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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QKF4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00842

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245551**

2.STATE VENDOR OR MEDICAID NO.
(L2) **908340500**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/28/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (L17)

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Kathy Lucas, Unit Supervisor 03/28/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 03/31/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/04/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/28/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245551
March 31, 2017

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

Dear Ms. McNamara:

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

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

Effective March 21, 2017 the above facility is certified for or recommended for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 31, 2017

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

RE: Project Number S5551027

Dear Ms. McNamara:

On February 16, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 2, 2017. 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 March 28, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 17, 2017 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 2, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 21, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 2, 2017, effective March 21, 2017 and therefore remedies outlined in our letter to you dated February 16, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245551 Y1	A. Building B. Wing Y2	3/28/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKFIELD CARE CENTER	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).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0279	Correction	ID Prefix	F0280	Correction	ID Prefix	F0282	Correction
Reg. #	483.20(d);483.21(b)(1)	Completed	Reg. #	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	Completed	Reg. #	483.21(b)(3)(ii)	Completed
LSC		03/21/2017	LSC		03/21/2017	LSC		03/21/2017
ID Prefix	F0312	Correction	ID Prefix	F0314	Correction	ID Prefix	F0315	Correction
Reg. #	483.24(a)(2)	Completed	Reg. #	483.25(b)(1)	Completed	Reg. #	483.25(e)(1)-(3)	Completed
LSC		03/21/2017	LSC		03/21/2017	LSC		03/21/2017
ID Prefix	F0323	Correction	ID Prefix	F0373	Correction	ID Prefix	F0425	Correction
Reg. #	483.25(d)(1)(2)(n)(1)-(3)	Completed	Reg. #	483.60(h)(1)-(3), 483.95(h)	Completed	Reg. #	483.45(a)(b)(1)	Completed
LSC		03/21/2017	LSC		03/02/2017	LSC		03/05/2017
ID Prefix	F0431	Correction	ID Prefix	F0441	Correction	ID Prefix		Correction
Reg. #	483.45(b)(2)(3)(g)(h)	Completed	Reg. #	483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #		Completed
LSC		02/20/2017	LSC		03/21/2017	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/2/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245551	A. Building 01 - MAIN BUILDING 01 B. Wing	3/17/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKFIELD CARE CENTER	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0300	Correction Completed 03/15/2017	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 02/28/2017	ID Prefix Reg. # NFPA 101 LSC K0920	Correction Completed 02/24/2017
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 (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/31/2017

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QKF4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00842

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245551**

2.STATE VENDOR OR MEDICAID NO.
(L2) **908340500**

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/02/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Jennifer Bahr, HFE NE II — 02/28/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 03/28/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/28/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 16, 2017

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

RE: Project Number S5551027

Dear Ms. McNamara:

On February 2, 2017, 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;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**

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

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

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

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

DEPARTMENT CONTACT

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

Kathy Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 14, 2017, 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 March 14, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 2, 2017 (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 August 2, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245551	A. BUILDING _____ B. WING _____	02/02/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 279		3/21/17

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

Electronically Signed | 02/23/2017

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F 279	Continued From page 1 (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 279	1. Corrective Action:	

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F 279	Continued From page 2 facility failed to ensure a comprehensive care plan was developed to prevent the decline of pressure ulcers for 1 of 4 residents (R37), reviewed for pressure ulcers. Findings include: R37's Pressure Ulcer Care Area Assessment (CAA) dated 10/18/16, indicated R37 needed total assistance with bed mobility, was always incontinent of urine and bowel, had weight loss, and was at risk for developing pressure ulcers. The CAA identified R37 had the following unhealed pressure ulcers: Two Stage 1 pressure ulcers (observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.) One Stage 2 pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister) One Stage 3 pressure ulcer (Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.) The CAA identified the resident was very particular on the way he desired to be	F 279	a. Care plan for R37 was reviewed with DON, Nurse Manager and MDS Coordinator. Discussion related to appropriate documentation, intervention, and coding with education provided by Corporate Quality Nurse on as well as Care Planning. Resident is no longer residing at the facility. 2. Corrective Action as it relates to other residents: a. Care plans for all residents will be reviewed for appropriate interventions following comprehensive assessment. b. DON, MDS Coordinator and Nurse Manager will be re-educated on comprehensive assessment and care planning on February 27, 2017 by Corporate Quality Nurse. c. Policy and Procedure for comprehensive assessment and care planning will be reviewed with all licensed nurses at mandatory meeting on 3/2/17. d. Education on Wound Care and Intervention Protocols will be given to all licensed nurses on 3/2/17. 3. Date of Completion: 3/21/2016 4. Reoccurrence will be prevented by: a. DON or designee will audit one record per week to assure that assessments and care plans are accurate and comprehensive. b. All wounds will be reviewed at daily stand-up meeting by the Interdisciplinary Team along with other significant events and incidents. 5. The Correction will be monitored by: a. DON or Designee b. QAPI Committee will review the results at quarterly meetings and provide	

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F 279	Continued From page 3 repositioned and directed staff with every move, and refused offloading positional changes at time. The CAA also identified staff managed his perineal cares and incontinent products and that his skin was monitored daily with cares and was repositioned every hour. Nursing staff managed all nutritional intakes by tube feedings. The CAA directed a care plan to be developed to slow or minimize a decline and for symptom relief or palliative care. R37's care plan dated 11/8/16, did not address R37's current pressure ulcers with interventions to slow or minimize a decline or for symptom relief or palliative care. During interview on 2/2/17, at 12:43 p.m. registered nurse (RN)-A stated R37 should have had a care plan related to pressure ulcers, however, a care plan was not developed. During interview on 2/2/17, at 1:32 p.m. the director of nursing (DON) verified R37 did not have a care plan to manage R37's pressure ulcers, and a care plan should have been developed seven days after the CAA was completed. A policy on developing a care plan was requested and was not received.	F 279	further guidance as needed.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:	F 280		3/21/17

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F 280	Continued From page 4 (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be-	F 280		

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F 280	Continued From page 5 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan with interventions after a resident exhibited physical behaviors toward staff for 1 of 3 residents (R42) reviewed for accidents.	F 280	Corrective Action: a. Care plan for R42 was reviewed with DON, Nurse Manager and MDS Coordinator. Revisions were made to care plan including appropriate	

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F 280	Continued From page 6 Findings include: R42's admission Minimum Data Set (MDS) dated 12/29/16, identified a severe cognitive impairment and wandering behaviors. However, it did not indicated that R42 exhibited any physical behaviors during the assessment period. R42's admission Care Area Assessment (CAA) dated 1/4/17, indicated R42 wandered "aimlessly and without purpose at least a few days a week," and had a history of a traumatic brain injury (TBI). The CAA further indicated R42 was easily redirected sometimes but other times it could take "4+ staff members to keep him safe." R42's progress notes were reviewed from 12/22/16 to 2/2/17. A behavior note dated 1/28/17, indicated R42 had been wandering the halls when he became "agitated and started talking about the war," but was redirected back into his room. Later, R42 "got aggressive with staff and tried to keep 2 CNA (nursing assistants) in his room by holding the door shut" as they were attempting to assist him to toilet. The behavior note further identified R42 was "back out wandering the halls hiding in bathroom and in time clock room. Some how he got a hold of a pen, threatening to stab someone, later he got a hold of a pair of scissors and was hiding in the time clock room and stated he was waiting on the sheriff." R42 was able to be redirected back to his room, however "would not let writer take the scissors away." R42's current care plan dated 12/23/16, identified that Haldol (an antipsychotic medication) was used related to target behaviors of "pacing,	F 280	interventions. a. Education provided by Corporate Quality Nurse on appropriate incident report, VA Report and Care Planning policies 2/27/2017 b. Education provided by Corporate Quality Nurse to DON, MDS Coordinator and Nurse Manager on behavioral interventions on 2/27/2017 2. Corrective Action as it relates to other residents: a. Care plans for all residents will be reviewed for appropriate interventions following comprehensive assessment. b. Education provided by Corporate Quality Nurse on appropriate incident report, VA Report and Care Planning policies 2/27/2017 c. Education provided by Corporate Quality Nurse to DON, MDS Coordinator and Nurse Manager on behavioral interventions on 2/27/2017. d. Residents identified with needing behavioral interventions are in the process of being identified by 3/10/17 by the RN clinical team and IDT team. The comprehensive assessments will be reviewed and care plans updated and implemented by 3/17/17. e. All staff will be given education on appropriate behavioral interventions for residents on 3/2/17. f. Policy and Procedure for comprehensive assessment and care planning will be reviewed with all licensed nurses at mandatory meeting on 3/2/17. g. Education on Incident Reporting, VA Reporting and Behavioral Interventions	

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F 280	Continued From page 7 wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others." The care plan further identified R42 was on a behavior management program which directed to use "alternatives to prn (as needed) medication use." It did not specify what those alternative non-pharmacological interventions were. R42's care plan also lacked any specific safety interventions related to the incident above, nor did it direct staff on how to manage R42's future behaviors. During interview on 2/2/17, at 12:41 p.m. NA-B reported being aware of the incident but was not aware of any new interventions since then incident. NA-B further reported still going into R42's room alone to provide care and stated staff scanned the room for sharp objects periodically with cares, but had no education since the incident to do so. During interview on 2/2/17, at 12:46 p.m. trained medication aide (TMA)-A stated she was aware of the incident and thought R42's antipsychotic medication had been re-started and had "settled him down a bit." However, TMA-A also stated she was not aware of any new interventions and hadn't received any new education since the incident. During interview on 2/2/17, at 1:12 pm. licensed practical nurse (LPN)-B stated she was aware of the incident and she knew R42 would hide in the conference room. However, LPN-B stated there hadn't been any new education since the incident. During interview on 2/2/17, at 2:14 p.m. the director of nursing (DON) stated she was aware of the incident; however, the incident had not	F 280	will be given to all nursing staff on 3/2/17. 3. Date of Completion: 3/21/2016 4. Reoccurrence will be prevented by: a. DON or designee will audit one record per week to assure that assessments and care plans are accurate and comprehensive. b. All incidents, significant events and clinical changes will be reviewed at daily stand-up meeting by the Interdisciplinary Team. 5. The Correction will be monitored by: a. DON or Designee b. QAPI Committee will review the results at quarterly meetings and provide further guidance as needed.	

