/6/12 at 12:10 PM, observation revealed low voltage wiring penetrating the smoke barrier wall on the 300-Wing Corridor, in the concealed space above the drop-ceiling assembly, above the smoke barrier doors. The interstitial space between the wiring and the surrounding smoke barrier wall was not properly sealed to provide at least a 1/2-hour fire resistance rating and to prevent the migration of smoke.

This finding was verified with the chief building engineer (JB) at the time of discovery.

K 144 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.

K 025

K 144

See K 144 for
Bldg 2 for POC 3-13-12

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

PRINTED: 03/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245551	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/06/2012
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NAME OF PROVIDER OR SUPPLIER

CLARKFIELD CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

805 FIFTH STREET, BOX 458

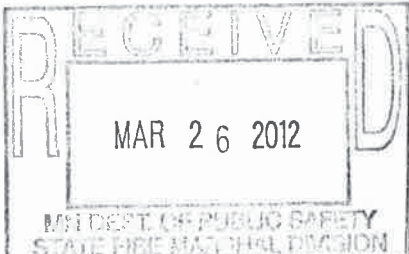
CLARKFIELD, MN 56223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 4 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - Generators must be inspected weekly and exercised under load at not less than 30% of the EPS nameplate rating, for 30 minutes per month and shall be in accordance with NFPA 99 (1999 edition) and NFPA 110 (1999 edition). FINDINGS INCLUDE: On 3/6/12 at 11:50 AM, observation revealed the facility's emergency generator was located outdoors, and this EPS equipment location was not equipped with battery-powered emergency lighting, in accordance with NFPA 110 (1999) Chapter 5, Section 5-3. In an emergency evacuation situation, this deficient practice could adversely affect 52 of 52 residents, staff and visitors.	K 144		

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

F 5551021

PRINTED: 03/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245551	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING TWO B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2012
NAME OF PROVIDER OR SUPPLIER CLARKFIELD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE 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 on March 6, 2012. At the time of this survey, Building 02 of Clarkfield Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 ST. Paul, MN 55101-5145	K 000	 POC ok B 3-27-12		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Paul L. Hughes

Executive Dir.

3-20-12

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

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

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K 000	Continued From page 1 Pat.Sheehan@state.mn.us Facsimile: 651-215-0525 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. Building 01 consists of the original 1955 building and the 1958 and 1970 Additions. These buildings were surveyed at NFPA 101 (00) Chapter 19 Existing Health Care Occupancies. Building 02 consists of the 2004 building Addition, and was surveyed at NFPA 101 (00) Chapter 18 New Health Care Occupancies. Two (2) Form CMS-2786R booklets were completed. The building is fully sprinklered. The facility has a	K 000			

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K 000	Continued From page 2 fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 52 beds and had a census of 47 at time of the survey.	K 000			
K 144 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - Generators must be inspected weekly and exercised under load at not less than 30% of the EPS nameplate rating, for 30 minutes per month and shall be in accordance with NFPA 99 (1999 edition) and NFPA 110 (1999 edition). FINDINGS INCLUDE: On 3/6/12 at 11:50 AM, observation revealed the facility's emergency generator was located outdoors, and this EPS equipment location was not equipped with battery-powered emergency lighting, in accordance with NFPA 110 (1999) Chapter 5, Section 5-3.	K 144	Environmental Service Director had bills electric install a battery back-up emergency light that has a 90 minute supply. Emergency lighting for engenerator was completed 3/13/12 The generator emergency light will be tested when the indoor emergency lights are tested and the battery will be replaced yearly or as needed. This will be the environmental service director's responsibility. Jeffrey Bailey.	3/13/12	

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

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K 144	Continued From page 3 In an emergency evacuation situation, this deficient practice could adversely affect 52 of 52 residents, staff and visitors.	K 144			



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8043 8867

March 13, 2012

Mr. Paul Luitjens, Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, Minnesota 56223

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5551022

Dear Mr. Luitjens:

The above facility was surveyed on March 6, 2012 through March 6, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Clarkfield Care Center

March 13, 2012

Page 2

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

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

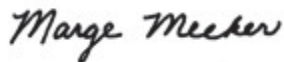
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 West Division Street, Suite 212, St. Cloud, Minnesota 56301-4557. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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,

A handwritten signature in cursive script that reads "Marge Meeker".

Marge Meeker, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7317 Fax: (320) 223-7348

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5551s12lic.rtf

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00842	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/01/2012
NAME OF PROVIDER OR SUPPLIER CLARKFIELD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223		
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On, February 27, 28, and 29 2012, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

N3L811

TITLE

Executive Dir.

(X6) DATE

3-20-12

If continuation sheet 1 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00842	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/01/2012
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2 000	Continued From page 1 Certification Program; 3333 West Division St, Suite 212, St. Cloud, MN 56301-4557	2 000	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. 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.		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified	2 255			

Minnesota Department of Health

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2 255	Continued From page 2 quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview, document and policy review, the facility failed to conduct quality assessment and assurance (QAA) activities that developed and implemented appropriate plans of action to correct identified quality deficiencies. The practice had the potential to affect all 48 residents in the facility. Findings include: The facility quality assessment and assurance committee did not identify significant deficient quality practices evident during the survey process that would have required appropriate plans of action be in process and/or policy revisions to demonstrate an effective oversight function. The 2012 licensing and certification survey identified deficient practices related to the following areas: -Infection control processes and resident care policies, nosocomial infection reporting and monitoring. -Medication administration and pharmacy practices and consulting services. -Safety practices and audit oversight by QAA. -Kitchen/dietary sanitation/storage issues that were cited for the past three years. -Oral/dental care practices. -Pressure ulcer prevention and treatment processes that included comprehensive assessments, care plan development and	2 255			

Minnesota Department of Health

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2 255	Continued From page 3 preventative interventions. -Adaptive seating assessments and necessary care and services. -Housekeeping and maintenance process and functions. -Medical director oversight of data reported, policy revision and monitoring of compliance with recommendations. The director of nursing (DON), who was responsible for direction of the QAA committee, verified during interview at 1:45 p.m. on 2/29/12 the committee met quarterly and the medical director had attended three of the last four meetings. The pharmacy consultant attended, on average, half of the meetings. The DON also verified that contracted services such as specialized rehabilitation did not participate or report information to the QAA committee. The DON verified she had been the primary infection control nurse/director, but had not monitored or reported specific objective data related to nosocomial infections acquired at the facility and reviewed and discussed infection trends in, "general terms" the QAA meetings. In addition, RN-B had recently been appointed as the new infection control nurse, but had not received specific training on the duties or expectations and she had not attended a QAA meeting. The DON reported that safety information from audits had not identified the safety issues with the side rails that exceeded dimensional safety standards from the Food and Drug Administration. The medical director reported telephonically at 11:48 a.m. on 3/1/12, she would like to have seen	2 255			

Minnesota Department of Health

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2 255	Continued From page 4 additional staff education for infection control concerns such as hand washing, but was not sure if the facility had followed through with the recommendations she made. The medical director had also asked for data related to medication errors that had not yet been provided in the QAA meetings. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, medical director and consulting pharmacist, could review and revise the facility's system used to identify quality of care concerns, develop and implement action plans to correct the identified quality issues, educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255			
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must	2 540			

Minnesota Department of Health

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2 540	Continued From page 5 include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on interview, document and policy review, the facility failed to perform initial or annual comprehensive assessments related to pressure ulcer care for 1 of 2 residents (R37), oral/dental status for 1 of 3 residents (R21), and for the use of side rail devices for 2 of 4 residents (R43 and R53) in the sample. Findings include: Resident 37's (R37) comprehensive assessment for pressure ulcers/skin integrity lacked accurate identification of all significant factors that promoted healing and prevented reoccurrence of the pressure ulcer. R37 had a pressure ulcer at admission that healed, later redeveloped, and still currently received treatment. R37 had diagnoses that included Parkinsonism, degenerative joint disease, dementia with episodic delirium, non insulin dependent diabetes	2 540			

Minnesota Department of Health

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2 540	Continued From page 6 mellitus, intermittent claudication and chronic leg edema. The admission minimum data set (MDS) identified R37 with moderately impaired cognitive skills (brief interview mental status BIMS=11), mood and behavioral symptoms present with the behavioral symptoms that placed R37 at risk of injury. The MDS also noted extensive assistance of 2+ staff for bed mobility, transfers and ambulation, impaired balance and loss of range of motion in both upper extremities and bowel and bladder incontinence. The MDS did not identify the presence of a pressure ulcer at admission but did note a turning and repositioning program and pressure reduction device for bed only. The care area assessment (CAA) was triggered for pressure ulcers. A Braden skin risk assessment completed upon admission on 8/15/11 noted a score of 20; 18 or lower indicated significant risk that required implementation of pressure relieving devices and weekly skin review. R37 had a pressure ulcer at the time the Braden was completed. The initial admission information sheet body diagram dated 8/15/11 identified R37 had [three/eighths (3/8) inch sore skin missing] noted over the right buttocks area; however, the skin assessment sheet noted, [(R37) was alert and had no evidence of pressure ulcers. Has specialty mattress and was repositioned every two hours. Wheelchair to /from destinations has own recliner he sits in between meals. The admission assessment did not recognize the presence of the open area present at admission and the care area assessment (CAA) summary was not completed and noted,[See ADL CAA.] The activity of daily living (ADL) CAA noted only	2 540			

