DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL E SURVEY AGENCY	ID:	
1. MEDICARE/MEDICAID PROVIDER N (L1) 245573		3. NAME AND ADD (L3) CLARA CITY	DRESS OF FACILIT	ſΥ	E SURVET AGENCI	4. TYPE OF ACTION:	1111 11111 1111 <t< td=""></t<>
2.STATE VENDOR OR MEDICAID NO. (L2) 454040900		(L4) 1012 NORTH (L5) CLARA CITY		EET POI	BOX 797 (L6) 56222	 Termination Validation On-Site Visit 	 CHOW Complaint Other
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Compl	
6. DATE OF SURVEY 07/29 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 1 Other	0/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DA 09/30	TE: (L35)
 ITC PERIOD OF CERTIFICATION From (a): To (b): I2.Total Facility Beds I3.Total Certified Beds I4. LTC CERTIFIED BED BREAKDOWN 	63 (L18) 63 (L17)	B. Not in Comp	ce With quirements		And/Or Approved Waivers Of The2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF)5. Life Safety Code * Code: A* 15. FACILITY MEETS	Following Requirements: 6. Scope of Services 7. Medical Director 8. Patient Room Size 9. Beds/Room (L12)	– Limit
18 SNF 18/19 SNF 63	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):	1			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY APP	PROVAL	Date:
Brenda Fischer, U	*	01	07/29/2015	(L19)	<u>Kate JohnsTon, Pr</u>	0 1	08/10/2015 (L20)
 DETERMINATION OF ELIGIBILIT _X_ 1. Facility is Eligible to Pa 2. Facility is not Eligible 	Y	20. COM	PLIANCE WITH C		21. 1. Statement of Financia		:13)
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	4. LTC AGREEME	NT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 10/01/1991	BEGINNING	DATE	ENDING DATE	2	VOLUNTARY 00 01-Merger, Closure 0	<u>INVOLUNTAR</u> 05-Fail to Meet I	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursemer 03-Risk of Involuntary Termination	t 06-Fail to Meet A	Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of	of Admissions:	(L44)		04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Stat 00-Active	tus Change
	B. Rescind Sus	pension Date:	(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/C			30. REMARKS		
20. 12.4.0.1.1.1.1.0.1.2.1.2.	_/	03001					
	(L28)	0.5001		(L31)	_		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION C 07/20/2015	F APPROVAL DAT	ΤE	Posted 08/25/2015 C		
	(L32)	07/20/2013		(L33)	DETERMINATION APPRO	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered August 10, 2015

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

RE: Project Number S5573024

Dear Mr. Stordahl:

On June 25, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 11, 2015. This survey found the most serious deficiencies to bewidespread 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 July 29, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 10, 2015 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 June 11, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 21, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 11, 2015, effective July 21, 2015 and therefore remedies outlined in our letter to you dated June 25, 2015, 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 Licensing and Certification Program Health Regulation Division kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

Post-Certification Revisit Report

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

lde	rovider / Supplier / CLIA / entification Number I5573	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/29/2015
Name of F	Facility		Street Address, City, State, Zip Code	
CLAR	A CITY CARE CENTER		1012 NORTH DIVISION STREET F CLARA CITY, MN 56222	PO BOX 797

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

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	ltem		Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0226		07/21/2015		ID Prefix	F0248		07/21/2015		ID Prefix	F0282		07/21/2015
•	483.13(c)					483.15(f)(1)				0	483.20(k)(3)(ii)		_
LSC					LSC					LSC			_
			Comodion					Comodion					Correction
			Correction Completed					Correction Completed					Correction Completed
ID Prefix	F0314		07/21/2015		ID Prefix			Completed		ID Prefix			Completed
Rea.#	483.25(c)				Reg. #					Reg. #			
LSC					•					0			_
									1				
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed					Completed
Reg. # LSC					Reg. #					Reg. #			_
					230					100			
			Correction					Correction					Correction
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ID Prefix			e empleted		ID Prefix			completed		ID Prefix			_
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			_
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg. #								_
LSC										LSC			
									+-				
Reviewed By	Review	wed E	3y	Da	te:	Signature of	Surve	yor:				Date:	
State Agency	, BF/	KJ		08,	/10/201	.5		1056	2			07/29	9/2015
Reviewed By	Review	wed E	^S y	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed on	:				Check fe	or any	Uncorrected D	eficie	encies. Was	a Summary of		
	6/11/2015					Unco	rrecte	d Deficiencies	(CMS	-2567) Sent	to the Facility?	YES	NO

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number 245573	(Y2) Multiple Construction A. Building B. Wing 01 - MAI	N BUILDING 01	(Y3) Date of Revisit 7/10/2015
Name of Facility		Street Address, City, State, Zip Code	
CLARA CITY CARE CENTER		1012 NORTH DIVISION STREET F CLARA CITY, MN 56222	°O BOX 797

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed _06/12/2015	ID Prefix		Correction Completed	ID Prefix		Correction Completed
Reg. #	NFPA 101		Reg. #			Reg. #		
LSC	K0144	-	LSC		-	LSC		
ID Prefix Reg. # LSC		Correction Completed 	Reg. #		Correction Completed	Reg. #		
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed
Reg. #		Correction Completed			Correction Completed			
Reg. #			Reg. #					
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:		Date:	
State Agency	, PS/KJ		08/10/201	5	347	64	07,	/10/2015
Reviewed By CMS RO	Reviewed	Ву	Date:	Signature of Surve	eyor:		Date:	
Followup to	Survey Completed on: 6/9/2015					Deficiencies. Was a s (CMS-2567) Sent to	•	NO

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245573	(Y2) Multiple Constru A. Building B. Wing	KITCHEN ADDITION	(Y3) Date of Revisit 7/10/2015
Name	of Facility		Street Address, City, State, Zip Code	
CL	ARA CITY CARE CENTER		1012 NORTH DIVISION STREET F CLARA CITY, MN 56222	°O BOX 797