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F 280	Continued From page 8 been reviewed by the interdisciplinary team nor had any new interventions been put into place on R42's care plan. The DON reported staff needed training after the incident, which hadn't been implemented.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement care plan interventions for timely repositioning and toileting for 1 of 4 residents (R6) reviewed for pressure ulcer development and urinary incontinence. Findings include: R6's quarterly Minimum Data Set (MDS) dated 11/15/16, identified a severe cognitive impairment with a diagnosis of dementia, and needed extensive assistance with bed mobility, transfers, and toileting. The MDS indicated R6 had moisture associated skin damage (MASD), tissue damage that results from prolonged exposure to moisure, and identified R6 having a turning and repositioning program. The MDS also indicated she was continent of bowel but frequently incontinent of urine, and was on a toileting program to manage continence.	F 282	1. Corrective Action: a. Care plan and interventions for toileting and reposition for R6 were reviewed and revised to reflect appropriate intervention. 2. Corrective Action as it relates to other residents: a. Care plans for all residents will be reviewed for appropriate Toileting and Repositioning programs following comprehensive assessment. b. Policy and Procedure for comprehensive assessment and care planning and toileting/repositioning will be reviewed with all licensed nurses at mandatory meeting on 3/2/17. c. All NAR's will be re-educated on Toileting and Repositioning of residents on 3/2/17. 3. Date of Completion: 3/21/2016	3/21/17

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F 282	Continued From page 9 R6's current care plan dated 11/9/16, identified impaired skin integrity to R6's coccyx with the following intervention, "encourage to lay down frequently; especially in the afternoon." The care plan also identified R6's mixed incontinence dated 7/28/15, with the following toileting scheduled, "Check upon waking in the AM (morning), between meals and at HS (bedtime) and as required for incontinence." A untitled nursing assistant sheet dated 2/1/17, identified staff were to encourage R6 to "lay down or offload in afternoon and at frequent intervals throughout the day," and directed staff to toilet R6 "upon waking, after all meals, at HS." During continuous observation, the follow was observed: On 2/1/17, at 7:10 a.m. R6 was dressed and sitting in her wheelchair by the medication cart. Trained medication aide (TMA)-A took her blood sugar and administered medications. At 7:18 a.m. TMA-A assisted R6 into the dining room for breakfast. R6 was observed to stay in the dining room. At 7:42 a.m. R6 was observed finishing her breakfast and began to self propel in her wheelchair out of the dining room. R6 was observed to self propel down the hallway and into her room. At 8:07 a.m. R6 continued to be in her room. Nursing assistant (NA)-C was observed walking by R6's room, and no offer of repositioning or toileting was made. At 8:31 a.m. R6 was observed to self propel out of her room and down the hallway toward the entrance way where she remained sitting. NA-C assisted R6 to move her wheelchair forward and out of the way for passerby's. Again, no staff offered to	F 282	4. Reoccurrence will be prevented by: a. DON or designee will audit one record per week to assure that assessments and care plans are accurate and comprehensive. b. DON or designee will audit toileting and repositioning weekly for 12 weeks then monthly on-going. 5. The Correction will be monitored by: c. DON or Designee d. QAPI Committee will review the results at quarterly meetings and provide further guidance as needed.	

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F 282	Continued From page 10	F 282		

reposition or toilet R6. At 9:06 a.m. R6 was not repositioned. At 9:20 a.m. R6 was observed to self propel down the hallway back to her room. She was observed rummaging through her closet. NA-C walked by her room twice, however, no offers of repositioning or toileting were made. At 9:30 a.m. activities assistant (A)-A asked R6 to play bingo. After being prompted, A-A asked R6 if she needed to go to the bathroom and R6 stated "no." A-A stated R6 had "a good bladder," and assisted her to bingo. From 9:40 a.m. to 10:27 a.m. R6 was observed in bingo. Following bingo, R6 was observed sitting in the entrance. At 10:45 a.m. R6 was observed to self propel from the entrance to her room. From 10:56 a.m. to 11:12 a.m. R6 was observed in her room. She then self propelled back down the hallway to the entrance. She had made it halfway down the hallway when licensed practical nurse (LPN)-A assisted her to the entrance. LPN-A asked R6 where she wanted to go, and took her into the dining room. No offers to reposition or toilet were made. From 11:25 a.m. to 11:56 a.m. R6 was observed eating lunch in the dining room. She then self propelled out of the dining room and back to her room. At 11:58 a.m. (4 hours and 50 minutes since the first observations) NA-C answered R6's call light and assisted her with the sit to stand lift to sit on the commode. R6's coccyx was observed to be covered by a Mepilex dressing. NA-C assisted R6 to remove her soiled brief, donned new clean gloves, and replaced the brief with a new one. NA-C stated the brief was soaked with a medium amount of urine. R6 was noted to be continent of bowel. NA-C transferred R6 with the sit to stand lift from the commode to her bed, then assisted R6 into a lying position. R6 began to cry as she laid in bed and NA-C re-assured her stating she just needed to lie down for a little while to get off

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F 282	Continued From page 11	F 282		

her bottom. During observation, NA-C stated R6 should be repositioned every two hours but would cry when staff tried to lay her down.

During interview on 2/1/17, at 12:10 a.m. NA-D stated R6 refused to lay down in the mornings, but would take a nap in the afternoons. NA-D stated staff offered to lay her down every two hours, but was unable to state the last time R6 was offered, further stating if R6 needed repositioning they would take care of it in between time. NA-D stated she would offer to toilet R6 about every two hours. NA-D thought R6 was offered toileting after breakfast.

During interview on 2/1/17, at 12:25 p.m. NA-B stated R6 was suppose to be repositioned every two hours and as needed. NA-B thought her partner (NA-D) assisted R6 to offload before she went to the morning activity. NA-B stated they would check on R6 and offer every two to three hours if she hadn't called. NA-B thought R6's incontinence varied. NA-B reported R6 was toileted with morning cares and thought her partner (NA-D) had offered toileting before she went to the morning activity.

During interview on 2/2/17, at 2:38 p.m. the director of nursing (DON) indicated residents individual tissue tolerances directed their repositioning schedules, which needed to be followed in order to prevent further skin breakdown. The DON further reported residents with incontinence should automatically be placed on individualized toileting plans to address the incontinence. The DON stated toileting plans needed to be followed and, specifically for R6, moisture had the potential to increase the risk of further skin breakdown and prevent healing.

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F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide assistance with shaving for 1 of 3 residents (R6) reviewed for activities of daily living. Findings include: R6's quarterly Minimum Data Set (MDS) dated 11/15/16, indicated a severe cognitive deficit and needed extensive assistance with grooming. R6's Documentation Survey Report for 1/16, indicated she was scheduled for a bath on Tuesday, day shift and identified her last bath was on 1/31/16. There was no additional documentation pertaining to why R6 was not shaved. R6's care plan dated 2/1/17, identified a self-care deficit in her ADL performance. The care plan directed staff to assist R6 with bathing. On 1/30/17, at 6:52 p.m. R6 was observed sitting in her wheelchair. Long white hairs were noted on her chin and upper lip. On 1/31/17, at 10:14 a.m. R6 was again observed with the same long white hairs on her chin and upper lip. On 2/1/17, at 6:16 a.m. R6 was observed sitting	F 312	1. Corrective Action: a. Resident R6 was shaved following the incident. 2. Corrective Action as it applies to other residents: a. All nursing staff were reminded of the policy of shaving residents and appropriate ADL provision. b. All nursing staff will be educated on the Dignity of residents and ADL cares at a mandatory meeting on 3/2/17. 3. Date of Completion: 3/21/2017 4. Reoccurrence will be prevented by: a. DON or designee will audit shaving on a weekly basis. 5. Correction will be monitored by: a. DON or Designee b. QAPI will review audit results at quarterly meetings and provide further guidance as needed.	3/21/17

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F 312	Continued From page 13 in her wheelchair. She was dressed and her morning cares appeared to be done. She continued to have long white hairs on her chin and upper lip. During interview on 2/1/17, at 12:25 p.m. nursing assistant (NA)- stated residents were usually shaved on bath days, further stating R6's bath day would've been Tuesday, the previous day. NA- reported R6 would typically get her bath after breakfast and didn't have a history of refusing shaving, further indicating R6 would sometimes stroke her chin and state "oh my whiskers." NA- observed R6 and stated she hadn't noticed R6's hairs, but that they would need to be shaved. During interview on 2/2/17, at 9:08 a.m. the director of nursing (DON) stated the nursing assistants were trained to look at the residents during their daily cares, see if they needed shaving, and communicate the need to the nurses. The DON stated R6's care plan did not specifically direct to shave her, although it would be included under personal hygiene. The DON observed R6's facial hair stating it was, "Not appropriate." A facility policy entitled Shaving the Resident, revised 10/10, directed staff how to perform shaving as well as to document the procedure or refusals in the resident's medical record.	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the	F 314		3/21/17

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F 314	Continued From page 14 facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement care plan interventions and comprehensively reassess a decline in pressure ulcer condition to promote the healing of pressure ulcers for 1 of 4 residents (R6). In addition, the facility failed to complete weekly monitoring and identify type of wound for each individual pressure ulcer for 1 of 4 residents (R37), reviewed for pressure ulcers. Findings include: R6's quarterly Minimum Data Set (MDS) dated 11/15/16, identified R6 had a severe cognitive impairment with a diagnosis of dementia, and needed extensive assistance with bed mobility, transfers, and toileting. The MDS indicated R6 was continent of bowel but frequently incontinent of urine. The MDS also identified R6 was at risk for pressure ulcers, however, did not currently have any. The MDS indicated R6 had moisture associated skin damage (MASD), tissue damage that results from prolonged exposure to moisure and identified a pressure relieving cushion and	F 314	1. Corrective Action: a. Care plan for R37 was reviewed with DON, Nurse Manager and MDS Coordinator. Discussion related to documentation, intervention, treatments and services with education provided by Corporate Quality Nurse on appropriate documentation and Care Plan Implementation. Resident is no longer residing at the facility. b. Care plan, interventions, treatment and services for R6 were reviewed and revised to reflect appropriate intervention. 2. Corrective Action as it relates to other residents: a. Care plans for all residents will be reviewed for appropriate interventions, treatments and services to prevent or heal pressure ulcers following comprehensive assessment. b. Residents identified with current pressure injuries or at risk for pressure injury are in the process of being identified by 3/3/17 by the RN clinical team and IDT	