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2 540	Continued From page 7 that R37 had a potential for skin breakdown and also did not review all the risk factors or detail strategies for interventions that would be included in R37's care plan. Unit registered nurse-B (RN-B) verified at 11:28 a.m. on 2/28/12 she was not sure how to view the CAA on the computer and a medical records licensed practical nurse (LPN) was responsible for entering the data into the CAA summaries. RN-B verified R37 had an open area at admission that should have been addressed in the MDS and CAA and it had healed and then reopened again about 12/8/12 and has remained open since that time until present. RN-B reported it gets smaller and larger, had been up to 1.5cm by .5 cm. and was not stageable, but was currently .5 cm by .5 cm. and was now classified a stage 2 ulcer because the slough was removed. RN-B stated the facility used a wound tracking record flow sheet; however, could only locate tracking that had been completed since 12/29/11. RN-B reported a skin care nurse employed by a dressing supply company vendor made regular visits to advise staff on dressing choices and techniques, but did not chart in the facility interdisciplinary progress notes but had a separate record keeping book. The book was reviewed and noted to primarily contain some data on the size and nature of the wound and information about the dressings selected for use but not collaboration about other treatment and care plan approaches and interventions. The facility skin assessment and care policy updated May 2011 identified tissue tolerance evaluation was to be completed and care plans should include individualized repositioning plan and identification of which pressure-redistributing	2 540			

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2 540	Continued From page 8 devices were used with completion of another skin assessment by an RN if a new pressure ulcer developed. R21 failed to have a periodic, comprehensive, and accurate assessment of her oral/dental status conducted. During initial observation and interview with R21 at 5:00 p.m. on 2/27/12 she was noted to have missing teeth on her upper mouth. R21's upper teeth were also noted to be broken and worn. The facility conducted a Functional/Safety assessment on 10/26/11 which had an oral/dental section. The assessment identified R21 with lower partial dentures. The Functional/Safety assessment prior to the 10/26/11 assessment was dated 12/10/10 and the assessment identified R21 with a lower partial and her own upper teeth. The assessment failed to identify the missing, broken, and worn teeth on the upper oral cavity region. R21's annual Minimum Data Set (MDS) assessment, dated 10/28/11 identified her with no oral/dental concerns under Oral Dental Status, section L of the MDS. R21's Care Plan, dated 2/15/12 identified her with a problem with functional balance chewing and mastication difficulty related to edentulous status manifested by signs and symptoms of altered chewing. During interview with R21's Registered Nurse (RN)-B case manager at 10:30 a.m. on 2/29/12 she stated the facility had attempted to have the resident seen by the dentist but R21 would refuse. She stated the facility would make the	2 540			

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2 540	Continued From page 9 appointment for R21 and she would refuse to go the day of the appointment. RN-B stated she believed the physician had assessed R21's oral/dental status during his last check but verified there was no documentation to identify her dental status was assessed. RN-B verified R21's medical record lacked a thorough assessment of her oral/dental status and verified the facility's most recent assessment identified only that she had a lower partial and did not address her upper dental status. The facility failed to conduct an assessment that accurately reflected the oral dental status of R21. The facility assessments failed to identify her missing, broken and worn teeth in her upper oral cavity. The facility lacked any evidence R21's oral cavity had been assessed to identify concerns. The facility failed to assess the safety of a specific bed side rail device for R43. The admission annual minimum data set (MDS) dated 08/24/11 revealed R43 was cognitively intact and was independent with bed mobility and transfers. Review of the Functional Safety Assessment dated 10/9/10, indicated R43 had increased independence for bed rail use. The assessment indicated R43 received education on the risk/benefits of bed rail use and the facility obtained consent to use the bed rails. Review of the plan of care dated 4/29/12 identified R43 had alteration in mobility with potential for injuries due to history of falls and did not always remember safety issues. Interventions included R43 was independent with bed mobility, used grab bars to reposition self, and was independent with transfers. The plan of care included to remind R43 of safety issues and assist as needed. During observation at 6:34 p.m. on 2/27/12, the	2 540			

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2 540	Continued From page 10 right side of R43's bed was noted to be flush with the wall and a silver metal side rail was attached to the left side of the bed, in the upright position. The side rail observed was an older metal design that had five separate openings between the rails (Zone 1) that exceeded standards set forth in the U.S. Health and Human Services, Food and Drug Administration (FDA) publication, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," dated 3/10/06. The openings between the rails in Zone 1 were measured to be at seven and one-half by fourteen (7 1/2 by 14) inches in the center opening. Two openings were six by fourteen (6 by 14) inches and two outer openings were six by nine (6 by 9) inches. The maximum opening between the rails in Zone 1 recommended by the FDA was four and three-quarter (4 and 3/4 inches) R 53, who utilized side rail devices with dimensions not fully in compliance with U.S. Department of Health and Human Services, Food and Drug Administration (FDA) guidance, lacked a comprehensive assessment that included/addressed safety factors related to the use of side rail devices. There was no physician order for the use of a half side rail on the bed and there was no physician order for the use of a grab bar on the bed. R 53 was admitted on 8/19/11, with a diagnosis of congestive heart failure, chronic obstructive pulmonary disease and high blood pressure. The facility form titled, Functional/Safety Assessment, read under bed mobility, extensive assist, and two person physical assist with two assistive devices used. During the initial tour at 1:00 p.m. on 2/27/12, and	2 540			

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2 540	Continued From page 11 throughout the consecutive days of the survey, R 53's bed was observed to have a single half side rail utilized on the outside of the bed in the down position. Interview of R53 at 7:00 p.m. on 2/27/12, revealed the side rail's were not used now, but if there was a need in the future then the rail should stay on "Just in case." Talked to R53 about a least restrictive device such as a grab bar and R53 stated, "That would be fine." . Interviews at 1:00 p.m. on 2/29/12 with nursing assistants (D), (F) and (G) all confirmed that it was a side rail on R53's bed and that R53 does not need a side rail. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review and revise policies and procedures pertaining to initial or annual comprehensive resident assessments to assure they comply with the regulations, retrain staff and develop a monitoring procedure. TIME PERIOD FOR CORRECTION: Twnty-one (21) Days	2 540			
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by:	2 550			

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2 550	Continued From page 12 Based on observation, interview, document and policy review the facility failed to perform quarterly comprehensive reviews and assessments related to side rail device use for 2 of 4 residents (R7 and R37) and wheelchair positioning for 2 of 3 residents (R37 and R4) in the sample. Findings include: Resident 7 (R7) utilized a single quarter side rail device that was not comprehensively assessed for all relevant factors to ensure safe and appropriate use. Additionally, the facility procedures were not followed for obtaining a consent for use of the device. R7 had diagnoses that included schizophrenia, pulmonary disease, hypertension and diabetes mellitus. The most recent quarterly minimum data set (MDS) dated 12/18/11 identified R7 with moderately impaired cognitive skills (brief interview mental status BIMS=12), independence in bed mobility, transfers and ambulation. The MDS noted bed rails were not used. The facility completed a functional /safety assessment tool with the admission MDS and updated with each quarterly re-assessment. The assessment completed 12/18/11 noted use of [top right half rail] and benefits of use of the bed rail were checked for [increased independence/participation.] The safety assessment also noted, [Education on risk benefit provided and consent obtained for use of bed rails.] R7 was observed in bed with an outside metal quarter side rail raised on the bed at 7:30 p.m. on	2 550			

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2 550	Continued From page 13 2/27/12 and 8:50 a.m. on 2/28/12. The side rail observed was an older metal design that had five separate openings between the rails (Zone 1) that exceeded standards set forth in the U.S. Health and Human Services, Food and Drug Administration (FDA) publication, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," dated 3/10/06. The openings within the side rails in Zone 1 were measured to be at seven and one-half by fourteen (7 1/2 by 14) inches in the center opening. Two openings were six by fourteen (6 by 14) inches and two outer openings were six by nine (6 by 9) inches. The maximum opening within the side rails in Zone 1 recommended by the FDA was four and three-quarter (4 and 3/4) inches. The facility assessments did not review all components related to the use of side rails that included individualized functional mobility needs related to the device, medical/safety risk factors, compliance with Federal agency dimensional guidance, potential for restrictiveness with use of the device, possible use of alternative devices to aide in safety or mobility, and a method to implement and monitor use. Additionally, the facility did not recognize the side rail device actually met the technical definition of a quarter side rail that had the potential to be restrictive or that it could potentially pose significant safety risks. Unit registered nurse-A (RN-A) reported during staff interview at 5:15 p.m. on 2/27/12 R7 did not use quarter or half side rails and there were no side rails utilized in the facility, only grab bar devices were used on the beds.	2 550			