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Yt	5) [Date
		Correction			Correction				Correction
ID Drofiv		Completed 06/12/2015	ID Profix		Completed	ID Drofiv			Completed
		06/12/2015			-				
•	NFPA 101 K0144		Reg. #			Reg. #			_
									_
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix			ID Prefix		-	ID Prefix			_
Reg. #			Reg. #			Reg. #			_
LSC			LSC _			LSC			_
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix			ID Prefix		-	ID Prefix			_
Reg. #			Reg. #			Reg. #			_
LSC			LSC _			LSC			
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix			ID Prefix		-	ID Prefix			_
Reg. #			Reg. #			Reg. #			
LSC		_	LSC			LSC			-
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix			ID Prefix			ID Prefix			
Reg. #			Reg. #			Reg. #			
LSC			LSC			LSC			-
Reviewed By	Reviewe	ed By	Date:	Signature of Surve	yor:		D	ate:	
State Agency	v P:	S/KJ	08/10/201	5	34764			07/1	0/2015
Reviewed By	Reviewe	ed By	Date:	Signature of Surve	yor:		D	ate:	
CMS RO									
Followup to	Survey Completed on:			•		Deficiencies. Was a	-		
	6/9/2015			Uncorrecte	d Deficiencies	(CMS-2567) Sent to	o the Facility?	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL E SURVEY AGENCY		D: S5IN acility ID: 00061
1. MEDICARE/MEDICAID PROVIDER N (L1) 245573 2.STATE VENDOR OR MEDICAID NO. (L2) 454040900	40.	(L3) CLARA CIT	DRESS OF FACILIT Y CARE CENTEF I DIVISION STRF Y, MN	ł	OX 797 (L6) 56222	 TYPE OF ACTION: Initial Termination Validation 	<u>2</u> (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SUI 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 8. Full Survey After Con 	9. Other mplaint
6. DATE OF SURVEY 06/11 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	L/2015 (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING 09/30	DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF	63 (L18) 63 (L17) 19 SNF	X B. Not in Com	ce With equirements	aivers:	And/Or Approved Waivers Of Th2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF)5. Life Safety Code * Code: B* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Servic 7. Medical Direct	or
63 (L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMARI	KS (IF APPLICABLE S	SHOW LTC CANCELL	ATION DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AF	PPROVAL	Date:
Michelle Thompson	n, HFE NE II	[07/09/2015	(L19)	Kate JohnsTon, Enf	forcement Specia	<u>llis</u> t 07/16/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE OR SINGLE STAT	FE AGENCY	
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Par 2. Facility is not Eligible 			IPLIANCE WITH CI ITS ACT:	VIL	 Statement of Financ Ownership/Control Both of the Above : 	Interest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEMEN	νT	26. TERMINATION ACTION:	[]	_30)
OF PARTICIPATION 10/01/1991	BEGINNING	DATE	ENDING DATE			n.	
			ENDING DITE		VOLUNTARY 00 01-Merger, Closure 0		<u>ARY</u> eet Health/Safety
(L24)	(L41)		(L25)		01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	05-Fail to Me	
	(L41) 27. ALTERNATIV				01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	05-Fail to Me ent 06-Fail to Me <u>OTHER</u>	vet Health/Safety vet Agreement
(L24)	(L41)		(L25)		01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	05-Fail to Me ent 06-Fail to Me <u>OTHER</u>	eet Health/Safety
(L24)	(L41) 27. ALTERNATIV	of Admissions:			01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	05-Fail to Me ont 06-Fail to Me <u>OTHER</u> 07-Provider 5	vet Health/Safety vet Agreement
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATIVI A. Suspension (of Admissions:	(L25)		01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	05-Fail to Me ont 06-Fail to Me <u>OTHER</u> 07-Provider 5	vet Health/Safety vet Agreement
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATIVI A. Suspension o B. Rescind Sus	of Admissions:	(L25) (L44) (L45)		01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	05-Fail to Me ont 06-Fail to Me <u>OTHER</u> 07-Provider 5	vet Health/Safety vet Agreement
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension B. Rescind Sus 29	of Admissions: pension Date:	(L25) (L44) (L45)		01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	05-Fail to Me ont 06-Fail to Me <u>OTHER</u> 07-Provider 5	vet Health/Safety vet Agreement
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension o B. Rescind Sus	of Admissions: pension Date: . INTERMEDIARY/C	(L25) (L44) (L45)	(L31)	01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	05-Fail to Me ont 06-Fail to Me <u>OTHER</u> 07-Provider 5	vet Health/Safety vet Agreement
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension of B. Rescind Sus 29 (L28)	of Admissions: pension Date: . INTERMEDIARY/C	(L25) (L44) (L45) ARRIER NO.	(L31)	01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	05-Fail to Me ont 06-Fail to Me <u>OTHER</u> 07-Provider 5 00-Active	vet Health/Safety vet Agreement



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered June 25, 2015

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

RE: Project Number S5573024

Dear Mr. Stordahl:

On June 11, 2015, 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7338 Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 21, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

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;

Clara City Care Center June 25, 2015 Page 3

- 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.

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

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

- 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.

Clara City Care Center June 25, 2015 Page 4

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 September 11, 2015 (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 December 11, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Clara City Care Center June 25, 2015 Page 5

> 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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulations Division Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

		AND HUMAN SERVICES		FO	RM APPROVED
		& MEDICAID SERVICES			NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		245573	B. WING _		06/11/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CLARA C	CITY CARE CENTER			1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 COMMENT	ſS	F 00	00	
	as your allegation on Department's accept	of correction (POC) will serve f compliance upon the otance. Your signature at the age of the CMS-2567 form will ion of compliance.			
F 226 SS=D	revisit of your facilit validate that substa regulations has bee your verification.		F 22	26	7/21/15
	policies and proced mistreatment, negle	evelop and implement written lures that prohibit ect, and abuse of residents on of resident property.			
	by: Based on interview facility failed to impl policy to ensure bac completed and curr (DA)-A, employee r background studies Findings include: Review of the facilit Center Abuse Preve	NT is not met as evidenced y and document review, the lement the abuse prohibition ckground studies were ent for 1 of 5 new employees ecords reviewed for s. y policy titled Clara City Care ention Plan dated 9/08, to be taken to minimize the		It is the policy of the Clara City Care Center to minimize the risk for resident abuse. This policy includes Initial screening of employees including background checks, as well as initial ar on-going training with employees regarding risks of abuse and preventior The background study for the affected employee was called into the Minnesota Health Department immediately followin the discovery that it had not been	ı. a
	risk of abuse, inclue	initiated at hire, and directed,		completed. During the time that has passed since the survey it has been	
	L Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE
Electron	ically Signed				07/06/2015

Electronically Signed

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.

PRINTED: 07/09/2015

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	0938-039 E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	à	СОМ	PLETED
		245573	B. WING	·····	06/	11/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CLARA (CITY CARE CENTER			1012 NORTH DIVISION STREET PO BOX 7 CLARA CITY, MN 56222	'97	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 226	residents pending t check." Review of new emp 6/11/15, indicated I a background Stud however, the result were not received I orientation in the facili background study s During interview or Business office ass background check Department of Hun "Somehow this was	ot have direct contact with the outcome of the background bloyee background checks on Dietary aide (DA)-A completed y Acknowledgement on 4/3/15, is of the background study by the facility prior to (DA)-A's icility. (DA)-A had been ty without a completed	F 226	determined that the individual is q to provide direct care to vulnerabl by the Minnesota Department of H To ensure that all employees have background study initiated prior to start we will have the Payroll Man designee audit the background st ensure there completion on a more basis. (See attached audit sheet), this audit the Payroll Manager or of will review all new hires and check form related to initiating the background the follow-up form that the results. This form will be sign the person doing the audit and will monitored periodically by the Administrator to ensure the audits completed on an ongoing basis.	e adults lealth. e a their ager or udies to hthly During designee c for a yround displays ed by I be	
F 248 SS=E	the facility was curr a tracking system, in place. 483.15(f)(1) ACTIV INTERESTS/NEED The facility must pr of activities designed the comprehensive		F 248	3		7/21/15
	by: Based on observa review, the facility f	NT is not met as evidenced tion, interview and document ailed to provide consistent, engagement for 4 of 5		It is the policy of the Clara City Ca Center to provide individualized as based programming for residents	ctivity	