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F 314	Continued From page 15 mattress, a turning and repositioning program, and a nonsurgical dressing. R6's annual pressure ulcer Care Area Assessment (CAA) dated 8/24/16, indicated R6 was at risk for pressure ulcer development related to being wheelchair bound and frequent incontinence. The CAA identified staff assisted R6 to reposition and off load every two hours, and as needed. Staff performed weekly skin assessments, and R6 had no pressure related skin breakdown. R6's care plan dated 11/9/16, identified impaired skin integrity to R6's coccyx with the following interventions, "apply aquacel and moisten with saline to skin breakdown daily, change dressing weekly and prn (as needed), encourage to lay down frequently, especially in the afternoon, ensure resident drink entire supplement of Arginaid (nutritional supplement), and use a lift sheet to prevent shear." A untitled nursing assistant sheet dated 2/1/17, identified staff were to encourage R6 to "lay down or offload in afternoon and at frequent intervals throughout the day." R6's Documentation Survey Report V2 dated 1/17, identified R6 had an every two hour turning and repositioning schedule. The report indicated R6 went for more than 3 hours without repositioning almost daily. R6's medical record lacked documentation of R6's refusals to reposition and/or offers to reposition. R6's Braden Scale completed 11/15/16, indicated R6 was at low risk for developing a pressure ulcer.	F 314	staff. The comprehensive assessments will be reviewed and care plans updated and implemented by 3/10/17. c. DON, MDS Coordinator and Nurse Manager will be re-educated on comprehensive assessment and care plan implementation on February 27, 2017 by Corporate Quality Nurse. d. Policy and Procedure for comprehensive assessment and care plan implementation will be reviewed with all licensed nurses at mandatory meeting on 3/2/17. e. Education on Wound Care and Intervention Protocols will be given to all licensed nurses on 3/2/17. 3. Date of Completion: 3/21/2016 4. Reoccurrence will be prevented by: a. DON or designee will audit one record per week to assure that assessments, care plans treatments and services are accurate and comprehensive. b. All wounds will be review at daily stand-up meeting by the Interdisciplinary Team along with other significant events and incidents. 5. The Correction will be monitored by: a. DON or Designee b. QAPI Committee will review the results at quarterly meetings and provide further guidance as needed.	

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F 314	Continued From page 16 R6's weekly Skin Assessments were reviewed and indicated the following: - 11/1/16, identified new MASD to the right buttock, measuring 5 centimeters (cm) x 2 cm, and left buttock, measuring 5 cm x 4 cm. The MASD was described as "cobblestone maceration" and "redness, scaling." The assessment did not identify there was any drainage, odor, or open areas noted with the MASD. The assessments further identified R6 sat in her wheelchair for most of the day, and was encouraged to lay down in the afternoon, but would refuse. It also indicated R6 was toileted every two hours, barrier cream was applied to buttocks, and occupational therapy (OT) was evaluating for an appropriate wheelchair cushion. - 11/9/16, identified MASD to the right buttock, measuring 5 cm x 2 cm, and left buttock, measuring 4 cm x 0.5 cm. Appearance of the MASD remained the same. The interventions remained the same. The assessment noted the skin was improving. - 11/16/16, identified MASD to the right buttock, measuring 5 cm x 2 cm, and left buttock, measuring 4 cm x 0.5 cm. Appearance of the MASD remained the same. The assessment identified R6's toileting program had been changed to upon waking, before and after meals, and at bedtime. The assessment noted the skin was improving. - 11/23/16, identified MASD to the right buttock, measuring 5 cm x 2 cm, and left buttock, measuring 3 cm x 0.5 cm. Appearance of the MASD remained the same. The assessment	F 314		

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identified R6's wound treatment had changed and was getting "aq silver (Aquacel Silver) to the wound bed and Mepilex." There was no indication of any open areas. The assessment noted the skin was improving.

- 11/29/16, identified MASD to the right buttock, measuring 4 cm x 2 cm, and left buttock, measuring 1 cm x 1 cm. Appearance of the MASD remained the same. The interventions remained the same. The assessment noted the skin was improving.

- 12/6/16, identified MASD to the right buttock, measuring 3 cm x 2 cm, and left buttock, measuring 0.5 cm x 0.5 cm. Appearance of the MASD remained the same. The assessment indicated that a pressure reducing wheelchair cushion had been established. The assessment noted the skin was improving.

- 12/11/16, identified MASD to the right buttock, measuring 3 cm x 2 cm, and left buttock, measuring 0.23 cm x 0.5 cm. Appearance of the MASD remained the same. The interventions remained the same. The assessment noted the skin was improving.

- 12/16/16, identified MASD to the right buttock and left buttock. There were no measurements and only "redness and erythema" were noted. The assessment indicated there was no open wound and no Aquacel Silver was used. A Mepilex dressing was placed on prophylactic. The assessment noted the skin was improving.

- 12/27/16, identified MASD to the right buttock and left buttock. There were no measurements and only "redness and erythema" were noted.

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The assessment indicated there was a very small open area and no Aquacel Silver was used. A Mepilex dressing was placed on prophylactic. The assessment noted the skin was improving.

- 1/4/17, identified MASD to the right buttock, measuring 0.5 cm x 0.5 cm, which was now open and presented with slough. The assessment indicated that Aquacel Silver was used "due to increasing size in wound," and R6 continued to be encouraged to lie down after dinner but remained combative to this. The assessment noted the skin was unchanged.

- 1/10/17, identified MASD to the right buttock, measuring 0.5 cm x 0.5 cm open area and presented with slough. The interventions remained the same. The assessment noted the skin was unchanged from the previous assessment.

- 1/19/17, identified MASD to the right buttock, measuring 1 cm x 1 cm open area and presented with slough. The assessment indicated the treatment had changed and was now to be wet with saline and the Aquacel replaced daily, covered with Mepilex dressing It also indicated that R6 consistently laid down after dinner and a supplement had been started. The assessment noted the skin had worsened from the previous assessment.

- 1/30/17, identified MASD to the right buttock, measuring 1 cm x 1 cm open area and presented with slough. The interventions remained the same. The assessment noted the skin was unchanged from the previous assessment.

R6's physician notes indicated the following:

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- 11/9/16, identified concerns with a coccygeal wound (pressure ulcer), which was described as containing granulation tissue (healthy tissue which promotes healing) in the wound bed without erythema or drainage. The physician recommended wound treatment Aquacel Silver and working with therapies on offloading. This contradicted nursing's assessment of the MASD and location of the wound.

- 1/3/17, noted R6 had a an "ulcer on her buttocks," recommended continuing current treatment, and described the ulcer was closing in and healing. This contradicted nursing's assessment of the MASD.

During continuous observation, the follow was observed:
On 2/1/17, at 7:10 a.m. R6 was dressed and sitting in her wheelchair by the medication cart. Trained medication aide (TMA)-A took her blood sugar and administered medications. At 7:18 a.m. TMA-A assisted R6 into the dining room for breakfast. R6 was observed to stay in the dining room. At 7:42 a.m. R6 was observed finishing her breakfast and began to self propel in her wheelchair out of the dining room. She was observed to self propel down the hallway and into her room. At 8:07 a.m. R6 continued to be in her room. Nursing assistant (NA)-C was observed walking by R6's room, no offer of repositioning or offloading was made. At 8:31 a.m. R6 was observed to self propel out of her room and down the hallway toward the entrance way where she remained sitting. NA-C assisted R6 to move her wheelchair forward and out of the way for passerby's. Again no offer to reposition or offload was made. At 9:06 a.m. R6 continued to be in the

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same position. At 9:20 a.m. R6 was observed to self propel down the hallway back to her room. She was observed rummaging through her closet. NA-C walked by her room twice; however, no offers of repositioning or offloading were made. At 9:30 a.m. activities assistant (A)-A asked R6 to play bingo and assisted her to the activities room. From 9:40 a.m. to 10:27 a.m. R6 was observed in bingo. Afterwards, R6 was observed sitting in the entrance. At 10:45 a.m. R6 was observed to self propel from the entrance to her room. From 10:56 a.m. to 11:12 a.m. R6 was observed in her room. She then self propelled back down the hallway to the entrance. She had made it halfway down the hallway when licensed practical nurse (LPN)-A assisted her to the entrance. LPN-A asked R6 where she wanted to go, and took her into the dining room. No offer to reposition or offload was made. From 11:25 a.m. to 11:56 a.m. R6 was observed eating lunch in the dining room. She then self propelled out of the dining room and back to her room. At 11:58 a.m. (4 hours and 50 minutes since the first observations) NA-C answered R6's call light and assisted her with the sit to stand lift to sit on the commode. R6's coccyx was observed to be covered by a Mepilex dressing. NA-C assisted R6 to removed her soiled brief, donned new clean gloves, and replaced the brief with a new one. NA-C stated the brief was soaked with a medium amount of urine and, while observing, R6 was noted to be continent of bowel. NA-C transferred R6 with the sit to stand lift from the commode to her bed, then assisted R6 into a lying position. R6 began to cry as she laid in bed and NA-C re-assured her stating she just needed to lie down for a little while to get off her bottom. During observation, NA-C stated R6 should be repositioned every two hours but would cry when

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F 314	Continued From page 21 staff tried to lay her down. During interview on 2/1/17, at 12:10 a.m. NA-D stated R6 refused to lay down in the mornings, but would take a nap in the afternoons. NA-D stated staff offered to lay her down every two hours, but was unable to state the last time R6 was offered, further stating if R6 needed repositioning they would take care of it in between time. During interview on 2/1/17, at 12:25 p.m. NA-B stated R6 was suppose to be repositioned every two hours and as needed. NA-B thought her partner (NA-D) assisted R6 to offload before she went to the morning activity. NA-B stated R6 liked to be involved in the activities in the morning and was not out of her wheelchair unless she went to the commode. NA-B reported R6 laid down after lunch when the activities died down. During observation of wound cares on 2/1/17, at 1:29 p.m. registered nurse (RN)-A measured the wound on R6's right coccyx as 1 cm x 0.5 cm, stating there was no depth, while licensed practical nurse (LPN)-A assisted with R6's positioning. RN-A further stated the wound bed was covered in a white/yellow tissue and the surrounding peri wound was reddened but blanchable. RN-A stated R6's wound was treated with Aquacel daily and the Mepilex dressing was changed weekly. LPN-A stated the Aquacel helped to keep the wound moist and debride it. During observation, RN-A described the R6's open area was located on the right side near the clef of her buttocks, was near the bony prominence of her coccyx, and stated she was just learning that that would be considered pressure related along with the moisture, but was	F 314		

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not sure how to stage the wound. RN-A was aware R6 would refuse and cry when laid down making it difficult for the nursing assistants; however, she stated R6 should be on a every two hours repositioning schedule. RN-A stated R6's refusals were not documented.