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2 550	Continued From page 14 The director of nursing (DON) reported during interview at 1:30 p.m. on 2/29/12 she was not aware there were any actual side rails in the facility or that there were side rail devices used that were not in compliance with the FDA standards. Unit registered nurse-B (RN-B) verified at 2:30 p.m. on 2/29/12 the facility did not obtain a written consent prior to use of the side rail devices and could not provide any documentation of what was provided to residents for the risk/benefit education noted in the assessment for R7. RN-B also reported the functional/safety assessment tool was the only method used by the facility to evaluate care components related to use of side rail devices. Resident 37 (R37) utilized a single quarter side rail device that was not comprehensively assessed for all relevant factors to ensure safe and appropriate use. Additionally, their procedures were not followed for obtaining a consent for use of the device. R37 had diagnoses that included Parkinsonism, degenerative joint disease in both shoulders, dementia and episodic delirium. The most recent quarterly minimum data set (MDS) dated 1/27/12 identified R37 with moderately impaired cognitive skills (BIMS=8), mood and behavioral symptoms present with behavior symptoms that placed R37 at risk of injury. The MDS also noted extensive assistance of 1 staff for bed mobility, extensive assistance of 2 staff for transfers and ambulation, impaired range of motion in both upper extremities, unsteady balance and noted bed rails were not used.	2 550			

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2 550	Continued From page 15 The functional/safety assessment initially completed at admission 8/22/11 with quarterly update 1/27/12 identified R37 required extensive assistance of staff for bed mobility and assistive devices were used for transfers; however, the section for side rails or transfer bars were not checked for use. Neither the initial safety assessment nor the quarterly updates noted the use of side rails. R37's bed was observed at 9:50 a.m. on 2/28/12 to have a side rail raised on the outside. R37 was not in the bed at the time. The side rail observed was an older metal design that had five separate openings between the rails (Zone 1) that exceeded standards set forth in the U.S. Health and Human Services, Food and Drug Administration (FDA) publication, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," dated 3/10/06. The openings within the side rails in Zone 1 were measured to be at seven and one-half by fourteen (7 1/2 by 14) inches in the center opening. Two openings were six by fourteen (6 by 14) inches and two outer openings were six by nine (6 by 9) inches. The maximum opening within the side rails in Zone 1 recommended by the FDA was four and three-quarter (4 and 3/4) inches. The facility assessment did not review all components related to the use of side rails that included individualized functional mobility needs related to the device, medical/safety risk factors, compliance with Federal agency dimensional guidance, potential for restrictiveness with use of the device, possible use of alternative devices to aide in safety or mobility, and a method to	2 550			

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2 550	Continued From page 16 implement and monitor use. Additionally, the facility did not recognize the side rail device actually met the technical definition of a quarter side rail that had the potential to be restrictive or that it could potentially pose significant safety risks. Unit registered nurse-A (RN-A) reported during staff interview at 5:15 p.m. on 2/27/12 R37 did not use quarter or half side rails and there were no side rails utilized in the facility, only grab bar devices were used on the beds. The director of nursing (DON) reported during interview at 1:30 p.m. on 2/29/12 she was not aware there were any actual side rails in the facility or that there were side rail devices used that were not in compliance with the FDA standards. Unit registered nurse-B (RN-B) verified at 2:30 p.m. on 2/29/12 the facility did not obtain a written consent prior to use of the side rail devices and could not provide any documentation of what was provided to residents for the risk/benefit education noted in the assessment for R37. RN-B also reported the functional/safety assessment tool was the only method used by the facility to evaluate care components related to use of side rail devices and the assessment did not identify the use of the side rail device for R37. RN-B stated R37 was initially resistant to sleeping in the bed and he currently primarily slept in the recliner in the room; however, could potentially still use the bed. R37 also was not reassessed for seating needs that maximized his functional mobility and minimized risk of pressure ulcers while seated.	2 550			

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2 550	Continued From page 17 R37's initial assessment information dated 8/22/11 identified R37 utilized a wheelchair and specialty mattress on the bed, with no mention of any wheelchair cushion utilized. The quarterly update to the functional/safety assessment dated 1/27/12 noted he used a wheelchair and could propel himself short distances. There was also no indication of the type of seat cushion used. R37 was observed at 9:48 a.m. on 2/28/12 seated in a Homecrest Rock and Go geri chair without legrests or wheelchair cushion. R37 complained of the armrests being too high and could not support his arms and he could not reach the front large wheels to propel the chair himself. R37 stated his bottom was always sore. At 9:50 a.m. the maintenance staff was requested by nursing to help locate the legrests for R37's geri chair and they were located and applied. RN-B verified at 11:28 a.m. on 2/28/12 there was no record of a referral to or recommendations by occupational or physical therapy related to proper chair fitting/use or pressure reduction cushion evaluation. RN-B also stated R37 did use a wheelchair at one time and had a gel cushion, but currently had a geri chair with a Roho air cushion but was not sure who changed the seating equipment and when. R37 stated the current care plan still noted the use of a wheelchair and gel cushion. The consultant physical therapist verified at 2:15 p.m. on 2/29/12 the occupational therapist (OT) was the person who did seating evaluations and there was no record the OT received a request for/or performed a seating evaluation of R37 and nursing must have taken the initiative to change the seating equipment utilized.	2 550			

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2 550	Continued From page 18 The facility policy (not dated) reviewed related to referral to specialized therapy identified one possible indicator for referral was resident's poor positioning in bed or chair R4 ' s positioning was not comprehensively assessed and addressed to maintain her highest level of well-being. R4 had multiple diagnoses which included Huntington's chorea, depression, and chronic pain syndrome. R4 ' s quarterly minimum data set (MDS) dated 12/7/11, identified she had a severe cognitive impairment, was totally dependent for wheelchair mobility, and revealed that no occupational or physical therapy services were being provided. The Functional/Safety Assessment revised on 12/7/11 indicated R4 required the use of a Hoyer lift and was totally dependent. During observation at 12:18 p.m. on 2/28/12, R4 was observed in a slightly reclined position and was slouched down in her Broda chair. The bucket foot rest, used to support her legs was approximately six inches longer than her legs. R4 ' s feet were unsupported; her toes were pointed forward and were touching the base of the foot pad. During interview at 9:15 a.m. on 2/29/12, occupational therapist (OT) confirmed R4 ' s feet were not supported and with manipulation, identified the presence of contractures in both feet and stated, " I can ' t hardly move her feet, they are contracted for sure. " OT stated occupational therapy was responsible for head to	2 550			

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2 550	Continued From page 19 toe positioning. OT confirmed they worked with R4 's wheelchair positioning but had never addressed her foot drop. OT reported occupational therapy sets up the range of motion (ROM) programs and expected nursing staff to complete. OT could not recall ever working on ROM with R4. OT confirmed no referral had been made for addressing wheelchair positioning or foot contractures in the past year. During interview at 11:00 a.m. on 2/29/12, OT explained that a hard board for foot support would not be appropriate for R4 due to her uncontrollable movements and fear of injury. OT confirmed no other devices had been tried to maintain proper foot positioning and prevent foot drop. During interview at 12:30 on 2/29/12, director of nursing (DON) indicated R4 's slouched position in Broda chair as being typical of how she was always positioned. DON confirmed absence of support for both feet and presence of a foot drop. Review of facility ' s Red Flag Indicators Triggering Referral to Occupational, Physical and Speech Therapy document listed poor positioning in bed or chair and decline in available movement or increased difficulty in performing passive range of motion exercises as indicators needing referral. SUGGESTED METHOD OF CORRECTION: The administrator and the director of nursing (DON) or her designee could develop policies and procedures to ensure all comprehensive assessments are completed/updated at the time of the quarterly MDS. The DON or her designee	2 550			

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2 550	Continued From page 20 could educate all appropriate staff on these policies and procedures. The DON or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twnty-one (21) days.	2 550			
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a plan of care related to dental status and dental care needs for 1 of 3 residents (R4), reviewed in the sample for dental services. R4 ' s care plan did not address specific oral care needs. R4 ' s diagnosis include: Huntington's chorea, dysphasia, depression, and chronic pain syndrome. R4 ' s care area assessment (CAA) dated 12/7/11 indicated she required total assistance for oral cares. It revealed that her Huntington's	2 560			

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2 560	Continued From page 21 movements made oral cares difficult. CAA identified the family requested that no dental referral was to be made for R4. The Physician note dated 4/5/11, identified R4's teeth, "Look to be very poor condition right now. " The Physician recommended the nursing staff discuss the plan for dental cares with the family although it would be difficult because of R4 ' s movements. The Functional/Safety Assessment dated 11/5/10, revealed boxes checked in the oral/dental section included: Obvious or likely cavity or broken natural teeth, and also inflamed or bleeding gums or loose natural teeth. The comments section, revised on 12/7/11, indicated R4 had missing teeth, her gums bled when her teeth were brushed and her remaining teeth were yellow and brown stained. No interventions or plan of care changes were made after this assessment. The care plan revised on 1/4/12 indicated R4 had her own teeth and required assist of two for all personal hygiene. The care plan did not address specific oral care needs that were identified on the oral needs assessment. During observation at approximately 7:30 a.m. on 2/29/12, nursing assistant (NA)-D assisted R4 with brushing her teeth and used a standard yellow, generic toothbrush. NA-D made three passes through R4 ' s mouth with the toothbrush. Blood was observed on the toothbrush and dripping down the side of R4 ' s mouth. NA-D gave R4 two small sips of regular water to rinse her mouth and R4 swallowed the water each time. NA-D confirmed that R4 ' s teeth usually bled with brushing. NA-D also stated R4 was not	2 560			