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		& MEDICAID SERVICES	()(0)		OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		245573	B. WING _		06 /1	1/2015
NAME OF I	PROVIDER OR SUPPLIER	• •		STREET ADDRESS, CITY, STATE	, ZIP CODE	
CLARA (CITY CARE CENTER			1012 NORTH DIVISION STREE CLARA CITY, MN 56222	ET PO BOX 797	
(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 C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE
F 248	Continued From pa	age 2	F 24	48		
		8, R62 and R31) reviewed for		cognitive impairments environment, on a cons		
	4/30/2015, indicate cognitive impairme assistance to comp The MDS staff asso indicated R34 prefe newspapers, or ma being around anima with groups of peop activities, and spen diagnoses, as idem Alzheimer's diseaso R34's Care Area As communication dat was rarely understo others. The CAA a was unclear and no distracted, was at r met, social isolation R34's activities qua 5/6/2015, indicated was, "Reviewed an also indicated R34 to music from the T	imum Data Set (MDS) dated d the resident had severe nt and required extensive olete activities of daily living. essment of activity preferences erred reading books, gazines, listening to music, als such as pets, doing things ole, participating in favorite ding time outdoors. R34's tified in the MDS, included e. seessment (CAA) for ed 2/2/22015, identified R34 bod and rarely understands lso indicated R34's speech on-sensical, she became easily isk for not having her needs h, and decreased activity. arterly assessment dated the plan of care for activities d remains." The assessment was read to by staff, listened V, and received music and on activity and hospice staff.		 R31, R34, R58, and R6 reassessed by the Active (ADC) or designee to a interests and needs. Recomplete assessments limited to interviews of nursing staff and activities plans will be individual is specific leisure interests present and specific, measurement and specific interests and care residents will be review to ascertain specific interests and specific active information Card; for a moderate to severe constant will be kept at the past interest interests and current initial Activities Assessions Comprehensive assessions specific activity interests and dislikes and activity interests activity inte	vities Director ascertain specific esources used to a include but are not resident, family, ties staff. Their care zed to include so both past and neasurable goals. a plans of all current ved and reassessed arests and needs. include specific pecific, measurable ignee will also t a ¿Resident all residents with gnitive impairments nurse¿s station on dent resides to vities staff in ities. This will nt interests (from ment and sments), food and s, special diet	
	language as we are verbal sounds." During observation	structed staff, "Watch for body e unable to understand [R34's] on 6/9/2015, at 3:11 p.m. R34 clined in a chair, facing the TV		when resident is agitate well as things that do n specific resident. Nursi staff will be encouraged interests as they are no things the resident no l	ot work for that ng and Activities d to add new oted and to remove	

Facility ID: 00061

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MELTI	PLE CONSTRUCTION	OMB NO.	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245573	B. WING		06/	11/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CLARA (CITY CARE CENTER			1012 NORTH DIVISION STREET PO BO> CLARA CITY, MN 56222	797	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 248	Continued From pa	age 3	F 248	8		
	attention to the TV and staff intermitte remained seated in During observation prior to the breakfar was reclined with h TV, which was tune Following breakfas ambulate out from R34 into the recline they exited the dini tuned to the news p 9:15 a.m. activities secured unit, and f the center of the live exercise activity. F recliner and was no activity. At 9:50 a.r concluded the ballo turned music on fo area. At 10:02 a.m and ambulated her	on 6/10/2015, at 7:05 a.m. Ist meal, until 8:01 a.m., R34 her feet up in a chair, facing the ed to a morning news program. t, NA-C assisted R34 to the dining room, positioning er chair directly to the left as ng area. The TV was still program during this time. At assistant (AA)-B entered the ormed a circle of residents in ring area, and led balloon R34 remained seated in the bt invited to participate in the m., activities assistant (AA)-B pon exercise activity, and r the residents in the living a., NA-C assisted R34 to stand to another recliner facing the ided no further engagement		admissions with moderate to see cognitive impairments. These wi initiated for residents with cognit decline per IDT consensus. The designee will be responsible for all resident care plans for 10% of residents weekly over the next 9 using the Activities Care Plan Au positive results, the frequency of will be changed to quarterly with assessments and randomly on a needed basis. Results of these a well as any concerns noted will b discussed at quarterly QA meeti It will be the responsibility of the designee to provide education to and activities staff regarding offer residents preferred activities and components of different activity how they are to be conducted (of example ¿ try pull residents in fr perimeter and if they choose not one on one time with them follow time) and charting of the activity	II also be ive ADC or audits of f 0 days dit tool. If audits audits, as be ngs. ADC or o nursing groups, ne om the to, spend ving group	
	During interview or AA-B stated R34 u activity's, and didn' could still observe A review of Caring 2015, indicated the music, physical gal reminisce, exercise care, devotions. Fo	n 6/10/2015, at 10:02 a.m., sually doesn't participate in t ask her to join because she the group doing the activity. Place Activity Calendar June e week day activities included: mes, cognitive stimulation, e, sensory stimulation, beauty or the majority of the activities did not identify specific times		The Caring Place (CP) activity c will now have set times for an ac (including off-unit activities) and activities held in the unit will be c AM and PM with corresponding Aide (AA) assigned to each. Th have a tracking /audit sheet in p full weeks of the times the activi in the CP, along with what activit offered and how many residents (See attached). This will include activities and number of residen attending. The ADC or designed	tivity the group lesignated Activity e AA will ace for 2 ty staff is ies were attended e off-unit ts	