During interview on 2/2/17, at 9:23 a.m. RN-B stated she was aware R6 had an open area near the right side of her coccyx, but stated she was not aware of the physician's note indicating it was a pressure ulcer. RN-B stated, from looking at the documentation, the wound would unstageable due to the slough. RN-B stated residents with pressure ulcers were often referred to the wound clinic; however, did not think that had been discussed with R6 or her family.

During interview on 2/2/17, at 11:30 a.m. RN-A stated R6's wound had healed and then re-opened and got worse at the beginning of January. RN-A stated R6's refusals to reposition could have contributed to the wound re-opening; however, R6 also had other contributing factors like weight loss and diabetes. RN-A further stated R6's wound had never been assess as a pressure ulcer nor had it been re-assessed as a pressure ulcer when it changed in January.

During interview on 2/2/17, at 12:53 p.m. occupational therapy assistant (OTA)-A stated R6 had been seen and was given a pressure relieving cushion in November. OTA-A stated therapy also worked with R6 on wheelchair positioning and was discharged on 12/22/16. OTA-A reported therapy was not aware R6's wound had opened, stating she was "under the impression her sore was healing." OTA-A stated R6 could be re-evaluated for a different cushion

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and had comorbidities putting her at a higher risk of skin breakdown the longer she sat in her chair.

During interview on 2/2/17, at 2:38 p.m. the director of nursing (DON) stated she was not aware that R6's wound had re-opened nor that there was conflicting documentation between the nursing assessments and physician notes. The DON stated she was under the impression the assessments were being doing, there was ongoing communication with the physician, and treatments were in place. The DON reported, by looking at the documentation, R6's wound be worsened and would be stageable with the slough. The DON further reported when the wound changed, a comprehensive assessment needed to be started and interventions put into place to treat the wound as pressure and not moisture. Lastly, the DON indicated residents individual tissue tolerances directed their repositioning schedules, which needed to be followed in order to prevent further skin breakdown.

During a follow up interview on 2/3/17, at 1:14 p.m. medical doctor (MD) stated R6's wound had been called an ulcer by the staff, had been covered at the time of his visit, and went off historical information. The MD stated the ulcer could have been the result of sheer or pressure, but would treat it the same way for both. The MD further stated the main thing would be to avoid further pressure and to keep R6 off of it as much as possible.

R37's admission MDS dated 10/17/16, indicated R37 was cognitively intact, and did not refuse

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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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care. The MDS indicated R37 needed total assistance with bed mobility and transfers and was always incontinent of bladder and bowel. The MDS identified a diagnosis of multiple sclerosis and was receiving hospice care. The MDS also identified R37 had the following unhealed pressure ulcers:
Two Stage 1 (An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.)
One Stage 2 (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister)
One Stage 3 (Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.)
The MDS identified a pressure relieving cushion and mattress along with a turning and repositioning program was in place, along with pressure ulcer care.

R37's Pressure Ulcer CAA dated 10/18/16, identified R37 was very particular on the way he desired to be repositioned, and directed staff with every move. R37 refused offloading positional changes at times. The CAA also identified staff managed his perineal cares and incontinent

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products and that his skin was monitored daily with cares and was repositioned every hour. Nursing staff managed all nutritional intakes by tube feedings. The CAA directed a care plan to be developed to slow or minimize a decline and/for symptom relief or palliative care.

R37's care plan dated 11/8/16, lacked R37's current pressure ulcers with interventions to slow or minimize a decline and or for symptom relief or palliative care.

R37's hospice care plan dated 12/20/16, indicated wound care was managed by the nursing home staff.

R37's Braden Scale dated 10/5/16, indicated R37 was at a very high risk to develop pressure ulcers. .

R37 Weekly Ulcer/ Complex Wound Observation Tool V-2 identified interventions that were listed weekly on the assessment, air mattress, hospital bed, turning and repositioning hourly, encourage R37 to sit in the wheelchair at least once daily, encourage to offload and catheter cares, the interventions remained the same week from week.. The weekly assessments were completed on the following dates:

- 10/5/16, identified the left buttock, which lacked the type of wound and measurements. A left thigh rear Stage 2 pressure ulcer and measured 1 centimeters (cm) x 2 cm. A sacrum wound, which lacked the type of wound: however, indicated it was a bony prominence, it also lacked measurements. A right gluteal fold wound, which lacked the type of wound; however indicated it was shearing skin damage and also lacked

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measurements. The assessment indicated the wound was present on admission, and the wound bed was pink without necrosis or slough. The assessment continued to note that there was serous drainage without odor; however did not identify which wound was being described.

- 10/12/16, identified a left thigh rear Stage 2 pressure ulcer and measured 1 cm x 1.5 cm. A left thigh rear Stage 2 pressure ulcer and measured 1 cm x 2 cm. A sacrum wound, which lacked the type of wound: however, indicated it was a bony prominence, it also lacked measurements. A right gluteal fold wound, which lacked the type of wound; however indicated it was shearing skin damage and also lacked measurements. The assessment indicated the wound was present on admission, was unchanged and the wound bed was pink without necrosis or slough. The assessment continued to note that there was serous drainage without odor; however did not identify which wound was being described.

- 10/14/16, identified a left thigh rear Stage 2 pressure ulcer and measured 1 cm x 1.5 cm. A left thigh rear Stage 2 pressure ulcer and measured 1 cm x 2 cm. A sacrum wound, which lacked the type of wound: however, indicated it was a bony prominence, it also lacked measurements. A right gluteal fold wound, which lacked the type of wound; however indicated it was shearing skin damage and also lacked measurements. The assessment indicated the wound was present on admission, was unchanged and the wound bed was pink without necrosis or slough. The assessment continued to note that there was serous drainage without odor; however did not identify which wound was being

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F 314	Continued From page 27 described. - 10/17/16, identified a left thigh rear Stage 2 pressure ulcer and measured 1 cm x 1.5 cm. A left thigh rear Stage 3 pressure ulcer and measured 2.5 cm x 2 cm x 0.5 cm. A sacrum wound, which lacked the type of wound: however, indicated it was a bony prominence, it also lacked measurements. A right gluteal fold wound, which lacked the type of wound; however indicated it was shearing skin damage and also lacked measurements. The assessment indicated the wound was present on admission, and was worsening and the wound bed was pink with speckled granulation tissue without necrosis with tan slough noted It also indicated there was tunneling of 0.5 cm at 12 o'clock. The assessment continued to note that there was serosanguinous drainage without odor; however did not identify which wound was being described. The assessment also lacked a comprehensive reassessment to indicated why the left thigh ulcer increased in stage from a Stage 2 to a Stage 3 and if any new interventions had been implemented. - 10/19/16, identified a left thigh rear Stage 2 pressure ulcer and measured 1 cm x 1.5 cm. A left thigh rear Stage 3 pressure ulcer and measured 2.5 cm x 2 cm x 0.5 cm. A sacrum wound, which lacked the type of wound: however, indicated it was a bony prominence, it also lacked measurements. A right gluteal fold wound, which lacked the type of wound; however indicated it was shearing skin damage and also lacked measurements. The assessment indicated the wound was present on admission, and was worsening and the wound bed was pink with speckled granulation tissue without necrosis with	F 314		

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tan slough noted It also indicated there was tunneling of 0.5 cm at 12 o'clock. The assessment continued to note that there was serosanguinous drainage without odor; however did not identify which wound was being described. The assessment also lacked a comprehensive reassessment to indicated why the left thigh ulcer increased in stage from a Stage 2 to a Stage 3 and if any new interventions had been implemented.

- 11/4/16, identified a left buttock pressure ulcer that was not staged and measured 1 cm x 1 cm. A left thigh rear Stage 2 pressure ulcer and measured 1 cm x 1.5 cm. A left thigh rear Stage 3 pressure ulcer and measured 2.5 cm x 2 cm x 0.5 cm. A sacrum wound, which lacked the type of wound: however, indicated it was a bony prominence, it also lacked measurements. A right gluteal fold wound, which lacked the type of wound; however indicated it was shearing skin damage and also lacked measurements. The assessment indicated the wound was present on admission, and was worsening and the wound beds on all the wounds were pink with speckled granulation tissue without necrosis with tan slough noted. It also indicated there was tunneling of 0.5 cm at 12 o'clock. The assessment continued to note that there was serosanguinous drainage without odor; however did not identify which wound was being described. The assessment lacked a comprehensive reassessment to the new pressure ulcer that developed on the left buttock that was previously not present according to the assessment dated 10/19/16.