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2 560	Continued From page 22 the best at rinsing and spitting. NA-D explained R4 was supposed to have thickened liquids but there was no way she can rinse and spit with thickened water. Review of the facility's oral care policy revised on 5/11, revealed residents would be assessed for oral health upon admission and at least on a quarterly basis. The oral care policy further indicated an individual care plan for each resident would be developed based on the assessment. The policy was not followed for R4. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to those resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830			

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2 830	Continued From page 23 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary care and services for 2 of 3 residents (R37 and R4) in the sample who were reviewed for positioning and 2 of 3 residents (R21 and R4) in the sample who were reviewed for oral/ dental care. Findings include: Resident 37 (R37) did not receive the necessary care and services related to assessment and consistent employment of proper seating devices and equipment that maximized his functional mobility and comfort and minimized the risk of excessive pressure while seated. R37 had diagnoses that included Parkinsonism, degenerative joint disease in both shoulders, dementia and episodic delirium. The most recent quarterly minimum data set (MDS) dated 1/27/12 identified R37 with moderately impaired cognitive skills (BIMS=8), mood and behavioral symptoms present with behavior symptoms that placed R37 at risk of injury. The MDS also noted extensive assistance of 1 staff for bed mobility, extensive assistance of 2 staff for transfers and ambulation, impaired range of motion in both upper extremities, unsteady balance and noted bed rails were not used. R37's initial assessment information dated	2 830			

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2 830	Continued From page 24 8/22/11 identified R37 utilized a wheelchair and specialty mattress on the bed, with no mention of any wheelchair cushion utilized. The quarterly update to the functional/safety assessment dated 1/27/12 noted he used a wheelchair and could propel himself short distances. There was also no indication of the type of seat cushion used. R37's care plan interventions dated 12/4/12 included gel cushion in wheelchair and recliner. The current use of the Roho air cushion and the Homecrest Rock and Go gerichair not included as interventions and a repositioning interval not indicated. The current nursing assistant care sheets did not identify a repositioning time interval for geri chair and recliner or the use of the Homecrest geri chair and Roho cushion or legrests. R37 was observed at 9:48 a.m. on 2/28/12 seated in a Homecrest Rock and Go geri chair without legrests or wheelchair cushion. R37 complained of the armrests being too high and could not support his arms and he could not reach the front large wheels to propel the chair himself. R37 stated his bottom was always sore. At 9:50 a.m. the maintenance staff was requested by nursing to help locate the legrests for R37's geri chair and they were located and applied. R37 had been moved by staff with feet dangling unsupported before the footrests were located. RN-B verified at 11:28 a.m. on 2/28/12 there was no record of a referral to or recommendations by occupational or physical therapy related to proper chair fitting/use or pressure reduction cushion evaluation. RN-B also stated R37 did use a wheelchair at one time and had a gel cushion, but currently had a geri chair with a Roho air cushion but was not sure who changed the seating	2 830			

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2 830	Continued From page 25 equipment and when. R37 stated the current care plan still noted the use of a wheelchair and gel cushion. The consultant physical therapist verified at 2:15 p.m. on 2/29/12 the occupational therapist (OT) was the person who did seating evaluations and there was no record the OT received a request for/or performed a seating evaluation of R37 and nursing must have taken the initiative to change the seating equipment utilized. The facility policy (not dated) reviewed related to referral to specialized therapy identified one possible indicator for referral was resident's poor positioning in bed or chair R21 failed to receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being related to oral/dental need.. During initial observation and interview with R21 at 5:00 p.m. on 2/27/12 she was noted to have missing teeth on her upper mouth. R21's upper teeth were also noted to be broken and worn. The facility conducted a Functional/Safety assessment on 10/26/11 which had an oral/dental section. The assessment identified R21 with lower partial dentures. The Functional/Safety assessment prior to the 10/26/11 assessment was dated 12/10/10 and the assessment identified R21 with a lower partial and her own upper teeth. The assessment failed to identify the missing, broken, and worn teeth on the upper oral cavity region. R21's annual Minimum Data Set (MDS) assessment, dated 10/28/11 identified her with no	2 830			

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2 830	Continued From page 26 oral/dental concerns under Oral Dental Status, section L of the MDS. R21's Care Plan, dated 2/15/12 identified her with a problem with functional balance chewing and mastication difficulty related to edentulous status manifested by signs and symptoms of altered chewing. During interview with R21's Registered Nurse (RN)-B case manager at 10:30 a.m. on 2/29/12 she stated the facility had attempted to have the resident seen by the dentist but R21 would refuse. She stated the facility would make the appointment for R21 and she would refuse to go the day of the appointment. RN-B stated she believed the physician had assessed R21's oral/dental status during his last check but verified there was no documentation to identify her dental status was assessed. RN-B verified R21's medical record lacked a thorough assessment of her oral/dental status and verified the facility's most recent assessment identified only that she had a lower partial and did not address her upper dental status. The facility failed to conduct a comprehensive assessment that accurately reflected the oral/dental status to identify if interventions needed to be initiated to enhance oral health for R21. The facility assessments failed to identify her missing, broken and worn teeth in her upper oral cavity and failed to identify if she had any oral cavity anomalies. The facility lacked any evidence R21's oral cavity had been assessed to identify concerns. Resident 4 (R 4) did not receive the necessary	2 830			

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2 830	Continued From page 27 care and services to attain or maintain the highest level of well-being related to wheelchair positioning. R4 had multiple diagnoses which included Huntington's chorea, depression, and chronic pain syndrome. R4 ' s quarterly minimum data set (MDS) dated 12/7/11, identified she had a severe cognitive impairment, was totally dependent for wheelchair mobility as well as activities of daily living, and revealed that no occupational or physical therapy services were being provided. The Functional/Safety Assessment revised on 12/7/11 indicated R4 required the use of a Hoyer lift and was totally dependent. Review of R4 ' s Plan of Care indicated an entry dated 2/5/10 which read, " Foot bucket added to Broda chair. Lamb ' s wool lining foot extension. " During observation at 12:18 p.m. on 2/28/12, R4 was observed in a slightly reclined position and was slouched down in her Broda chair. The bucket foot rest, used to support her legs was approximately six inches longer than her legs. R4 ' s feet were unsupported; her toes were pointed forward and were touching the base of the foot pad. During interview at 9:15 a.m. on 2/29/12, occupational therapist (OT) confirmed R4 ' s feet were not supported and with manipulation, identified the presence of contractures in both feet and stated, " I can ' t hardly move her feet, they are contracted for sure. " OT reported the contracture development was likely related to her	2 830			

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2 830	Continued From page 28 disease progression but could not say for sure. OT stated occupational therapy was responsible for head to toe positioning. OT confirmed they worked with R4 ' s wheelchair positioning but had never addressed her foot drop. OT confirmed no referral had been made for addressing wheelchair positioning or foot contracture in the past year. During interview at 11:00 a.m. on 2/29/12, OT explained that a hard board for foot support would not be appropriate for R4 due to her uncontrollable movements and fear of injury. OT confirmed no other devices had been tried to maintain proper foot positioning and prevent foot drop. During interview at 12:30 on 2/29/12, director of nursing (DON) indicated R4 ' s slouched position in Broda chair as being typical of how she was always positioned. DON confirmed absence of support for both feet and presence of a foot drop. Review of facility ' s Red Flag Indicators Triggering Referral to Occupational, Physical and Speech Therapy document listed poor positioning in bed or chair and decline in available movement or increased difficulty in performing passive range of motion exercises as indicators needing referral. R4 ' s diagnosis include: Huntington's chorea, dysphasia, depression, and chronic pain syndrome. R4 ' s care area assessment (CAA) dated 12/7/11 indicated she required total assistance for oral cares. It revealed that her Huntington's movements made oral cares difficult. CAA	2 830			

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2 830	Continued From page 29 identified the family requested that no dental referral was to be made for R4. Review of West Station B ' s most recent nursing assistant (NA) care sheet reviewed 2/29/12, identified R4 had her own teeth and needed total assistance with oral cares. The Physician note dated 4/5/11, identified R4's teeth, "Look to be very poor condition right now. " The Physician recommended the nursing staff discuss the plan for dental cares with the family although it would be difficult because of R4 ' s movements. The Functional/Safety Assessment dated 11/5/10, revealed boxes checked in the oral/dental section included: Obvious or likely cavity or broken natural teeth, and also inflamed or bleeding gums or loose natural teeth. The comments section, revised on 12/7/11, indicated R4 had missing teeth, her gums bled when her teeth were brushed and her remaining teeth were yellow and brown stained. No interventions or plan of care changes were made after this assessment. The care plan revised on 1/4/12 indicated R4 had her own teeth and required assist of two for all personal hygiene. The care plan did not address specific oral care needs that were identified on the oral needs assessment. During observation at approximately 7:30 a.m. on 2/29/12, nursing assistant (NA)-D assisted R4 with brushing her teeth and used a standard yellow, generic toothbrush. NA-D made three passes through R4 ' s mouth with the toothbrush. Blood was observed on the toothbrush and dripping down the side of R4 ' s mouth. NA-D	2 830			