Facility ID: 00061

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/09/2015 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245573	B. WING	i	06/-	11/2015		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CLARA C	CITY CARE CENTER			1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 248	exercise group calle unit. During the gro room getting her ha hair care, NA-A stor ambulate from her then assisted R34 i the activity ended a anyone wanted to w and tuned the TV to remained seated in During interview on NA-A stated when F ambulatory" she wo entertainment activ simply watch than p did not participate in group because she recliner watching T ¹ R34's activity attend identified a list of act for staff to write a c indicating the reside involvement in an a indicated the follow 1. independent par 2. limited participat 3. extensive assist 4. total dependenc 5. refused 6. not available 7. observed 8. present but not e	45 a.m. AA-A was leading an ed movercise on the secured oup activity, R34 was in her ir shampooed. After providing od next to R34, guided her to room to the living area, and nto a recliner. At 9:14 a.m., nd AA-A asked the residents if vatch a black and white movie, o some old time music. R34 the recliner. 6/11/2015, at 10:01 a.m. R34 was "cognizant and ould often attended numerous ities, but R34 would rather participate. NA-A stated R34 n this morning's exercise spends a lot of time in the V. dance sheet dated June 2015, ctivities, and provided space ode (the numbers 0-9) ent's response to or ctivity. The numbers ing: ticipation ion ance e	F	248	responsible for weekly audits of this tracking form, including resident responses for 90 days. The ADC of designee will review the results of a and if needed will re-educate the st audit results are positive, the audits then be changed to quarterly and randomly as needed. Audit results discussed at quarterly QA meetings The activity attendance sheet was changed to reflect the specific active resident initiated and `self directed, activity was removed. The corresp activity policies will be reviewed and updated to include current plan of correction. CNAs will now have a supplementa activity schedule that will include structured activities to offer resident times a day, after breakfast, after lu after dinner and before hour of sleet They will take attendance on the sa form by recording resident respons then initial the activity. The ADC or designee will monitor these forms of for 90 days weeks and reeducate so needed. Then the ADC will monito records quarterly with resident assessments and include the inform in the assessments. Activities and Nursing staff will be using the Term for Resident Engagement (TRE) lis consistent description of the reside response to the activity between departments (See attached). A sun of staff compliance and resident re	r audits taff. If s will will be s. vity the ż oonding d al ats 4 unch, ep. ame se and veekly staff as r these mation ation st for a nt mary sponse		
	 present but not e resident choice; done twice 	and			to these additional structured activi be brought to the next facility QA m	ties will leeting.	Page 5 of 29	

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245573	B. WING			06/ [.]	11/2015
NAME OF F	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CLARA C	CITY CARE CENTER				012 NORTH DIVISION STREET PO BOX 79 CLARA CITY, MN 56222	7	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	Continued From pa	ge 5	F 2	248			
	3/10/2015, to 5/10/2	ctivity attendance sheets from 2015, indicated R34 had a ed interactions, and her activity s follows:					
	"provided music by 23 times "tape/CD/radio and "outdoors/swing, ga "small group social, "therapy/rehab/phys "self-directed act" [a "TV/movie" 29 tim "massage therapy, times "sensory stimulant, "lobby" 90 times "Church service/con "pastoral, animal or "One - one program "pop visit" 68 times "hospice visits" 18	es beauty shop, manicure" 8 b' day,coffee" 22 times mmunion" 10 times baby visit" 13 times h & family visits" 13 times times					
	the majority of R34 "lobby," (90 times o	r 18%) ties (78 times or 16%)					
	activities director (A need due to her dia to provide for her.	6/11/2015, at 1:31 p.m., the AD) stated R34 had an activity ignosis, and it was challenging The AD stated R34 was g, and not as engaged as she					

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PRINTED: 07/09/2015

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	07/09/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245573	B. WING	ì		06/11/2015	
NAME OF	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CLARA	CITY CARE CENTER				1012 NORTH DIVISION STREET PO BOX 79 CLARA CITY, MN 56222	17	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	was upon admissio enjoyed music, goir small groups, and to the "pop visits" were residents, which inde eye, and telling there interactions lasting directed activity was his or her own, with "A resident going up waving their arms. The AD stated there documentation of F and stated R34 spec lobby time, because the stimulation in the activity staff spend Caring Place (secu- calendar is only sug staff may go on the if it doesn't work, the residents want to do chose not to partici- activity staff should some kind of individe over. The AD state one visits and R34 always be invited to activities During interview on activities assistant of usually two or three each staff member one hour on the Ca- which meant the set three hours of direct staff typically worked	on. The AD stated R34 always ng outside, engaging her in patting the balloon. AD stated re simple "greetings" to cluded "looking them in the m 'hello, which were brief a minute or two. The self s anything a resident did on nout staff involvement such as, p and down the hall, and They're getting exercise."		248			

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		AND HUMAN SERVICES				FORM	07/09/2015 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION		E SURVEY PLETED
		245573	B. WING	i		06/11/2015	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CLARA (CITY CARE CENTER				012 NORTH DIVISION STREET PO BOX 79 CLARA CITY, MN 56222	7	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	3:30 to about 5 p.m unit's activity calend staff, and before ea secure unit, activity each other as what whatever was left. pretty good idea wh the past, and each goals." During an interview nursing assistant (N shift, activities in the suggested by the re- have anything plane activities' staff work Thursdays for BING place outside the se about 3 residents fr play. NA-B stated fi play BINGO, and as and toileting, "There activity on the secu Although R34's acti averaged nearly 16 nearly half (48%) of interactionspop via lobby timerequired with the resident. F consistent, organize activity engagement as no evidence of c engagement followi secured unit, as affi in the facility. A facility policy, "Ca	age 7 h. AA-A stated the secured dar was just a guideline for ach staff member went into the r staff would communicate with t had been done, and then do AA-A stated staff, "Had a hat they [the residents] liked in resident had care planned r on 6/11/2015 at 2:52 p.m., NA)-B stated during the p.m. e secured unit were what was esidents, and the NA's don't ned. NA-B also stated the ked later on Mondays and GO, however, the BINGO took ecured unit, and usually only rom the secured unit went to R34 did not go off the unit to side from usual cares, eating, e really are no organized irred unit after supper." ivity record indicated she GO contact interactions monthly, f the documented activity isits, self-directed activities and d little or no staff engagement Further, there was a lack of a ed resident invitation and at on the secured unit, as well opportunity of a structured ing the evening meal on the forded to residents elsewhere	F2	248			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/09/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245573	B. WING		06/	11/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CLARA	CITY CARE CENTER			012 NORTH DIVISION STREET PO BOX 7 CLARA CITY, MN 56222	97	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 248	"to provide individ programming for re impairments in a sti constant basis." R31's quarterly MD severe cognitive im dependent on staff locomotion on and and personal hygiel R31's cognitive skil were severely impa made decisions. R in the MDS, include Disease (a disorder that affects movem R31's annual MDS, activity preferences preferred reading b magazines, listenin groups of people, p activities, spending participating in relig R31's care plan dat for R31 was, "Will b (Life Enrichment for visits, massage and weekly and other or up for small groups R31's Activities Qua 6/10/15, identified " remained the same	S dated 5/25/15, indicated pairment, and R31 was for for transfers, bed mobility, off the unit, eating, toileting, ne. The MDS also indicated ls for daily decision making ired and R31 never/rarely 31's diagnoses, as identified ed dementia and Parkinson's of the central nervous system ent, often including tremors). staff assessment of daily and d, dated 8/26/14, indicated R31 ooks, newspapers, or g to music, doing things with articipating in favorite time outdoors, and ious activities or practices.	F 248			