- 11/19/16, identified a right buttock pressure ulcer that was not staged and measured 1 cm x 1

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cm. A left buttock pressure ulcer that was not staged and measured 1 cm x 1 cm. A left thigh rear Stage 2 pressure ulcer and measured 1 cm x 1.5 cm. A left thigh rear Stage 3 pressure ulcer and measured 2.5 cm x 2 cm x 0.5 cm. A sacrum wound, which lacked the type of wound: however, indicated it was a bony prominence, it also lacked measurements. A right gluteal fold wound, which lacked the type of wound; however indicated it was shearing skin damage and also lacked measurements. The assessment indicated the wound was present on admission, and was worsening and the wound beds on all the wounds were pink with speckled granulation tissue without necrosis with tan slough noted. It also indicated there was tunneling of 0.5 cm at 12 o'clock. The assessment continued to note that there was serosanguinous drainage without odor; however did not identify which wound was being described. The assessment lacked a comprehensive reassessment to the new pressure ulcer that developed on the right buttock that was not previously not present according to the assessment dated 11/4/16.

- 11/28/16, identified a right buttock pressure ulcer that was not staged and measured 1 cm x 1 cm. A left buttock pressure ulcer that was not staged and measured 1 cm x 1 cm. A sacrum wound, which lacked the type of wound: however, indicated it was a bony prominence, it also lacked measurements. A right gluteal fold wound, which lacked the type of wound; however indicated it was shearing skin damage and also lacked measurements. The assessment indicated the wound was present on admission and was improving and all the wound beds were pink with speckled red granulation tissue. The assessment continued to note that there was serosanguinous

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F 314	Continued From page 30 drainage without odor; however did not identify which wound was being described. The assessment did not address all the previous wounds that were identified during the assessment on 11/19/16. - 12/5/16, identified identified a right buttock pressure ulcer that was not staged and measured 0.5 cm x 0.5 cm. A left buttock pressure ulcer that was not staged and measured 1 cm x 1 cm. A sacrum wound, which lacked the type of wound: however, indicated it was a bony prominence, it also lacked measurements. A right gluteal fold wound, which lacked the type of wound; however indicated it was shearing skin damage and also lacked measurements. The assessment indicated the wound was present on admission and was worsening and all the wound beds were pink with speckled red granulation tissue. The assessment continued to note that there was serosanguinous drainage without odor; however did not identify which wound was being described. - 12/16/16, identified identified a right buttock pressure ulcer that was not staged and measured 0.5 cm x 0.5 cm. A left buttock pressure ulcer that was not staged and measured 1.5 cm x 1 cm. A sacrum wound, which lacked the type of wound: however, indicated it was a bony prominence, it also lacked measurements. A right gluteal fold wound, which lacked the type of wound; however indicated it was shearing skin damage and also lacked measurements. The assessment indicated the wound was present on admission and was worsening and all the wound beds were pink with speckled red granulation tissue. The assessment continued to note that there was serosanguinous drainage without odor; however did not identify which wound was being described.	F 314		

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- 12/24/16, identified identified a right buttock pressure ulcer that was not staged measuring 0.5 cm x 0.5 cm. A left buttock pressure ulcer that was not staged measuring 1.5 cm x 1 cm. A sacrum wound, which lacked the type of wound: however, indicated it was a bony prominence, it also lacked measurements. A right gluteal fold wound, which lacked the type of wound; however indicated it was shearing skin damage and also lacked measurements. The assessment indicated the wound was present on admission and was worsening and all the wound beds were pink with speckled red granulation tissue. The assessment continued to note that there was serosanguinous drainage without odor; however did not identify which wound was being described.

During interview via telephone on 2/2/17, at 12/9/07 hospice (RN)-C stated that the nursing home was responsible for monitoring R34's pressure ulcers and to updated her with any changes. RN-C stated that R34 had a lot of pain and refused repositioning frequently and only saw the wounds "maybe" once. RN-C stated that hospice provided R34 with a full air mattress. RN-C further stated that the goal was not to heal R34's pressure ulcers but to prevent infections and provide comfort. RN-C stated that she was updated weekly regarding the pressure ulcers and did not recommend any different treatment. RN-C could not recall how many pressure ulcers R34 had or the stages of the ulcers.

During interview on 2/2/17, at 12:43 p.m. RN-A stated that R34 had a really complex skin situation which changed frequently. RN-A stated that she used one wound sheet to record the multiple pressure ulcers as she was not taught

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any different and continued where the previous nurse left off in October. RN-A could not explain why the locations of the wounds were different from week to week, other than when she took over she just documented what she saw. RN-A stated that hospice was involved and was updated every week. RN-A stated that they had great difficulty keeping the dressings in place and the wounds were redressed multiple times a day and the R34 refused cares and repositioning. RN-A could not stated if the sacrum or gluteal fold were open and why they lacked measurements. RN-A further stated she had a lack of education on documentation and staging of pressure ulcers or how to differentiate between different types of skin ulcers. RN-A further stated that a comprehensive assessment was not completed following the worsening of the wounds, and that a note was not completed on the discrepancies in amount of wounds and the locations. RN-A could not recall how many pressure ulcers R34 had at the time of his death and if he acquired any in the facility as the documentation indicated he was admitted with them.

During interview on 2/2/16, at 1:32 p.m. the DON stated that R34 should have had a comprehensive care plan completed seven days after the care area assessment had been completed. The DON further stated that all wounds need to be identified and charted on a separate wound sheet weekly to accurately describe, categorize, treat and assess them for progress. The DON also stated that when a wound gets worse she would expect a comprehensive assessment be completed to implement new interventions. She also stated that she would expect the nurse to document any clarification to the location to the wound sites or if

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F 314	Continued From page 33 they had healed, as it was not clear how many pressure ulcers R34 had and where they were located. The facility policy Pressure Ulcer/ Skin Breakdown - Clinical Protocol dated 3/14, directed the nurse to complete a full assessment of a pressure sore including " location, stage, length, width, depth, presence of exudates or necrotic tissue." The policy did not address a nursing assessment when the ulcer worsened.	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and	F 315		3/21/17

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F 315	Continued From page 34 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement interventions and timely toileting to promote continence and prevent further skin breakdown for 1 of 3 residents (R6) reviewed for urinary incontinence. Findings include: R6's quarterly Minimum Data Set (MDS) dated 11/15/16, identified a severe cognitive impairment with a diagnosis of dementia, needed extensive assistance with toileting, was on a toileting program to manage continence, and was frequently incontinent of urine. R6's annual Urinary Incontinence Care Area Assessment dated 8/24/16, indicated needing extensive assist with toileting related to Dementia, impaired mobility, and history of a CVA (cerebral vascular accident). It further identified R6 was frequently incontinent of urine and wore incontinent products at all times. R6's current Bowel and Bladder Assessment dated 11/15/16, identified no change in her	F 315	. Corrective Action: b. Assessment, care plan and interventions for toileting for R6 were reviewed and revised to reflect appropriate intervention. 2. Corrective Action as it relates to other residents: a. Assessments and care plans for all residents will be reviewed for appropriate Toileting and Repositioning programs following comprehensive assessment. b. Policy and Procedure for comprehensive assessment and care planning and toileting/repositioning will be reviewed with all licensed nurses at mandatory meeting on 3/2/17. c. All NAR's will be re-educated on Toileting Programs for residents on 3/2/17. 3. Date of Completion: 3/21/2016 4. Reoccurrence will be prevented by: a. DON or designee will audit one record per week to assure that assessments and care plans are accurate and comprehensive. b. DON or designee will audit toileting	

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F 315	Continued From page 35 incontinence status and indicated a toileting program had been trialed with no improvement in continence. The assessment further identified R6 had mixed incontinence (a combination of stress and urgency incontinence) and function incontinence (creating an impairment due to cognition and mobility). The Assessment indicated R6 was never aware of her need to toilet and of the moisture associated skin damage (MASD), tissue damage that results from prolonged exposure to moisure to her buttocks related to incontinence. Lastly, R6's assessment identified that a scheduled voiding plan (fixed intervals) was implemented to assist with incontinence. R6's current care plan dated 7/28/15, directed staff to toilet R6 with a sit to stand lift and commode. The care plan further directed to toilet with the following schedule, "Check upon waking in the AM (morning), between meals and at HS (bedtime) and as required for incontinence." An untitled nursing assistant sheet dated 2/1/17, identified staff were to toilet R6 "upon waking, after all meals, at HS." During continuous observation, the follow was observed: On 2/1/17, at 7:10 a.m. R6 was dressed and sitting in her wheelchair by the medication cart. Trained medication aide (TMA)-A took her blood sugar and administered medications. At 7:18 a.m. TMA-A assisted R6 into the dining room for breakfast. R6 was observed to stay in the dining room. At 7:42 a.m. R6 was observed finishing her breakfast and began to self propel in her wheelchair out of the dining room. She was observed to self propel down the hallway and into	F 315	programs weekly for 12 weeks then monthly on-going. 5. The Correction will be monitored by: a. DON or Designee b. QAPI Committee will review the results at quarterly meetings and provide further guidance as needed.	

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her room. At 8:07 a.m. R6 continued to be in her room. Nursing assistant (NA)-C was observed walking by R6's room, no offer of toileting was made. At 8:31 a.m. R6 was observed to self propel out of her room and down the hallway toward the entrance way where she remained sitting. NA-C assisted R6 to move her wheelchair forward and out of the way for passerby's. Again, no offer of toileting was made. At 9:06 a.m. R6 continued to be in the same position. At 9:20 a.m. R6 was observed to self propel down the hallway back to her room. She was observed rummaging through her closet. NA-C walked by her room twice, however, no offers of toileting were made. At 9:30 a.m. activities assistant (A)-A asked R6 to play bingo. After being prompted, A-A asked R6 if she needed to go to the bathroom and R6 stated "no." A-A stated R6 had "a good bladder," and assisted her to bingo. From 9:40 a.m. to 10:27 a.m. R6 was observed in bingo. Afterwards, R6 was observed sitting in the entrance. At 10:45 a.m. R6 was observed to self propel from the entrance to her room. From 10:56 a.m. to 11:12 a.m. R6 was observed in her room. She then self propelled back down the hallway to the entrance. She had made it halfway down the hallway when licensed practical nurse (LPN)-A assisted her to the entrance. LPN-A asked R6 where she wanted to go, and took her into the dining room. No offer of toileting was made. From 11:25 a.m. to 11:56 a.m. R6 was observed eating lunch in the dining room. She then self propelled out of the dining room and back to her room. At 11:58 a.m. (4 hours and 50 minutes since the first observations) NA-C answered R6's call light and assisted her with the sit to stand lift to sit on the commode. R6's coccyx was observed to be covered by a Mepilex dressing. NA-C assisted R6 to removed her soiled brief, donned new clean

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gloves, and replaced the brief with a new one. NA-C stated the brief was soaked with a medium amount of urine and, while observing, R6 was noted to be continent of bowel. During observation, NA-C stated R6 varied with incontinence but was incontinent of urine at least daily, usually being wet in the mornings. NA-C didn't think R6 could feel the urge to urinate and thought R6 had put the call light on to have a bowel movement.