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2 830	Continued From page 30 gave R4 two small sips of regular water to rinse her mouth and R4 swallowed the water each time. NA-D confirmed that R4 's teeth usually bled with brushing. NA-D also stated R4 was not the best at rinsing and spitting. NA-D explained R4 was supposed to have thickened liquids but there was no way she can rinse and spit with thickened water. Review of the facility's oral care policy revised on 5/11, revealed residents would be assessed for oral health upon admission and at least on a quarterly basis. The oral care policy further indicated an individual care plan for each resident would be developed based on the assessment. The policy was not followed for R4. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and reeducate all staff on the policies and procedures to ensure that all resident's health issues are properly monitored. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830			
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home	2 900			

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2 900	Continued From page 31 without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure all residents who were at risk of, or had pressure ulcers received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for 1 of 2 residents (R37) reviewed in the sample. Findings include: R37 had diagnoses that included Parkinsonism, degenerative joint disease, dementia with episodic delirium, non insulin dependent diabetes mellitus, intermittent claudication and chronic leg edema. The admission minimum data set (MDS) identified R37 with moderately impaired cognitive skills (brief interview mental status BIMS=11), mood and behavioral symptoms present with the behavioral symptoms that placed R37 at risk of injury. The MDS also noted extensive assistance of 2+ staff for bed mobility, transfers and ambulation, impaired balance and loss of range of motion in both upper extremities and bowel and bladder incontinence. The MDS did not identify the presence of a pressure ulcer at	2 900			

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2 900	Continued From page 32 admission but did note a turning and repositioning program and pressure reduction device for bed only. The care area assessment (CAA) was triggered for pressure ulcers. The initial admission information sheet body diagram dated 8/15/11 identified R37 had [three/eighths (3/8) inch sore skin missing] noted over the right buttocks area; however, the skin assessment sheet noted, [(R37) was alert and has no evidence of pressure ulcers. R37 had a specialty mattress and was repositioned every two hours, used a wheelchair to /from destinations and had his own recliner he sat in between meals. A Braden skin risk assessment completed upon admission on 8/15/11 noted a score of 20; 18 or lower indicated significant risk that required implementation of pressure relieving devices and weekly skin review. R37 had a pressure ulcer at the time the Braden was completed. The admission assessment did not recognize the presence of the open area present at admission and the care area assessment (CAA) summary was not completed and noted,[See ADL CAA.] The activity of daily living (ADL) CAA noted only that R37 had a potential for skin breakdown and also did not review all the risk factors, repositioning interval tolerance or detail strategies for interventions that would be included in R37's care plan. R37's care plan dated 11/9/11 identified the initial pressure ulcer at 1X1 (unit of measurement not indicated) that was crossed off on 11/9/11 and replaced with, [At risk of pressure areas/ulcers. The pressure ulcer that redeveloped on 12/8/12 was not identified on the care plan. Interventions	2 900			

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2 900	Continued From page 33 dated 12/4/12 included gel cushion in wheelchair and recliner, monitor skin integrity as needed (PRN), wound nurse visits PRN. The current use of the Roho air cushion and the Homecrest Rock and Go gerichair not included as interventions. The care plan and current nursing assistant care sheets did not identify a repositioning time interval. R37 was observed at 9:48 a.m. on 2/28/12 seated in a Homecrest Rock and Go geri chair without legrests and without a gel or Roho wheelchair cushion. R37 complained of the armrests being to high and could not support his arms and he could not reach the front large wheels to propel the chair himself. R37 stated his bottom was always sore. R37 was also continuously observed from 1:30 p.m. to 4:00 p.m. on 2/28/12. R37 was apparently sleeping in the recliner in his room and no staff was observed to reposition him during the two and one-half hour period. The Roho cushion was noted in use in the recliner. The treatment nurse, licensed practical nurse-A (LPN-A) reported at 9:45 a.m. on 2/29/12 the Roho cushion was on the treatment sheet to check for proper inflation each day. LPN-A stated she just, "Pushed on it to see if it had air. If not, I pump it up until it's full." LPN-A was not sure what the proper inflation level was and could not locate a procedure for correct inflation that was given to nursing. At 11:00 a.m. the dressing change for R37 by LPN-A was observed. LPN-A stated the wound, "comes and goes" and gets "smaller and larger," but was now generally improving. Unit registered nurse-B (RN-B) verified at 11:28 a.m. on 2/28/12 she was not sure how to view the	2 900			

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2 900	Continued From page 34 CAA on the computer and a medical records licensed practical nurse (LPN) was responsible for entering the data into the CAA summaries. RN-B verified R37 had an open area at admission that should have been addressed in the MDS and CAA and it had healed and then reopened again about 12/8/12 and has remained open since that time until present. RN-B reported it gets smaller and larger, had been up to 1.5cm by .5 cm. and was not stageable, but was currently .5 cm by .5 cm. and was now classified a stage 2 ulcer because the slough was removed. RN-B stated the facility used a wound tracking record flow sheet; however, could only locate tracking that had been completed since 12/29/11. RN-B reported a skin care nurse employed by a dressing supply company vendor made regular visits to advise staff on dressing choices and techniques, but did not chart in the facility interdisciplinary progress notes but had a separate record keeping book. The book was reviewed and noted to primarily contain some data on the size and nature of the wound and information about the dressings selected for use but not collaboration about other treatment and care plan approaches and interventions. The facility skin assessment and care policy updated May 2011 identified tissue tolerance evaluation was to be completed and care plans should include individualized repositioning plan and identification of which pressure-redistributing devices were used with completion of another skin assessment by an RN if a new pressure ulcer developed. The facility policy for pressure ulcer care dated May 2011 also identified the need for accurate documentation and timely interventions for problems and outlined details for dressing	2 900			

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2 900	Continued From page 35 product selection and wound care. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures regarding care for residents at risk or with pressure ulcers, educate staff on pressure ulcers protocols and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 900			
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow equipment sanitation and food storage procedures that would minimize the possibility of food borne illness. This had the potential to affect 48 of 48 residents who ate at the facility. Findings include: The facility did not ensure sanitary conditions related to proper food storage and labeling, maintenance and cleaning of ice machine, up-right freezer, and electric can opener. During the initial kitchen observation at 1:45 p.m. on 2/27/12 the following was observed and	21100			

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21100	Continued From page 36 confirmed by the dietary manager (DM): A white plastic container with original red lettering read, "Sliced Strawberries," was observed with a hand written label, "sloppy joe hamburger mix," located in the walk-in-freezer. The walk-in cooler located in the kitchen had a cottage cheese container dated 2/11/12 and a clear plastic container with hard boiled eggs dated 2/19/12. DM confirmed this should have been discarded after three days. An open half gallon milk container was also noted as not dated. DM stated the facility did not date the milk containers and verified staff was unable to determine when the milk was opened and when to discard the milk. Ice build-up was noted on the interior ceiling of the small, up-right freezer which contained frozen ice cream products and whipped cream packages. DM pulled large chunks of ice from the cool whip bags located on the top shelf of the freezer and placed the ice chunks in the sink. DM reported freezer was new and had been defrosted approximately one month ago. Review of the Cleaning, Sanitation and Maintenance manual for the facility's ice machine, dated 7/06, indicated the ice machine sanitation process was to use a sanitizer solution after using the scale remover solution. During interview at 11:45 a.m. on 2/29/12, Maintenance-A verified the solution used to clean the ice machine was Scale Remover. Maintenance-A acknowledged the directions identified on the Scale Remover bottle identified the product was not to be used as a sanitizer. Maintenance-A admitted he did not realize the Scale Remover was not a sanitizer and a different	21100			

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21100	Continued From page 37 solution was needed to sanitize the ice machine was not being done. A blender was noted on top of the counter, DM verified the blender was clean. The lid of blender was removed with water residue noted at the bottom of blender. DM confirmed the blender should be dried after cleaning. A white oblong container with a worn blue ill fitted lid labeled butter, dated 2/24 and a tan container marked margarine dated 12/16 were observed on the kitchen counter. DM stated, "Obviously this is not correct, the staff must not be changing the date because the margarine is used up in a day." During follow-up observation at 11:00 a.m. on 2/29/11, the sloppy joe mix stored in the plastic container labeled, "Sliced Strawberries." was again noted in to be in the walk-in-freezer. DM stated, "Oh right that[sloppy joe mix] is still in here." At 11:30 a.m., small metal shavings were observed on the counter in the front and sides of the Edlund electric can opener. During interview at 12:45 p.m. on 2/29/12, Cook-A stated the Edlund electric can opener was purchased last May, and the blades would be changed when there were problems opening the cans. DM verified the date of the can opener purchase and stated blades would be changed when the kitchen staff informed her that the blades were dull. DM added the can opener was cleaned after every use. Review of Edlund Product Manual - M090, undated, manufactures instructions for the facility's can opener, instructed to replace knife blades when excessively dull or when slivers were found on can lids or in food products.	21100			