Facility ID: 00061

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	07/09/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245573	B. WING			06/11/2015	
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CLARA (CITY CARE CENTER				012 NORTH DIVISION STREET PO BOX 79 CLARA CITY, MN 56222	17	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	continues to movel contact at times, a deeper breath as he takes in the fresh a During observation 3:20 p.m., R31 was open continuously s down and from side against one anothe During observation was in bed lying on was in constant mo down and back and hitting the other. At lying on his right a forth, often hitting h R31 was observed were feeding him lu During observation was sitting in his wh During interview on stated the staff do r NA-D stated she be in bed because, "W do?" NA-D stated t for residents who h but R31 had severe isn't a lot of activity R31 does not have the nurses try to ke doesn't attend man During interview on	his arms about, will make eye rare smile or a word, and a e is taken outdoors as he ir." on 6/9/15, from 3:02 p.m. to s lying in bed with his eyes swinging his arms up and e to side, bumping his arms er and against his abdomen. on 6/10/15, at 6:59 a.m. R31 his left side. His right arm ovement, swinging up and d forth and often one arm was t 9:26 a.m. R31 was in his bed de with his eyes closed arm up and down and back and his other arm. At 12:25 p.m. in the dining room and staff unch. on 6/11/15, at 1:14 p.m. R31 heelchair outside of his room. n 6/10/15, at 12:57 p.m. NA-D not do much activity with R31. elieved R31 spent a lot of time /hat else is there for him to the facility had a lot of activities have no cognitive impairment, e cognitive impairment so there for him to do. NA-D stated a TV (television), and stated eep him off his bottom, so he		248	DEFICIENCY)		

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		AND HUMAN SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILE		LE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		245573	B. WING	i		06/	/11/2015
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				1	1012 NORTH DIVISION STREET PO BOX 7	797	
CLARA	CITY CARE CENTER			0	CLARA CITY, MN 56222		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 248	his arms, and has r activities. R31's Activity Attent from March 2015, t identified a list of ac staff to document "of the resident's involve follows: 1. Independent Pa 2. Limited Participa 3. Extensive Assist 4. Total Dependent 5. Refused, 6. Not Available, 7. Observed, 8. Present But Not 9. Resident Choice 0=Done Twice The record identifie following activities f 2015: "Read to" attended "Reminisce" attend "Cognitive Stimulati "Taped Stories" one engaged; "Crafts/Art" attende "Dining Music" attent "Special Music" attent "Staff/Peer Music" at "Music Therapy" at "Outdoors/Swing" a	d R31 cannot do anything with no cognitive ability to go to any dance Sheet were reviewed hrough May 2015, which civities and provided space for codes" for each one to identify vement in the activity as rticipation, ation, tance, ce, Engaged, e, d R31 had attended the from March 2015, through May twelve times; ed one time; ion" attended one time; e time, present but not ed one time; nded 19 times; ended two times; attended four times; tended one time; tended 13 times;	F	248			

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PRINTED: 07/09/2015

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMEN	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE	E SURVEY PLETED
		245573	B. WING			06/ [.]	11/2015
NAME OF	PROVIDER OR SUPPLIER						
CLARA	CITY CARE CENTER				1012 NORTH DIVISION STREET PO BOX 79 CLARA CITY, MN 56222	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	"Small Group Socia "Intergenerational" "Intervention" attent "Self-Directed Act" "TV/Movie" attende engaged; "Bird Watching" atte "Massage Therapy! "Sensory Stimulatio "Special Snack" att assistance; "B/day/Coffee Party "Lobby" attended 74 "Special/Holiday Pa" "Bible Study" attende "Church Service" at "LEEP" attended 16 "One-One Program "One-One Social" a "Pop Visits" attende "Med Visit In or Out The March 2015, th sheets indicated the at activities was "Se involved R31 movin "Lobby," or "Pop Vis During interview on stated R31 had mo R31's arm moveme exercise and docur activity on R31's ac are unsure if R31's because R 31 does R58's annual MDS	 attended one time; attended one time; ded five times; attended 76 times; d five times, present but not ended one time; d attended 13 times; on" attended 11 times; ended two times, extensive attended one time; d times; unty" attended one time; ded three times; ded three times; d tim	F2	248			

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PRINTED: 07/09/2015

		AND HUMAN SERVICES				FORM	07/09/2015 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		245573	B. WING	i		06/ ⁻	11/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLARA	CITY CARE CENTER				012 NORTH DIVISION STREET PO BOX 79 CLARA CITY, MN 56222	7	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	was understood and others, had difficulty was legally blind wif frequently incontine required assistance R58 had behaviors disorganized thinkin others, rejection of R58's Clara City Ca Assessment dated interests included c knitting, quilting and variety of music, trip church, concerts, vi movies, news, and listed as highly impo- see objects. R58's care plan dat behavioral symptom paranoid statement aggression, wanden planned goals for R agitation, physical a paranoid statement transfers through th Avoid over-stimulat Divert behavior by: activities." R58's ca 9/30/14, identified s preferences as Mad resident goes back confused. The resid cards, dominoes, b dancing, baseball, r and socials. The ca R58 will participate	age 12 Id usually able to understand y putting sentences together, ith a visual field deficit, ent of bowel and bladder, and e for all activities of daily living. including inattention, ng, physical behavior toward care, and wandering. are Center Activity Interest 5/18/13, indicated R58's cards and games, baking, d sewing, dancing, baseball, a ps to the casino, parades, isiting family and peers, comedies. R58's vision was aired indicating she could only ted 10/10/2013, indicated ms exhibited by delusions, ts, physical and verbal ring, and rummaging. Care 858 was to, "Exhibit decreased and verbal aggression, ts, exit seeking, and self ne following approaches: tion (e.g., noise, crowding), providing meaningful are plan for activities dated strengths, needs and cular degeneration, and and forth in time, and is dent enjoyed in the past bingo, waking, knitting, sewing, music, reading, church, TV, are planned goals included in activities to the best of her ion, cognitive, and mobility	F	248			

Facility ID: 00061

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	07/09/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		(X3) DAT	E SURVEY IPLETED
		245573	B. WING	i			06/	11/2015
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIF	CODE		
CLARA (CITY CARE CENTER				1012 NORTH DIVISION STREET	PO BOX 79	17	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD	BE	(X5) COMPLETION DATE
F 248	attends each day. S the resident assista destinations, provid vision and cognitive the resident goes b from young child he children. Staff was Minnesota Twin gar R58's Clara City Ca Sheets reviewed fro indicated R58 regul following activities: Being read to 41 da Staff/peer music or days. Sitting in the lobby days. Self directed activity While R58's assess listening to the Minn evidence this activity During observation residents on the un unit, and no activitie time. During observation activities staff was p	e and small groups that she Staff was directed to provide ince to and from her le prompts and cues for both impairments, and be aware ack and forth in time of her life erself to having her own to read to her and turn on mes for her to listen to. The Center Activity Attendance om March 2015, to June 2015, larly participated in the hys. listening to a compact disc 36 (common area on unit) 75 y 77 days. Sement indicated she enjoyed hesota Twins, there was no	F	248				
		on 06/10/15, at 2:32 p.m., no ogress on the unit. All the						