During interview on 2/1/17, at 12:10 p.m. NA-D stated R6 usually needed to be toileted once or twice during the day shift. NA-D stated R6 usually knew when she needed to use the toilet and would put the call light on. NA-D reported R6 as being mostly dry during her shifts and further stated she would offer to toilet R6 about every two hours. NA-D thought R6 was offered toileting after breakfast.

During interview on 2/1/17, at 12:25 p.m. NA-B stated R6 would call when she needed to use the toilet, but further stated they would check on R6 and offer every two to three hours if she hadn't called. NA-B thought R6's incontinence varied. NA-B reported R6 was toileted with morning cares and thought her partner (NA-D) had offered toileting before she went to the morning activity.

During interview on 2/2/17, at 9:23 a.m. registered nurse (RN)-B stated R6 improved in bowel continence, but remained frequently incontinent of urine. RN-B further stated R6 would sometimes put on her call light when she needed to go, but not always. RN-B thought R6 couldn't feel the urge to void because she didn't always use the call light appropriately, which was why she was on a toileting program and staff were

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F 315	Continued From page 38 encouraging her to void. During interview on 2/2/17, at 2:38 p.m. the director of nursing (DON) stated residents with incontinence should automatically be placed on individualized toileting plans to address the incontinence. The DON stated toileting plans needed to be followed and, specifically for R6, moisture had the potential to increase the risk of further skin breakdown and prevent healing. A policy on toileting was requested but not received.	F 315		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 323		3/21/17

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F 323	Continued From page 39 (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement interventions in response to physical aggression for 1 of 3 residents (R42) reviewed for accidents. Findings include: R42's admission Minimum Data Set (MDS) dated 12/29/16, identified a severe cognitive impairment and wandering behaviors. However, it did not indicated that R42 exhibited any physical behaviors during the assessment period. R42's admission Care Area Assessment (CAA) dated 1/4/17, indicated R42 wandered "aimlessly and without purpose at least a few days a week," and had a history of a traumatic brain injury (TBI). The CAA further indicated R42 was easily redirected sometimes but other times it could take "4+ staff members to keep him safe." R42's current care plan dated 12/23/16, identified that Haldol (an antipsychotic medication) was used related to target behaviors of "pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others." The care plan further identified R42 was on a behavior management program which directed to use "alternatives to prn (as needed) medication use." It did not specify what those alternative non-pharmacological interventions were. R42's progress notes were reviewed from	F 323	Corrective Action: a. Care plan for R42 was reviewed with DON, Nurse Manager and MDS Coordinator. Revisions were made to care plan including appropriate interventions. Education provided by Corporate Quality Nurse on appropriate incident report, VA Report and Care Planning policies 2/27/2017 c. Education provided by Corporate Quality Nurse to DON, MDS Coordinator and Nurse Manager on behavioral interventions on 2/27/2017 d. All staff will receive education on behavioral interventions and VA Reporting on 3/2/17. 6. Corrective Action as it relates to other residents: a. All residents with behaviors and vulnerabilities have assessment and care plan interventions reviewed for appropriateness. b. Policy and Procedure for vulnerability assessment and behavioral care planning will be reviewed with all licensed nurses at mandatory meeting on 3/2/17. c. Education on Incident Reporting, VA Reporting and Behavioral Interventions will be given to all nursing staff on 3/2/17. 7. Date of Completion: 3/21/2017 8. Reoccurrence will be prevented by: a. DON or designee will audit one record	

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F 323	Continued From page 40 12/22/16 to 2/2/17. A behavior note dated 1/28/17, indicated R42 had been wandering the halls when he became "agitated and started talking about the war," but was redirected back into his room. Later, R42 "got aggressive with staff and tried to keep 2 CNA (nursing assistants) in his room by holding the door shut" as they were attempting to assist him to toilet. The behavior note further identified R42 was "back out wandering the halls hiding in bathroom and in time clock room. Some how he got a hold of a pen, threatening to stab someone, later he got a hold of a pair of scissors and was hiding in the time clock room and stated he was waiting on the sheriff." R42 was able to be redirected back to his room, however "would not let writer take the scissors away." R42's medical record lacked any further documentation indicating what happened to the scissors nor did it address any follow up after the incident. During interview on 2/1/17, at 9:05 a.m. nursing assistant (NA)-B stated R42 thought he was still in a war and staff would find him finding behind a wall and liked to sit in the dining room with his back against the wall so he could see everything. NA-B stated staff would try to re-direct him with activities or food. However, when interviewed on 2/2/17, at 12:41 p.m. NA-B reported being aware of the incident but was not aware of any new interventions since then incident. NA-B further reported still going into R42's room alone to provide care and stated staff scanned the room for sharp objects periodically with cares, but had no education since the incident to do so. During interview on 2/1/17, at 10:46 a.m. NA-A	F 323	per week to assure that vulnerability assessments and behavioral care plans are accurate and comprehensive. b. All incidents, significant events and clinical changes will be reviewed at daily stand-up meeting by the Interdisciplinary Team. 9. The Correction will be monitored by: e. DON or Designee f. QAPI Committee will review the results at quarterly meetings and provide further guidance as needed.	

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stated R42 was stuck in the war time mentally, could be a little combative with redirection, but further stated they tried to intervene in "his time frame" telling him he needed to go the "mess hall."

During interview on 2/2/17, at 12:46 p.m. trained medication aide (TMA)-A stated she was aware of the incident and thought R42's antipsychotic medication had been re-started and had "settled him down a bit." However, TMA-A also stated she was not aware of any new interventions and hadn't received any new education since the incident.

During interview on 2/2/17, at 1:12 pm. licensed practical nurse (LPN)-B stated she was aware of the incident and she knew R42 would hide in the conference room. However, LPN-B stated there hadn't been any new education since the incident. LPN-B stated she would hold out her name badge to R42 when working with him because it seemed to bring R42 back to the present. Although it worked for her, LPN-B didn't think there were any specific behavior related interventions on R42's care plan.

During interview on 2/2/17, at 2:14 p.m. the director of nursing (DON) stated she was aware of the incident and, at the time, had directed nursing staff to call the physician and/or police. The DON stated she would have expected an incident report to filled out, further stating, without the report, the follow up had been missed. The incident had not been reviewed by the interdisciplinary team nor had any new interventions been put into place. The DON reported staff needed training after the incident, which hadn't been implemented. The DON

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F 323	Continued From page 42 reported there was no documentation to show what had happened to the scissors; however, she had personally checked R42's room for sharp objects and found none. The DON acknowledged R42's behavior had not been assessed after the incident for potential safety concerns for staff and other residents. A facility policy dated Resident Incidents/Accident Reports, dated 12/31/16, directed "A report must be completed any time that an event occurs which is potentially harmful to the safety and welfare of residents, visitors, or staff." It further directed that follow up assessments and documentation were to completed within 24 hours.	F 323		
F 373 SS=D	483.60(h)(1)-(3), 483.95(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT 483.60 (h) Paid feeding assistants- (h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if- (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law. (h)(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed	F 373		3/2/17

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F 373	Continued From page 43 practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help. (h)(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan. 483.95 (h) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.60 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the safety of a resident to be fed by an non-nursing staff for 1 of 2 residents, (R10) reviewed for assistance non-nursing staff. Findings include:	F 373	1. Corrective Action: a. Only certified nursing assistants and licensed nurses will be allowed to assist residents with feeding. A memo to all staff has been posted to inform them of this as of 2/2/17. b. In Addition, this information will be discussed and re-iterated at the ALL staff	

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F 373	Continued From page 44 R10's quarterly Minimum Data Set (MDS) dated 10/17/16, identified R10 was cognitively intact, received assistance with set up for meals, and was able to feed self with supervision and encouragement. R10's care conference summary dated 1/31/17, identified that R10 has increased in her dependence in eating, and required extensive to total assistance in the dining room. The summary identified that resident was on a regular consistency diet with thin liquids. A Nutritional Summary dated 1/12/17, identified that R10's current problems included; "weight loss, skin breakdown, and comfort cares." A review of R10's record lacked documentation that she was assessed for safety in receiving assistance with feeding from a non-licensed staff. During observation on 2/1/17, at 8:12 a.m. residents R10 was joined by dietary manager (DM) and assistance was offered to resident. DM offered choice of food items to R10, who requested coffee. DM went on to provide coffee as requested. DM provided R10 assistance to eat bites of cereal. DM stated that R10's intake was limited. During interview on 2/1/17, at 8:50 a.m. DM stated that she has been trained to assist residents in eating. DM stated that she only feeds certain residents and does not feed residents who are at risk for choking. During interview on 2/1/17, at 8:50 a.m. director of nursing (DON) stated that there were no staff assisting residents that were not licensed or certified. DON stated that she was unaware of additional staff having been provided training to	F 373	meeting scheduled for 3/2/17, and staff will sign off on that the information was received. 2. Corrective Action as it applies to other residents: a. All staff will be notified that only certified nursing assistants and licensed nurses will be allowed to assist residents with feeding at a mandatory all staff meeting on 3/2/17. 3. Date of Completion: 3/2/2017 4. Reoccurrence will be prevented by: a. DON or designee will monitor the Dining Room daily for 2 weeks, weekly for one month and on a monthly basis ongoing to ensure all residents are fed by qualified personnel only. 5. Correction will be monitored by a. DON or designee b. QAPI Committee will review the audit results at quarterly meetings and provide further guidance as needed.	