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21100	Continued From page 38 Review of the facility's Standard Procedures: Food Preparation on Sanitation and Safety, undated, indicated potentially hazardous foods held for more than 24 hours were to be labeled and discarded within seven days. Review of the facility ' s Sanitation Procedure on Food Storage, undated, indicated "Containers will be of a type approved by the National Sanitation Foundation, seamless, tightly covered and constructed of easily cleanable material. " The procedure went on to indicate, "Food freezers will be defrosted and cleaned at regular intervals [intervals]." SUGGESTED METHOD FOR CORRECTION: The administrator, Dietary Director or designee (s) could review the policies and procedures related to storage of perishable and non perishable food . The administrator, Dietary Director of designee (s) could provide education to all staff related to the appropriate storage of food and maintenance of coolers/freezers in order to prevent contamination and ensure proper storage temperatures. The administrator, Dietary Director or designee (s) could do random audits to ensure that food items are stored appropriately, labeling has been done and equipment properly maintained. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21100			
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing	21375			

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21375	Continued From page 39 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 record review and interview the facility failed to establish and maintain an infection control program to prevent development and transmission of disease and infection, including handwashing and handling urinary catheter equipment, for the potential to affect 48 of 48 residents. Findings include: At 11:20 a.m. on 2/29/12 the DON was unable to provide a complete infection control program for review. Although no infections were noted from the sample of residents during the survey, the facility failed to have an effective Infection Control Program. The program lacked a system to provide tracking, analysis and ongoing evaluation of infections which might occur with staff and residents. There was no evidence of policies and procedures, logs or tools in place to ensure there was a system to investigate, control and prevent infections in the facility. At 11:20 a.m. on 2/29/12 the director of nursing (DON) provided an infection control manual for long-term care facilities with blank samples for development of a program. No information specific to the facility was provided, with the exception of an influenza and vaccination policy, dated 6/11. During the survey a handwashing procedure was provided. The DON stated that another registered nurse (RN-A) would be	21375			

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21375	Continued From page 40 responsible for the infection control program and had not previously developed one. At 11:40 a.m. on 2/29/12 registered nurse-A (RN-A) stated the infection control program coordinator position had not been turned over to her to date. She had not presented infection control data to the quality assurance meeting. During the initial tour at 5:30 p.m. on 2/27/12, a urinary Foley catheter drainage bag and tubing was hung on the resident grab bar in the bathroom of R40 and the tubing to the urinary catheter drainage bag was on the floor in the bathroom. There was no cap on the end of the urinary Foley catheter drainage bag tubing and the floor of the bathroom was sticky to the step and there were yellow stained areas in the floor tile with a strong urine odor present. Interview at 6:30 p.m. on 2/27/12, with nursing assistant NA-A and NA-B who generally care for R40, confirmed the urinary drainage Foley catheter tubing should not have been on the floor and there should be a cap on the end of the tubing to protect against contamination. R 40 uses a urinary drainage leg bag during the day when up and the urinary Foley catheter drainage bag when in bed. NA-A and NA-B said the urinary drainage leg bag and urinary drainage catheter bag are to be rinsed with half and half vinegar and water but they have not seen a policy and procedure for this. NA-F stated "Someone told us to use half and half (vinegar and water), and drain it out" "I have not seen a policy they just kind of tell you what to do." A policy and procedure was requested for changing and cleaning of the urinary drainage leg bag, and urinary Foley catheter bag and tubing	21375			

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21375	Continued From page 41 from the director of nursing at 10:00 a.m. on 2/29/12. The undated policy received at 1:00 p.m. on 2/29/12 was for a leg bag used for a Suprapubic Catheter care and read, "Clean drainage bags with warm water and soap every day or two. Place one teaspoon of vinegar in rinse water to reduce odor." Resident 4 (R4) was observed to receive incontinence care without full compliance with accepted infection control procedures. R4 's diagnoses include Huntington's chorea, depression, and chronic pain syndrome. R4 's quarterly minimum data set (MDS) dated 12/07/11 identified she had a severe cognitive impairment, and was totally dependent on staff for cares. During observation at approximately 7:30 a.m. on 2/29/12, nursing assistant (NA)-D assisted R4 with morning cares including washing face, combing hair and brushing teeth. NA-D removed her gloves after cares were complete. NA-D turned the water on, briefly wet her hands, applied one pump of soap to both hands, rubbed her hands together for a couple of seconds and finally rinsed her hands under running water for a total handwashing time of less than five seconds. During observation at approximately 7:30 a.m. on 2/29/12, NA-C donned gloves and used Prevail wipes to provide incontinence care for R4 who was incontinent of urine. NA-C put the soiled brief and wipes into the garbage can and removed her gloves. NA-C assisted NA-D with application of the clean brief and pulled up R4 ' s pants. NA-C then touched the door handle, opened the door and left the room to obtain a lift sling from the	21375			

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21375	Continued From page 42 clean supply area. NA-C returned within a minute and continued to assist NA-D in transferring R4 from bed into a Broda chair. NA-C gathered garbage bag out of garbage can, touched the door handle, opened the door and left the room. NA-C then entered the utility room, threw garbage bag into garbage can, turned the water on, briefly wet her hands, applied one pump of soap to both hands, rubbed her hands together for a couple of seconds and rinsed under running water for less than five seconds. During interview at 12:38 p.m. on 2/29/12, NA-C confirmed she had failed to wash her hands after removing gloves and prior to leaving R4's room during observation that morning. NA-C verified that training had been provided by the facility on hand washing via the computer. NA-C reported that proper hand washing should be completed when removing gloves, before leaving a resident's room and should last for 15-20 seconds. NA-C was unable to recall the last time an in-service had been provided. Review of the facility's Basic Infection Control policy (undated) identified, hand washing was the most important thing you can do to prevent transmission of infections including 20 seconds of hand washing (using friction) before and after visiting each resident. The Infection Control policy further indicated when staff were to wash their hands and included before and after resident contact, before and after removing gloves and after contact with a source of microorganisms. The policy was not followed to prevent the transmission of infection disease for R4. Suggested Method of Correction: The administrator or designee could review policy and procedures regarding the infection control	21375			

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21375	Continued From page 43 program to include all required components. Facility could educate staff on policy and procedures and develop a monitoring system to ensure compliance as well as accurate and objective reporting of data to the quality assurance committee. Time Period for Correction: Twenty one (21) days.	21375			
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by:	21535			

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21535	Continued From page 44 Based on observation, interview and document review the facility failed to ensure a gradual dose reduction was addressed for an antidepressant medication for 1 of 10 residents (R4) reviewed for unnecessary medication. Findings include: R4 received Zoloft (antidepressant medication) 125 milligrams (mg) daily for depression without a gradual dose reduction or an appropriate justification for maintaining current dose since 2009. R4 's diagnoses include Huntington's chorea, depression, and chronic pain syndrome. R4 's quarterly minimum data set (MDS) dated 12/07/11 identified she had a severe cognitive impairment, was nonverbal and had a total severity score of three which indicated minimal depression risk. A nursing home note from the Physician dated 6/7/11 indicated that R4 did not have as many chorea-like movements as usual and was not overly sedated although she was on Zoloft 125 mg per day. The Plan of Care revised 10/11, instructed staff to monitor for mood and effectiveness of R4 's antidepressant. The Behavior Medication Monitoring document dated 1/19/12, identified the consulting pharmacist recommended to address the risk/benefit from the medication as well as the need for the medication to be continued at the current dose related to Zoloft 125 mg daily for depression. The physician ' s response (undated) stated " Pt. [patient] seems stable and not overly	21535			

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21535	Continued From page 45 sedated. " Physician orders dated 2/7/12, instructed staff to administer Zoloft 125 mg every day for depression with and order start date of 2/3/09. Nursing home note from the Physician dated 2/7/12, noted R4 was stable and did not appear overly sedated. The document instructed staff to determine R4 ' s qualification for the awakenings program for help from psychiatry regarding medications. During interview at 2:50 p.m. on 2/28/12, trained medication administration (TMA)-A did not recall R4 had any mood or behavior issues. TMA-A confirmed R4 did not have a target mood/behavior monitoring worksheet in her chart. TMA-A stated R4 had not exhibited signs or symptoms of depression and R4 ' s shaking movements were under control. During observation at approximately 7:30 a.m. on 2/29/12, R4 was assisted by staff and responded with smiles and laughter to the interactions. At 12:37 p.m. R4 smiled and appeared happy as staff set her up to eat lunch. R4 did not exhibit signs or symptoms of depression. During interview at 8:13 a.m. on 2/29/12, licensed practical nurse (LPN)-A reported R4 had a history of wailing and crying day after day, but had not seen that for a long time. LPN-A attributed these changes to either the drugs or the disease process. At 9:06 a.m. LPN-A confirmed a gradual dose reduction had not been attempted or addressed. During interview at 12:12 p.m. on 2/29/12, director of nursing (DON) confirmed that	21535			