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	07/09/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245573	B. WING	i		06 / [.]	11/2015
NAME OF I	PROVIDER OR SUPPLIER	·		5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CLARA (CITY CARE CENTER				1012 NORTH DIVISION STREET PO BOX 79 CLARA CITY, MN 56222)7	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	Continued From pa	age 14	F	248	3		
	wandering around t	it were sitting in chairs or the unit with no direction or taff. R58 was pacing on the					
	was sitting in a cha window. There was	on 6/10/15, at 2:33 p.m. R58 ir in the day room, facing the a cooking show on the TV, looking straight ahead and not roundings.					
	was pacing around wiping the window Staff gave her a cu immediately walked	on 06/10/15, at 2:38 p.m. R58 the common area of unit, sill and table with her hands. p of coffee, and R58 d over to the piano, placed the op of the piano, and continued					
	entered the secure room where the res morning meal, and residents in the din	on 6/11/15, at 8:41 a.m. AA-C d unit, went in to the dining sidents were eating their read devotions to the ing room. This activity was ninutes at which time (AA)-C					
	(AA)-Č entered the exercise group. R activity. At 9:18 a.m after completing ac	on 6/11/15, at 8:54 a.m., unit and led a video taped 58 did not participate in the n., activity aide left the unit stivity. R58 was sitting in a chair a, not engaged in the activity.					
	stated Activity staff hour every morning about three hours of	n 6/10/15, at 2:22 p.m. (AA)-B go to the secured unit for an g, and are usually in the unit daily. AA-B stated on Monday they do activities including					

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		AND HUMAN SERVICES				FORM	07/09/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245573	B. WING			06/ [.]	11/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLARA	CITY CARE CENTER				012 NORTH DIVISION STREET PO BOX 79 CLARA CITY, MN 56222	17	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	hitting the balloon, pand going outside. AA-B stated anythir is considered a self wandering on the u During interview on stated R58 did not p unit. She stated on cognitive stimulatio residents try to finis department comes the residents, and c staff will put a video and nursing staff pu- over. During interview on stated R58 likes to games, folding and bat the balloon, ball outside, and likes a During multiple obs to 6/11/15, the resid participating in any identified to enjoy a assessment or by s During interview on stated R58 will do a "mood," and if not t and try later. R62's annual MDS resident had severe required assistance living, had minimal	playing kick ball, doing trivia, For self directed activities, ng a resident is doing willingly f directed activity, including nit. 6/11/15, at 1:21 p.m. NA- D participate in activities off the the unit activities include n (e.g. staff start a riddle and sh it). She stated the activity to the unit to do activities with on Friday evenings activity to the unit to do activities with on Friday evenings activity to tape of a church service on ut in a movie when church is 0/06/11/15, at 1:21 p.m. NA-C dance, enjoys doing memory cleaning, enjoys music, will I toss, ball kick, likes to sit mimals. servations of R58 from 6/8/15, dent was not observed of the activities she was according to the activity	F 2	248			

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	-	AND HUMAN SERVICES				FORM	07/09/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245573	B. WING			06/	11/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLARA C	CITY CARE CENTER				D12 NORTH DIVISION STREET PO BOX 79	} 7	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 248	behaviors, rejection R62's Clara City Ca Initial Assessment of expressed interest in puzzles, baking, ner sewing, dancing, va gardening, parades the news on televisitien enjoys visiting with R62 care plan dated had moderate to se periods of crying, ag hallucinations, refus of cares with interver over-stimulation (e., meaningful activitien restlessness. Resid likes to have her put is seated where cor observation is poss psychosocial well-b the resident enjoyed to, reminiscing, sma sensory, and social was to stay in group time and to socialize peers. Care planner provide prompts, cu make simple concis time for comprehener encourage favorite to one to keep her i 10 minutes. Review of R62's Cla	are Center Activity Long Term dated 1/29/14, indicated R62 in cards and games, jig saw edle work, quilting and arious music, books, s, wheeling outside, watching ion, liked dogs and cats, and peers. d 9/30/2014, indicated R62 evere cognitive impairment with gitation, delusions, sal of medications, and refusal entions including to avoid g., noise, crowding), provide s as appropriate to decrease dent enjoyed sorting things, urse, and ensure the resident nstant or near constant bible. R62's care plan for being and activities indicated d music, visiting, being read all groups, physical games, activities. The activity goal o activities for 10 minutes at a e appropriately with staff and d interventions include: ues and redirection as needed, se statements, provide extra asion and response, group activities, and work one interest in group activities for	F 2	48	DEFICIENCY)		
		between March 2015, and ed R62 participated in the					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED	
245573		B. WING			06/	11/2015	
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CLARA CITY CARE CENTER					1012 NORTH DIVISION STREET PO BOX 79)7	
				0	CLARA CITY, MN 56222		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	following activities: Being read to 26 da Staff/peer music or days. Sitting in the lobby (days. Self-directed activity Gardening four time During observation was sitting in her wh common area of the activities were in pro During observation was in her wheel ch of secured unit, and progress during the During observation was brought to chur staff. During observation was seated in her w area of the secured shirt and had her sw no activity's going of During observation AA-C entered the daily of meal. The activity w minutes later, and A During observation entered the unit and group. R62 did not	ays. listening to a compact disc 22 (common area of unit) 60 y 58 days. es. 06/09/2015, at 3:27 p.m. R62 heel chair at a table in the e secured unit, and no ogress during the observation. on 6/10/15, at 9:22 a.m. R62 hair sitting in the common area d there were no activities in e observation. on 6/10/15, at 9:27 a.m., R62 rch off the unit by an activity on 6/10/15, at 2:33 p.m. R62 wheel chair in the common l unit and was pulling on her weater pulled off. There was on during this observation. on 6/11/15, at 8:41 a.m., ining room of the secured unit devotions during the breakfast vas completed at 8:45 a.m., 4	F 2	248			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	07/09/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245573	B. WING	ì		06/11/2015	
NAME OF F	PROVIDER OR SUPPLIER	·		S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CLARA C	CITY CARE CENTER				1012 NORTH DIVISION STREET PO BOX 7 CLARA CITY, MN 56222	97	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 248	Continued From pa 9:18 a.m.	ıge 18	F 2	248	3		
	was sitting in the ha her wheel chair and herself down to the there facing the exi 5 minutes. During the were observed walk	on 6/11/15, at 2:45 p.m. R62 allway of the secured unit in d was crying. R62 propelled e end of the hall and remained it door crying for an additional this time, three staff members king past her, however, no intervene or engage R62 in any					
	stated R62 attends the birthday party o balloon and particip memory games. Sh unable to participate activities outside the	a 6/11/15, at 9:37 a.m. NA-C mass on Wednesday, goes to of the month, will bat the pate in ball toss, and does ne stated sometimes R62 is the. Staff offer to bring her to be secured unit and sometimes o go, or she goes and comes on.					
	stated, R62 cries, " give her blankets, h stated R62 enjoys h	6/11/15, at 1:16 p.m. NA- A Quite a bit," and staff try to neat pads, and food. NA-A having her back scratched and her purse and loves to drawers.					
	stated R62 had bee crying since staff go stated staff will try t give her medication however, she was r	a 6/11/15, at 2:45 p.m. NA-B en wandering in the hallway ot her up from her nap. NA-B to repostion the resident and hs when she is crying, not sure what activities the r what could be tried to try to he was sad.					
	During interview on	n 6/11/15, at 2:45 p.m. NA- E					