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F 373	Continued From page 45 assist with eating. On 2/1/17, at 9:13 a.m. DON stated that DM had completed a training program in 2004, with a passing score of 100%. A policy was requested for the use of trained feeding assistance. On 2/1/17, at 12:57 p.m. the DON stated that there was no policy for use of trained feeding assistants. The DON stated that DM was trained and would know who she was allowed to assist. A policy was requested for the assessment of individuals who could potentially receive assist safely from trained feeding assistance was requested. The DON stated that they do not have a process for this.	F 373		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that medications were given by the correct route for 1 of 1 residents (R44) observed during provision of cares.	F 425	1. Corrective action: a. Order was obtained from R44's MD to administer the lorazepam rectally. b. MAR for R44 was revised to reflect the correct route of administration.	3/5/17

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F 425	Continued From page 46 Findings include: R44's admission Minimum Data Set (MDS) completed on 1/12/17, identified that resident had intact cognitive ability and exhibited mild depressive symptoms, periods of inattention, and episodes of verbal outbursts. R44 received assistance of 1 to 2 staff members to complete activities of daily living, including dressing, grooming, and bathing. R44's note from clinic visit date of 1/13/17, identified that resident's had multiple medical conditions, including cancer, acute renal failure (kidney failure), and lower leg pain. The progress note identified that resident appeared chronically ill. During observation on 2/1/17, at 8:30 a.m. trained medical assistant (TMA)-A entered room with medication. TMA-A stated that resident had received lorazepam rectally with good effect on 1/31/17. R44 was given Ativan rectally during this observation, with application of surgical lubricant and use of gloves while providing cares. Resident was then assisted with completion of personal cares and was repositioned at this time onto his left side with pillows behind his back, and under his legs to promote good alignment and alleviate pressure. Upon review of electronic documentation of 2/1/17, LPN-A identified that R44 had been in bed all morning. The noted indicated that R44 was restless and moving around and had been repositioned several times. The documentation identified Ativan (lorazepam) was given rectally, LPN-A documented that she had been in contact	F 425	2. Correction as it applies to other residents: a. All resident orders, MAR's and TAR's will be reviewed for accuracy. b. Nursing staff will be informed moving forward all orders will be double checked by 2 nurses for accuracy upon transcription and entering in to the resident record. c. In-service for licensed nursing staff has been scheduled for 3/2/17 to review/educate medication administration and 5 rights, and then applying to the MAR. d. In addition to education, policy and procedure of medication administration will also be reviewed on 3/2/17. 3. Date of Completion: 3/5/2017 4. Reoccurrence will be prevented by: a. DON or designee will audit for accuracy for all residents by 3/5/2017. b. DON or designee will audit one record and MAR/TAR for accuracy monthly. 5. Corrections will be monitored by: a. DON or designee b. QAPI Committee will review the audit results at quarterly meetings and provide further guidance as needed.	

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with family, who wished to only use Ativan as needed.

During interview on 2/2/17, at 12:08 p.m. TMA-A stated that the route of administration of lorazepam on the medication record indicated it was to be given orally. TMA-A stated that there should have been the two separate entries on the medication record to differentiate whether medication was given orally or rectally. TMA-A stated that she had not administered any medications today as R44 was comfortable. TMA-A stated that lorazepam had been reported as being given rectally on 1/31/17. TMA-A stated authorization for rectal administration was addressed under standing orders.

A copy of facility standing orders, signed by the facility's medical director effective 4/11/16, identified under 17 a. directed staff "May change oral medications from pill form to liquid or liquid to pill form prn." however, the orders did not identify that medications can be given rectally if unable to manage orally.

During interview on 2/2/17, at 2:12 p.m. registered nurse (RN)-B stated that R44 had been noted to have an increased level of pain and discomfort as noted by calling out and restlessness. RN-B stated that R44's overall status had declined. RN-B stated that if meds were unable to be administered orally, staff should then follow up with the physician as to how to proceed. RN-B stated medication was not given rectally without a physician's order. RN-B stated that there had been no further administration of medication rectally. RN-B stated that R44 was on comfort cares, with the goal to maintain resident comfort level. RN-B stated that

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F 425	Continued From page 48 the physician has been consulted and new orders had been received. The new physician orders were dated 2/2/17, for Roanoke (a controlled pain medication) 5 mg by mouth or SL (sublingual, under the tongue) every 2 hour as needed. Additionally, the order indicated that the lorazepam my given sublingual or in the cheek, or dissolved in water and given sublingual. The order did not indicate to adminsiter rectally. During interview on 2/2/2017, at 3:16 p.m. the director of nursing (DON) stated standing orders are authorized by the primary doctor upon admission to the facility. The DON further stated that the orders are entered in to the medical record as they are initiated by staff. The DON stated that if there were problems with medication administration, the nurse should contact the physician in follow up. The facility policy, titled Administering Meds, revised December 2012, identified under bullet 7.: "The individula adminstering the mediction must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration beofre giving the medication.	F 425		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 431		2/20/17

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F 431	Continued From page 49 (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431		

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F 431	Continued From page 50 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin pens were properly labeled with open dates for 1 of 5 residents (R9) who received insulin. Findings include: R9's quarterly Minimum Data Set (MDS) dated 11/3/16, indicated no cognitive impairment and an active diagnosis of diabetes mellitus. R9's Medication Review Report dated 1/1/17, directed staff to administer Lantus (a long acting insulin) 24 unit subcutaneously (SQ) one time a day for diabetes. The orders indicated R9 had been receiving the same dose of Lantus since 11/30/16. During observation on 1/30/17, at 5:39 p.m. of the East medication cart, R9's Lantus insulin pen was opened, but was not dated with the open date. The label indicated the pens had been originally dispensed by the pharmacy on 12/2/16, more that 30 days prior to use. During interview on 1/30/17, at 5:39 p.m. licensed practical nurse (LPN)-C stated the pen should be labeled with the open date the first time the pen is used. LPN-C stated sometimes staff used an orange "date opened" sticker and some used a sharpie to write the date. LPN-C reported the insulin pens were only good for 30 days.	F 431	1. Corrective Action: a. All insulin pens were observed for dating. Those not dated were thrown out and replaced. 2. Corrective Action as it applies to other residents: a. Nursing staff were reminded of the policy for dating medications when opening. Both the box and the actual medication need to be dated. 3. Date of Completion: 2/20/2017 4. Reoccurrence will be prevented by: a. DON or designee will audit med carts weekly ongoing. 5. Correction will be monitored by: a. DON or designee b. QAPI Committee will review the audit results at quarterly meetings and provide further guidance as needed.	

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F 431	Continued From page 51 During interview on 2/1/17, at 9:01 p.m. LPN-A stated there were five residents on insulin and when an insulin pen is opened it was suppose to be labeled with the open date. LPN-A further stated the orange sticker didn't always stick well so she used a piece of paper tape and a sharpie to write the date. During interview on 2/1/17, at 1:11 p.m. the director of nursing (DON) stated insulin pens were stored in the refrigerator until opened. The DON further stated the pens were good for about 28 days and should be labeled with the date opened. The DON reported pharmacy provided orange "date opened" stickers which she thought would be better to use so "you don't mark off any of the label." The DON further reported the nurses should be checking the date opened as part of the administration process. A facility policy entitled Administering Medications, revised 12/12, directed that the expiration date be checked prior to administering. It further instructed "When opening a multi-dose container, the date opened shall be recorded on the container." Review of the manufacturer's instuctions from SoloStar (insulin manufacturer) instucted Lantus insulin pens expired 28 days after they were opened and directed to discard them thereafter.	F 431		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 441		3/21/17

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F 441	Continued From page 52 a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 441		

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F 441	Continued From page 53 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop an infection control program which included trending and analysis of resident infection data to reduce the risk of spread of infections to other residents in the facility. This had the potential to affect all 26 residents who resided in the facility. Findings include: The facility's infection control logs were reviewed from August, 2016 to January, 2017. The facility documentation included two documents. The first document was titled "Monthly Infection Log including; room number, resident name, site with N (nosocomial), C (community-acquired), and Ch (chronic infection-same infection site for 3	F 441	1. Corrective Action: a. All infections will be logged completely and accurately moving forward. b. Systems for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases has been put into place as of 2/27/17. 2. Corrective action as it applies to all residents: a. Education on Infection Control Policies and Procedures will be provided by Corporate Quality Nurse to DON and Nurse Manager on 2/27/2017. b. All licensed nurses will be educated on Infection Control Policies and Procedures on 3/2/17. c. An infection control designee has	

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F 441	Continued From page 54 months or more) , criteria met?, age, date of admission, date onset of symptoms, signs/symptoms, risk factors, chest x-ray Results/Date, culture results (pathogen) and treatment/comment. The documents for August through October included a resolved date. The documents for November through January did not include the date of resolution. The second document provided for each month, titled Monthly Infection Control Report, included data from each month by site of infection, unit, and total percentage. A comment section is noted at the bottom of this document with space for information to be recorded including; general, nursing department, dietary department, housekeeping department/laundry department, maintenance department, and signature line for the person submitting the report. Review of these logs identified the following: NOVEMBER 2016: The Resident Infection Control Log for November 2016 indicated that nine residents had been treated with antibiotics for infections; seven incidents of urinary tract infections (UTI), one episode of tooth infection, and one incident of lower respiratory infection (LRI). The report included all data on log completed with the exception of culture reports documented on the log for only 4 of 7 residents with UTI, however, the culture reports were included in submission of documents. Resolution of infection was documented for 8 of 9 entries, with the final being noted as N/A (not applicable). A review of the identified UTI's identified all residents for having a chronic condition. One resident was noted as	F 441	been assigned and education on data analysis and specific data collection for infection control is being completed and implemented by 3/3/17. d. A new tracking format has been obtained that requires the recommendations and regulations for infection control and has been implemented and included with education for the infection control designee that will be current as of 3/10/17. 3. Date of Completion: 3/21/2017 4. Reoccurrence will be prevented by: a. DON or designee will audit infections control logs for accuracy and completion on a weekly basis ongoing. b. All nursing staff will be responsible to ensure the all pertinent information is obtained and utilized to determine appropriate treatment. c. DON or designee will provide education and guidance to all licensed nurses on an as needed basis. 5. Correction will be monitored by: 6. DON or designee 7. QAPI Committee will review the audit results at quarterly meetings and provide further guidance as needed.	