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21535	Continued From page 46 antipsychotic medications typically were addressed on an annual basis for a gradual dose reduction. DON verified a Worksheet for Interdisciplinary Team (IDT) Review of Resident Medication Regimen had not been completed for R4. DON stated she believed the physician addressed the medication by noting R4 ' s condition was stable and was not overly sedated. During interview at 12:21 p.m. on 2/29/12, registered nurse (RN)-B reported R4 did not qualify for the awakenings program because of her terminal prognosis. RN-B stated the facility staff were responsible for addressing a gradual dose reduction because she did not qualify for the program. RN-B confirmed no gradual dose reduction had been attempted or addressed since initiation of the medication in 2009. The facility ' s Unnecessary Drugs policy revised on 5/11, indicated an expected outcome as, " Each resident receives only those medications, in doses and for the duration clinically indicated to treat the resident ' s assessed condition (s). " The Unnecessary Drugs policy further identified, the IDT reviews residents who receive psychotropic medication to assess for gradual dose reductions and behavioral interventions (unless clinically contraindicated) in an effort to discontinue the medication. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee and pharmacy consultant could review and develop policies and procedures, educate staff, and conduct random audits of resident medication regimens to ensure compliance with state and federal regulatory requirements.	21535			

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21535	Continued From page 47	21535			
21600	TIME PERIOD FOR CORRECTION: Twenty-one (21) days. MN Rule 4658.1335 Subp. 2 Stock Medications; Emergency Supply Subp. 2. Emergency medication supply. A nursing home may have an emergency medication supply which must be approved by the QAA committee. The contents, maintenance, and use of the emergency medication supply must comply with part 6800.6700. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain the facility emergency supply medication kit in a secured manner. Findings include: During inspection of the East medication storage room at 12:30 p.m. on 2/29/12 the emergency supply kit was observed sitting on a shelf in the room. The kit was noted to be unlocked and accessible to staff who had access to the medication storage room. During interview with licensed practical nurse (LPN)-A who accompanied the surveyor on the inspection she verified the kit was left uncontrolled by not being locked/cinched. The LPN stated the facility did have cinches that were used but the cinches were not coded to control access to the emergency supply. The LPN stated if staff opened one of the medications in the box it would be used until completely dispensed and then refilled. She stated tracking for the use of the medications in the kit was conducted orally and	21600			

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21600	Continued From page 48 there was no system to track the medications upon removal from the kit other than verbal notification. The facility failed to meet the standard of storage of emergency supply medications as directed under chapter 6800.6700 Board of Pharmacy which required the emergency kit to be locked or cinched.. Suggested Method of Correction: The Director of Nursing or designee could develop policy and procedure for proper storage of emergency medication kit and timely notification of pharmacist when emergency medications are used or unsealed. The Director of Nursing or designee could train all appropriate staff on the procedures. The Director of Nursing or designee could monitor all appropriate staff to ensure compliance. Time Period for Correction: Seven (7) days	21600			
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, policy and document review the facility failed to assure the resident environment remained as free of accident hazards as was possible related to an evaluation of safety and appropriate use for 4 of 4 residents (R7, R37, R43 and R53) who were	21665			

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21665	Continued From page 49 observed to have metal side rails on their bed that did not meet the safety standards as defined by the U.S. Health and Human Services, Food and Drug Administration for dimensions of openings within the side rails (Zone 1.) Findings include: Resident 7 (R7) utilized a single quarter side rail device that was not comprehensively assessed for all relevant factors to ensure safe and appropriate use. Additionally, the facility procedures were not followed for obtaining a consent for use of the device and the device was not in compliance with safety audits that were to be completed by the facility according to their policies. Resident 7 (R7) had diagnoses that included schizophrenia, pulmonary disease, hypertension and diabetes mellitus. The most recent quarterly minimum data set (MDS) dated 12/18/11 identified R7 with moderately impaired cognitive skills (brief interview mental status BIMS=12), independence in bed mobility, transfers and ambulation. The MDS noted bed rails were not used. The facility completed a functional /safety assessment tool with the admission MDS and updated with each quarterly re-assessment. The assessment completed 12/18/11 noted use of [top right half rail] and benefits of use of the bed rail were checked for [increased independence/participation.] The safety assessment also noted, [Education on risk benefit provided and consent obtained for use of bed rails.]	21665			

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21665	Continued From page 50 R7 was observed in bed with an outside metal quarter side rail raised on the bed at 7:30 p.m. on 2/27/12 and 8:50 a.m. on 2/28/12. The side rail observed was an older metal design that had five separate openings between the rails (Zone 1) that exceeded standards set forth in the U.S. Health and Human Services, Food and Drug Administration (FDA) publication, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," dated 3/10/06. The openings between the rails in Zone 1 were measured to be at seven and one-half by fourteen (7 1/2 by 14) inches in the center opening. Two openings were six by fourteen (6 by 14) inches and two outer openings were six by nine (6 by 9) inches. The maximum opening between the rails in Zone 1 recommended by the FDA was four and three-quarter (4 and 3/4) inches. The facility assessments did not review all components related to the use of side rails that included individualized functional mobility needs related to the device, medical/safety risk factors, compliance with Federal agency dimensional guidance, potential for restrictiveness with use of the device, possible use of alternative devices to aide in safety or mobility, and a method to implement and monitor use. Additionally, the facility did not recognize the side rail device actually met the technical definition of a quarter side rail that had the potential to be restrictive or that it could potentially pose significant safety risks. Unit registered nurse-A (RN-A) reported during staff interview at 5:15 p.m. on 2/27/12 R7 did not use quarter or half side rails and there were no side rails utilized in the facility, only grab bar	21665			

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21665	Continued From page 51 devices were used on the beds. The director of nursing (DON) reported during interview at 1:30 p.m. on 2/29/12 she was not aware there were any actual side rails in the facility or that there were side rail devices used that were not in compliance with the FDA standards. Unit registered nurse-B (RN-B) verified at 2:30 p.m. on 2/29/12 the facility did not obtain a written consent prior to use of the side rail devices and could not provide any documentation of what was provided to residents for the risk/benefit education noted in the assessment for R7. RN-B also reported the functional/safety assessment tool was the only method used by the facility to evaluate care components related to use of side rail devices. Resident 37 (R37) utilized a single quarter side rail device that was not comprehensively assessed for all relevant factors to ensure safe and appropriate use. Additionally, the facility procedures were not followed for obtaining a consent for use of the device and the device was not in compliance with safety audits that were to be completed by the facility according to their policies. R37 had diagnoses that included Parkinsonism, degenerative joint disease in both shoulders, dementia and episodic delirium. The most recent quarterly minimum data set (MDS) dated 1/27/12 identified R37 with moderately impaired cognitive skills (BIMS=8), mood and behavioral symptoms present with behavior symptoms that placed R37 at risk of injury. The MDS also noted extensive assistance	21665			

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21665	Continued From page 52 of 1 staff for bed mobility, extensive assistance of 2 staff for transfers and ambulation, impaired range of motion in both upper extremities, unsteady balance and noted bed rails were not used. The functional/safety assessment initially completed at admission 8/22/11 with quarterly update 1/27/12 identified R37 required extensive assistance of staff for bed mobility and assistive devices were used for transfers; however, the section for side rails or transfer bars were not checked for use. Neither the initial safety assessment nor the quarterly updates noted the use of side rails. R37's bed was observed at 9:50 a.m. on 2/28/12 to have a side rail raised on the outside. R37 was not in the bed at the time. The side rail observed was an older metal design that had five separate openings between the rails (Zone 1) that exceeded standards set forth in the U.S. Health and Human Services, Food and Drug Administration (FDA) publication, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," dated 3/10/06. The openings between the rails in Zone 1 were measured to be at seven and one-half by fourteen (7 1/2 by 14) inches in the center opening. Two openings were six by fourteen (6 by 14) inches and two outer openings were six by nine (6 by 9) inches. The maximum opening between the rails in Zone 1 recommended by the FDA was four and three-quarter (4 and 3/4) inches. The facility assessment did not review all components related to the use of side rails that	21665			

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21665	Continued From page 53 included individualized functional mobility needs related to the device, medical/safety risk factors, compliance with Federal agency dimensional guidance, potential for restrictiveness with use of the device, possible use of alternative devices to aide in safety or mobility, and a method to implement and monitor use. Additionally, the facility did not recognize the side rail device actually met the technical definition of a quarter side rail that had the potential to be restrictive or that it could potentially pose significant safety risks. Unit registered nurse-A (RN-A) reported during staff interview at 5:15 p.m. on 2/27/12 R37 did not use quarter or half side rails and there were no side rails utilized in the facility, only grab bar devices were used on the beds. The facility maintenance director verified at 10:00 a.m. on 2/29/12 the dimensions of the four metal side rails that exceeded FDA guidance. Initially, the maintenance director stated he was not aware of the standards, then recalled he had seen some information about the issue. The director reported nursing requested side rails on beds for residents; however, he did not differentiate between the metal side rails for the older beds or the several other types of different and newer beds that utilized a variety of side rail designs and dimensions. He reported the side rails were not removed unless requested to by nursing and were not deactivated if not used. The director of nursing (DON) reported during interview at 1:30 p.m. on 2/29/12 she was not aware there were any actual side rails in the facility or that there were side rail devices used that were not in compliance with the FDA standards.	21665			