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		AND HUMAN SERVICES				FORM	: 07/09/2015 APPROVED
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA		. ,		IPLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
		245573	B. WING	à		06	/11/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	_ <u>.</u>	
CLARA CITY CARE CENTER					1012 NORTH DIVISION STREET PO BOX CLARA CITY, MN 56222	797	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 248	from her nap about unsure what staff c upset, and was una enjoyed or what intra appropriate. During interview on stated R62 liked bir when she was adm the resident was no activities anymore. directed activities in take things from on up to residents and "mother them." AD with music, loves d stated if staff puts t usually participate i Review of a policy I Activity Department 6/22/10: "It is the polic Center to have an of that shall be design residents for occup maintenance." The outlined in the polic create a normal livi compatible with the residents, The resid involved in his own activity program that maximum physical, capacity.	en crying since they got her up 5 minutes ago. NA-E was ould do for R62 when she was ware of what activities R62 erventions would be 6/11/15, at 3:25 p.m., AD ngo, cards, and jigsaw puzzles itted to the facility, however, o longer capable of doing those AD-D stated R62's self included "fiddling" with things, e place to another, and going touch their arm and try to stated R62 liked to sing along ogs, cats, and any pets. AD-D hings in R62's hands she will	F	248			

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3) DA). 0938-039 TE SURVEY MPLETED
		A. BUILDING	a		
		B. WING		/11/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CLARA CITY CARE CENTER				1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 248	Continued From pa	age 20	F 248	8	
	and those who do	ve low functioning residents not come to group activities, p]., preferences, disease, bed			
F 282 SS=D	483.20(k)(3)(ii) SE	RVICES BY QUALIFIED ARE PLAN	F 282	2	7/21/15
	must be provided b	ded or arranged by the facility by qualified persons in ach resident's written plan of			
	by: Based on observa review the facility fa	NT is not met as evidenced tion, interview, and document ailed to follow the care plan for 28) reviewed for pressure		It is the goal of the Clara City Care Center that the services provided or arranged by the facility be provided by qualified persons in accordance with each	1
	Findings include:			resident; s plan of care.	
	R28's current Physician Orders dated 6/4/15, indicated the resident had diagnoses including diabetes mellitus, ischemic heart disease, hypertension, post hip replacement, and kidney disease.			R28; s care plan was reviewed and a new Tissue Tolerance Test (TTT) was completed. The new TTT assessment indicated that R28 is able to tolerate 2 hours up in a chair with a ROHO cushion and 1; hours in bed with an MA-85 low air loss alternating pressure mattress	
	risk for pressure ul skin breakdown rel repair, impaired mo coronary artery dis hypertension, eden assistance with act The care plan indic	ted 6/5/15, indicated he was at cer development, potential for lated to diabetes, recent left hip obility, chronic kidney disease, ease, hypothyroidism, na, and required staff tivity of daily living function. cated R28 had a pressure ulcer uttock cheek which resolved		without areas of redness noted on any area of the body. Since his sacral ulcer has healed, he is able to be up in his chai more frequently (for all meals and activities as he desires). R28¿s turning and repositioning program was changed from every hour to every two hours while in chair and every 1 ¿ hours while in bed. Heel-lift boots were purchased for R28 to	

Facility ID: 00061

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		(X1) PROVIDER/SUPPLIER/CLIA				
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	· · /	(X3) DATE SURVEY COMPLETED	
		B. WING			/2015	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP (ODE	
CLARA CITY CARE CENTER				1012 NORTH DIVISION STREET PO CLARA CITY, MN 56222	D BOX 797	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 282	Continued From pa	ge 21	F 2	82		
	discolored. The cat treatment per media daily skin checks by cares, and to turn a hour. During continuous of 7:01 a.m. until 8:29 minutes) R28 was n registered nurse (R (NA)-F repositioned During interview on stated R28 was on repositioning sched current pressure ula resident had a pres had healed on 6/5/1 ulcer on his right he During interview on stated she had last NA-F stated R28 sh again at 8:00 a.m. a however, she was b able to reposition hi Although R28 had o pressure ulcers on follow the individual	6/10/15, at 8:34 a.m. NA-F repositioned R28 at 7:00 a.m. hould have been repositioned according to his plan of care, busy with cares and wasn't im until 8:29 a.m. current and reoccurring his heels, the facility failed to lized interventions on the care rent pressure ulcers and		 being utilized, as it seemed breakdown on his heels occ was up in his wheelchair, ra bed. The existing dark area heel has lightened and dec significantly since changing boots. The new repositionir and pressure reduction boc implemented and communi- via Focus Sheet Change For The DON or designee will b for auditing staff compliance turning and repositioning so ensure that the pressure re devices are used appropria plan of care one time week In addition, the DON or des responsible for randomly au compliance with the turning repositioning schedules and pressure relieving devices of residents at risk for skin brea their plans of care one time days and if results of these positive, they will then be do on an as needed basis. Rea audits as well as any conce be discussed at quarterly C Turning and repositioning s be added to Focus Sheets carry on their person at all t facility will continue to add a Change Form that all direct responsible to read at the b 	curred when he ather than in a on his right reased in size to the heel- lift og schedule ots were cated to staff orm. be responsible e with R28;s chedule and duction tely per his ly for 60 days. ignee will be uditing staff and d use of of different eakdown per weekly for 60 audits are one randomly sults of these one randomly sults of these trns noted will that CNAs imes. The a Focus Sheet care staff are	