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having two episodes of UTI in November. This document did not have a date of resolution column, the document identified only the length of antibiotic treatment ordered.

The Monthly Infection Control Report for November 2016 identified that 3 of the 7 residents affected by a UTI resided on the "East" wing, and 3 of 7 residents resided on the "South" unit. The percentage of residents who experienced UTI's represented 22% per calculation listed on the report. It was noted on the comment section that there were 8 staff call-ins, ill with URI (upper respiratory illness), flu-like symptoms, and nausea.

No further information was provided to demonstrate any analysis of the collected data had been completed to determine if the identified infections were related and/or spreading; or if any action plans had been identified or implemented to address them

DECEMBER 2016:

The Resident Infection Control Log of December 2016 indicated that there were four individuals treated for infections; three residents were noted to have upper respiratory infections (URI's) and one resident was noted to have a UTI. The individual with a UTI was noted to have chronic infections. This document did not have a date of resolution column, the document identified only the length of antibiotic treatment ordered.

The December Monthly Infection Control Report identified that 2 of the 3 residents with URI's resided on the "East" hallway and one on the "West" hallway. The individual treated for UTI

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resided on the "South" hallway. A narrative note under "Comments" section indicated "Resp [respiratory] illness dates correlate w/staff [with staff] illness-URI +LRI/Investigated. No cross contamination suspected due to staff location on West Unit and chronic/smoking staff".
The Monthly Infection Log for January 2017 identified two residents with infections, both UTI's. The document included only signs and symptoms for 1 of the 2 residents identified. The date of onset of symptoms was noted for only 1 of 2 residents identified. This document did not have a date of resolution column, the document identified only the length of antibiotic treatment ordered.

No further information was provided to demonstrate any analysis of the collected data had been completed to determine if the identified infections were related and/or spreading; or if any action plans had been identified or implemented to address them

JANUARY 2016:

A log, lacking month or year, was provided with two entries, including one resident admitted in January. This log indicated that both residents had UTI's, but lacked documentation for "criteria met" for 1 of 2 residents, date of onset for 1 of 2 residents, signs/symptoms for 1 of 2 residents, and start date for antibiotic therapy for 2 of 2 residents.

The January Monthly Infection Control Report was not provided to surveyor.

During dining room observation on 1/30/17, at

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5:34 p.m. residents R1, R6, and R9 were interviewed about the food served in the dining room. The residents stated that the food was good, however, their appetites were decreased as they were just "Getting over the flu."

During interview on 2/1/17, at 9:13 a.m. the director of nursing (DON) stated that resident tracking is completed on a month to month basis. The DON stated that there is not a program or system where she compares month to month information or where the information is compared formally to the previous patterns of the past months or years. The DON stated that there is no formalized system for tracking and analyzing of the data on the logs. Upon review of the logs, the DON noted that no viral symptoms or infections were tracked. The DON stated that this information was not currently logged but was documented in the individual records upon occurrence. The DON stated there is no system to track illness/infection not treated with antibiotics.

In review of the patterns of infections presented it was noted that R39 had been identified as having chronic infections, with UTI's documented in October, November, and December. The DON stated that when residents had chronic infections it would be addressed in the plan of care. A review of the care plan at this time with DON identified that a care plan problem was initiated on 10/19/16 with the problem statement identified as "The resident had a Urinary Tract Infection." Interventions were identified as antibiotic therapy as ordered, monitor/document/report to MD [medical doctor] PRN [as needed] for signs and symptoms of UTI". Additional interventions included assistance with incontinence,

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F 441	Continued From page 58 teaching/assisting with handwashing, and use of clean undergarments. This care plan has not been updated since initial identification of UTI. The DON stated that they have used information to implement training. An example of this practice was identified when they had noted an increase occurrence of UTI's in November. The DON stated that they completed handwashing training, with return demonstrations. This was followed by handwashing audits. A review of the hand washing audit documents did not identify the staff members audited and listed only the date the audit was completed, and by whom. A request was made for an Infection Control Policy for monitoring, tracking, and analyzing infections or illness presented in facility but was not received.	F 441		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245551	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 2/2/2017

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F 156	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

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

The above isolated deficiencies pose no actual harm to the residents

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(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:

(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

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(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.

(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.

(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.

v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to provide the appropriate non-coverage notice for 2 of 3 residents (R11, R3) reviewed for liability notice, who remained in the facility after Medicare coverage had ended.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245551	A. BUILDING: _____ B. WING _____	2/2/2017

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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Findings include:

R11 was given the Notice of Medicare Non-Coverage (CMS 10123) dated 9/22/16, identifying Medicare coverage would end on 9/22/16. This was signed by R11's power of attorney (POA) on 9/22/16. R11's progress note dated 9/20/16, at 1:24 p.m. indicated verbal notice was provided over the phone to R11's POA. However, the facility did not give R11 a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), or any of the five denial letters from Medicare, that identified how R11 would be paying for services when discharged from Medicare on 9/22/16, while R11 remained in the facility.

R3 was given the CMS 10123 dated 12/30/16, identifying Medicare coverage would end on 12/30/16. This was signed by R3 on 12/28/16. However, the facility did not give R3 a SNFABN, or any of the five denial letters from Medicare, that identified how R3 would be paying for services when discharged from Medicare on 12/30/16, while R3 remained in the facility.

During interview on 2/1/17, at 11:00 a.m. the bookkeeper (B)-A stated that R11 and R3 had remained in the facility following the discontinuation of Medicare A services. B-A further stated that the SNABN or one of the five denial letters from Medicare was not provided to either R11 or R3. B-A stated that she had misinterpreted the flow sheet she used to provide notices to the residents.

The facility policy Medicare Non-Coverage Notification/Demand Bill/ Benefit Exhaust Claims dated 10/07, directed that "The facility has the responsibility of notifying Medicare beneficiaries whenever Medicare Part A will not be the source of payment for their nursing facility costs. The denial notice must be in writing, using specific CMS [Centers for Medicare and Medicaid Services] mandated language and must be issued in a timely manner."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245551	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/31/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Clarkfield Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/24/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245551	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/31/2017**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Clarkfield Care Center is a 1-story building with partial basement. The building was constructed at 4 different times. The original building was constructed in 1955 and was determined to be of Type II(111) construction. In 1958 an addition was constructed and was determined to be of Type II(111) construction. In 1970, an addition was constructed and determined to be of Type II(111) construction. The most recent addition was constructed in 2004 and determined to be of Type II(111) construction. These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The building is fully sprinklered. The facility has a	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245551	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/31/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is monitored for automatic fire department notification. The facility has a capacity of 42 beds and had a census of 28 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 300 SS=F	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to maintain complete documentation on the Annual Fire/Smoke Door Inspection per NFPA 80. The deficient practice could affect 28 out of 28 residents. Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. FINDINGS INCLUDE:	K 300	The fire/smoke doors are inspected for: 1. Open areas or breaks in the surfaces of the door or frame 2. Glazing, vision light frames, and glazing beads are intact and securely fastened if equipped with them 3. The door frame, hinges, hardware and non-combustible threshold are secured, aligned, and working with no visible damage 4. No parts missing or broken 5. Door clearance at the door edge to the frame on the pull side of the door do not exceed 1/8 inch or ¾ inch undercut 6. The self-closing device works 7. If a coordinator is in place, the inactive leaf closes before the active leaf	3/15/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245551	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/31/2017**

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K 300	Continued From page 3 On facility tour between 10:00 AM and 1:00 PM on 01/31/2017, documentation reviewed revealed that not all the required information is being documented during the Annual Fire and Smoke Door Inspection per the NFPA 80. This deficient practice was verified by the Facility Maintenance Director.	K 300	8. The door or frame has no auxiliary hardware items that interfere with operation 9. Latching hardware operates and secures the door when it is in the closed position 10. The door assembly has no field modifications that void the label 11. Inspections verify the integrity of gasketing and edge seals where required The Environmental Services Director is responsible to document these inspections, ensure this correction is complete and for on-going compliance. The Executive Director will bring the results of the inspection to the QAA meeting for review. Date of completion: 3/15/17	
K 918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete	K 918		2/28/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 4 simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide complete written records of Generator maintenance and testing are maintained and readily available. This deficient practice could affect 28 of 28 residents. Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test	K 918	The documentation on the monthly emergency generator load test was not complete at the time of the survey. The documentation now includes the transfer time of how long it takes the emergency generator to assume power and the cool down time after the 30 minute monthly load test is completed. A generator test was completed on 2-16-17 and the documentation reflects the required information. The Environmental Services Director is responsible to ensure this correction is complete. The Executive Director will audit monthly documentation for 3 months to ensure on-going compliance and bring results to the QAA meeting for review. Date of completion: 2-28-17	

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K 918	Continued From page 5 under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 01/31/2017, documentation reviewed revealed that not all the required information is being documented during the Month Emergency Generator Load Test.The transfer time of how long it takes the emergency generator to assume power and the cool down time after the 30 minute monthly load test is not being recorded. This deficient practice was verified by the Facility Maintenance Director.	K 918		
K 920 SS=F	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only	K 920		2/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 920	Continued From page 6 used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to comply with 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5.This deficient practice could affect 28 of the 28 residents. Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident	K 920	The power strip was removed from the west boiler room on 2-24-17. A walk through inspection revealed no further power strips being used inappropriately. Monthly inspections will take place to ensure compliance. The Environmental Services Director is responsible to ensure this correction is complete. The Executive Director will bring results of monthly inspections to the QAA meeting for review. Date of Completion: 2-24-17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 920	Continued From page 7 rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 01/31/2017, observation during the inspection revealed a power strip being used used as a source of fixed wiring in the West Boiler Room. This deficient practice was verified by the Facility Maintenance Director.	K 920		