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21665	Continued From page 54 Unit registered nurse-B (RN-B) verified at 2:30 p.m. on 2/29/12 the facility did not obtain a written consent prior to use of the side rail devices and could not provide any documentation of what was provided to residents for the risk/benefit education noted in the assessment for R37. RN-B also reported the functional/safety assessment tool was the only method used by the facility to evaluate care components related to use of side rail devices and the assessment did not identify the use of the side rail device for R37. RN-B stated R37 was initially resistant to sleeping in the bed and he currently primarily slept in the recliner in the room; however, could potentially still use the bed. Facility policy for the safety program dated May 2011 identified the safety program was acted upon and reported to the quality assurance (QA) for processes to evaluate and implement interventions to reduce hazards and risks. The policy directed safety audits were to be completed and results reported to the QA committee. Included on the audit form was one section that read as follows: [Bed rails applied correctly, fit to mattress, no gaps greater than four and three-quarters (4 3/4") inches The facility failed to determine R43's risk for side rail entrapment by evaluating the dimensional limits of the potential zones of entrapment and overall safety of the rails for R43 who utilized side rails. R43 diagnoses included rheumatoid arthritis, hypertension (high blood pressure), osteoarthritis, macular degeneration, cataract, mild cognitive impairment, congestive heart failure and chronic obstructive pulmonary disease (COPD).	21665			

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21665	Continued From page 55 The admission annual minimum data set (MDS) dated 08/24/11 revealed R43 was cognitively intact and was independent with bed mobility and transfers. Review of the Functional Safety Assessment dated 10/9/10, indicated R43 had increased independence for bed rail use. The assessment indicated R43 received education on the risk/benefits of bed rail use and the facility obtained consent to use the bed rails. Consent form was not in medial record. Review of the plan of care dated 4/29/12 identified R43 had alteration in mobility with potential for injuries due to history of falls and did not always remember safety issues. Interventions included R43 was independent with bed mobility, used grab bars to reposition self, and was independent with transfers. The plan of care included to remind R43 of safety issues and assist as needed. During observation at 6:34 p.m. on 2/27/12, the right side of R43's bed was noted to be flush with the wall and a silver metal side rail was attached to the left side of the bed, in the upright position. The side rail observed was an older metal design that had five separate openings within the side rails (Zone 1) that exceeded standards set forth in the U.S. Health and Human Services, Food and Drug Administration (FDA) publication, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," dated 3/10/06. The openings between the rails in Zone 1 were measured to be at seven and one-half by fourteen (7 1/2 by 14) inches in the center opening. Two openings were six by fourteen (6 by 14) inches and two outer openings were six by nine (6 by 9) inches. The maximum opening within the side rails in Zone 1 recommended by the FDA was four and three-quarter (4 and 3/4) inches	21665			

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21665	Continued From page 56 R 53, who utilized side rail devices with dimensions not fully in compliance with U.S. Department of Health and Human Services, Food and Drug Administration (FDA) guidance, lacked a comprehensive assessment that included/addressed safety factors related to the use of side rail devices. There was no physician order for the use of a half side rail on the bed. R53 was admitted on 8/19/11, with a diagnosis of congestive heart failure, chronic obstructive pulmonary disease and high blood pressure. The facility form titled, Functional/Safety Assessment, dated 8/26/11, read, under bed mobility, extensive assist, and two person physical assist with two assistive devices used. During the initial tour at 1:00 p.m. on 2/27/12, and throughout the consecutive days of the survey, R 53's bed was observed to have a single half side rail utilized on the outside of the bed in the down position. Interview of R53 at 7:00 p.m. On 2/27/12, revealed the side rail's are not used now, but if there is a need in the future then the rail should stay on "Just in case." Talked to R53 about a least restrictive device such as a grab bar and R53 stated, "That would be fine." . Interviews at 1:00 p.m. on 2/29/12 with nursing assistants (D), (F) and (G) all confirmed that it was a side rail on R53's bed and that R53 does not need a side rail. SUGGESTED METHOD FOR CORRECTION: The administrator or designee (s) could revise	21665			

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21665	Continued From page 57 policies and procedures to ensure that residents who use facility equipment and devices are assessed before use and deemed to be safe from potential hazards. The administrator, or designee (s) could provide inservicing to all staff related how to ensure the policies and procedures are followed and all equipment and devices are in compliance with current and acceptable state and federal standards. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21665			
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure cleanable surfaces for a sanitary environment related to the kitchen floor, with the potential to affect 48 of 48 residents in the facility. Findings include: During the initial kitchen observation at 1:45 p.m. on 2/27/12, floor grout was noted to be black in color throughout the main areas of the kitchen floor compared to the whitish color of grout in areas of the kitchen where less foot traffic	21685			

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21685	Continued From page 58 occurred (i.e., under the sinks and outer perimeters). During follow-up kitchen observation at 11:00 a.m. on 2/29/12, the floor grout remained black in color and was not flush with kitchen floor tile, leaving a small groove between the tiles. Dietary Manager (DM) verified the grout looked dirty and acknowledged there were many products on the market to clean grout. DM stated their initial plans were to use a darker color grout but this was not available at the time kitchen floor tile was laid. During this observation Cook-B stated staff would get down on their hands and knees to scrub with a brush, but nothing worked. Cook-A added maintenance brought a machine in a couple of months ago to clean the grout with Uric Acid, admitting it helped some, but the smell was so bad they discontinued using it. During interview at 2:35 p.m. on 2/29/12, Maintenance-A verified cleaning the kitchen floor three months ago with Bromic Acid on an area of 4 x 4 feet, but discontinued using the Bromic Acid even though it "brightened it up some, [because] it smelled really bad." Maintenance-A reported the facility currently used Tuff Green which he verified was effective. Maintenance-A added, "I feel if they just get down on their hands and knees and scrubbed it [kitchen floor], it would brighten it [grout] up." During follow-up interview at 2:45 p.m. on 2/29/12, DM reported every night the staff cleaned the kitchen floor with a small scrub brush, attached to a handle, with either Oasis or bleach, and then mopped the kitchen floor. Review of the facility policy Standard Procedure, Attachment 6034A: Procedure for washing walls,	21685			

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21685	Continued From page 59 floors and ceilings, undated, indicated floors were to be swept well, washed with hot water and non-sudsing cleaning solution, rinsed well with mop, wiped with sanitizer and air dried. The policy/procedure did not address how to clean floor grout or how to ensure cleanable surfaces. SUGGESTED METHOD OF CORRECTION: The director of maintenance or his designee could develop and implement policies and procedures to ensure that the nursing home was maintained in a safe, clean, functional, comfortable and homelike manner. Ongoing maintenance, monitoring and record keeping to ensure that the environment, including floor surfaces and equipment in rooms, common areas and food preparation areas are maintained to ensure cleanable surfaces. Develop a system to audit the environment on an ongoing basis to ensure compliance and monitor staff for adherence to these policies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21685			
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, and interview the facility failed to provide housekeeping and maintenance	21695			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00842	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/01/2012
NAME OF PROVIDER OR SUPPLIER CLARKFIELD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE	
21695	Continued From page 60 services for 10 of 53 residents (R14, 4, 36, 24 ,9,37, 5, 7, 12 and 16. observed during the environmental tour. Findings include: During observations of resident rooms the following housekeeping/maintenance concerns were observed: Resident 14's bathroom floor was discolored around the toilet, a bedpan was on the floor. Resident 4 had a dusty bathroom ceiling vent. Resident 36's room door had chips/scratches and paint chips off the bathroom door. Resident 24's bathroom had no baseboard so exposed old glue, discolored floor surrounding toilet and spackling areas not painted by the bathroom sink. Resident 9's bathroom door had the veneer coming off on the bottom and the closet door was not secured on the bottom. Resident 37's room had a floor mat with tears in it making it an uncleanable surface. Resident 5's bathroom floor had a sticky substance, with the odor of urine. The wiring from the wall telephone jack was hanging loose near the room doorframe. Resident 7's room door had an unsecured sharp plastic piece with some damage to the veneer. Resident 12's bathroom baseboard was missing on 3 sides of toilet. Wires behind the television	21695			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00842	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/01/2012
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21695	Continued From page 61 were wound in a circular shape, noticeable next to the door frame. Resident 16's phone jack was hanging loose with wires exposed and visible. Ointment and wipes were on the toilet tank. At 10:15 a.m. on 2/29/12 during an environmental tour the maintenance/housekeeping director stated he was aware of some of the items, but not all of the above areas were reported to the department. The maintenance/housekeeping director also stated that painting was an ongoing task and all the department employees would be notified of expectations to keep the rooms in good repair and clean. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing, Housekeeping and/or designee could monitor to assure all areas and rooms in the facility are clean, sanitary and well maintained. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21695			