Facility ID: 00061

If continuation sheet Page 22 of 29

AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING O6/11/20 AND PLAN OF CORRECTION 245573 B. WING O6/11/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 06/11/20 CLARA CITY CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222 CLARA CITY, MN 56222 CLARA CITY, MN 56222 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID			AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/09/2015 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CLARA CITY CARE CENTER 1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222 CLARA CITY, MN 56222 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) (COMP COMP						(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CLARA CITY CARE CENTER 1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222 CLARA CITY, MN 56222 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	245573			B. WING	ì		06 / [.]	11/2015
CLARA CITY CARE CENTER CLARA CITY, MN 56222 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ((COMP COMP DEFICIENCY)	ME OF PRO	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMP D	ARA CIT	Y CARE CENTER					7	
	RÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETION DATE
F 282 Continued From page 22 F 282 Management of Skin Integrity will be included with the Temporary Care Plan for all new admissions until a comprehensive care plan has been completed. The DON or designee will audit 10% of the Focus Sheets weekly until all current the Focus Sheets may care plan has been audited to ensure that they match the care plan and that the care plan has been implemented. If positive results, the audits will be changed to randomly on an as needed basis. Results of these audits and any concerns noted will be discussed at quarterly QA meetings. The facility has policies and procedures in place to ensure that a resident who enters our facility without pressure ulcers will not develop pressure ulcers will not development of pressure ulcers was unavoidable, and a resident who has pressure ulcers from developing. These policies were reviewed and updated as well. A policy will be monitored with the RN Managers responsible for this. This will be monitored with the audits of focus sheets and care plans as mentioned in the previous paragraph. Statf education regarding the importance of turning/ repositioning and offloading as	= 282 C4	ontinued From pa	ge 22	F	282	Management of Skin Integrity will be included with the Temporary Care F all new admissions until a compreh care plan has been completed. The or designee will audit 10% of the Fo Sheets weekly until all current the F Sheets and care plans of all current residents have been audited to ens that they match the care plan and th care plan has been implemented. If positive results, the audits will be ch to randomly on an as needed basis Results of these audits and any cor noted will be discussed at quarterly meetings. The facility has policies and proced place to ensure that a resident who our facility without pressure ulcers we develop pressure ulcers, unless the clinical condition demonstrates that development of pressure ulcers wa unavoidable, and a resident who has pressure ulcers receives the necess treatment and services to promote healing, prevent infection, and prev new pressure ulcers from developin These policies were reviewed and updated as well. A policy will be developed regarding the development implementation of care plans and reviewed with the RN Managers responsible for this. This will be mo with the audits of focus sheets and plans as mentioned in the previous paragraph. Staff education regarding the impor	Plan for ensive DON ocus Focus t ure nat the nanged ncerns QA ures in enters will not er the s sary ent ng. ent and nitored care	

Event ID:S5IN11

Facility ID: 00061

If continuation sheet Page 23 of 29

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				
		B. WING					
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	1/2015	
	TY CARE CENTER			1012 NORTH DIVISION STREET PO BO	X 797		
	IT CARE CENTER			CLARA CITY, MN 56222			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLÉTIC DATE	
F 282	Continued From pa	age 23	F 282				
				necessary interventions to mair current skin integrity and preven breakdown, as well as use of su surfaces will be provided by W0 staff meetings scheduled for Ju Education regarding the same talso be provided on a shift to sh ensure the information reaches members.	nt skin upport CC RN at Ily 9, 2015. topics will nift basis to		
				The facility employs a Wound C She is responsible for assessm management of the skin condit residents in the facility. She has completed the Wound Care Ce course. She does intend to com in the near future; however ther WCC (Wound Care Certified) F available on the campus for cor In collaboration with the DON a RN (if needed), the Wound Car responsible for assessing all sk concerns, development and implementation of policies and procedures, and development a implementation of the plan of car residents relating to skin issues wound nurse is responsible for to the QA committee and initiation monitoring, and assessing and improvement measures based collected and analysis of such o QA committee will then determin root-cause analysis is indicated the data collected and the analy such data.	ent and ion of all s not yet rtification nplete this re is a N nsultation. and WCC re Nurse is in and are for all s. The reporting ing, quality on data data. The ne if a I based on		
F 314 SS=D	483.25(c) TREATM PREVENT/HEAL F	IENT/SVCS TO PRESSURE SORES	F 314			7/21/15	

		AND HUMAN SERVICES			F	ORM A	07/09/2015 APPROVED 0938-0391
STATEMENT			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245573	B. WING	i		06/1	1/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLARA (CITY CARE CENTER				012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 314	Continued From pa	ge 24	F	314			
	resident, the facility who enters the facility does not develop p individual's clinical they were unavoida pressure sores reco services to promote prevent new sores This REQUIREMEN by: Based on observat review, the facility fa (R28) who had had	brehensive assessment of a rmust ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that uble; and a resident having eives necessary treatment and e healing, prevent infection and from developing. NT is not met as evidenced tion, interview, and document ailed to ensure 1 of 1 resident a history of pressure ulcers, as assessed to prevent the			It is the policy of the Clara City Care Center that based on the comprehens assessment of the resident, the facility	ty	
	development of new Findings include: R28's current Physi indicated the reside on 11/21/14, and ha diabetes mellitus, is hypertension, post disease. R28's significant ch			 must ensure that a resident who e the facility without pressure sores individual ¿s clinical condition demonstrates that they were unavand a resident having pressure so receives necessary treatment and services to promote healing, preverinfection and prevent new sores frideveloping. R28¿s care plan was reviewed and Tissue Tolerance Test (TTT) was completed. The new TTT assessminitation in the service is the service in the service in the service in the service is the service in the service in the service is the service is the service in the service is the service is the service in the service is the service is the service in the service is the serv		es able; ;	
	ulcers, had a stage 1/19/15, had a stag unstagable deep tis tissue injury in evol identified the dimer or 4 pressure ulcer (cm) x 2.4 cm x 1.0	2 pressure ulcer dated e 4 pressure ulcer, and one sue, with suspected deep ution. The MDS further ision of the unhealed stage 3 or eschar was 4.0 centimeter cm, and the most severe pressure ulcer had eschar with			indicated that R28 is able to tolerate 2 hours up in a chair with a ROHO cusl and 1 ¿ hours in bed with an MA-85 lo air loss alternating pressure mattress without areas of redness noted on any area of the body. Since his sacral ulce has healed, he is able to be up in his o more frequently (for all meals and	2 shion ow y er	

Facility ID: 00061

If continuation sheet Page 25 of 29

		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		245573	B. WING			06/11/2015	
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CLARA	CITY CARE CENTER				012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222	7	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 314	Continued From pa	ge 25	F 3	314			
	brown, black, or tar the wound bed or u harder then surrour identified R28 had a chair/bed, was on a program, and had r interventions in place R28's Care Area As 2/3/15, indicated R2 ulcer development" meal due to current had a gradual weig On 1/26/15, resider kidneys), vitamin da in wound healing) started on Juvan (s pressure ulcers) da (nurse practioner) v and ulcer on left up R28's current care the resident was at development, poter to diabetes, recent mobility, chronic kic disease, hypothyroi and need for assist function. The care ulcer on the upper I 6/5/15, and had a p and the left heel is I care plan listed app medical doctor and checks by NA's (nu and to turn and rep	 b tissue that adheres firmly to loer edges, maybe softer or ording skin. The MDS further a pressure relieving device in a turning repositioning butrition or hydration beto manage skin problems. c to manage skin prossure (for a skin concerns. {R28} has ht decline since admission. t was started on Renal (for a skin concerns. the aling ily per Nancy Drange NP who is following him for heel per buttocks." plan dated 6/5/15, indicated risk for pressure ulcer ntial for skin breakdown related left hip repair, impaired diney disease, coronary artery dism, hypertension, edema, with activity of daily living plan identified, the pressure eff buttock cheek resolved on ressure ulcer on right heel boggy and discolored. The boggy and discolored. The proaches of treatment per wound clinic, daily skin rsing assistant) with cares, osition every one hour. The up until 6/5/15, R28 was up in 	ΓJ		activities as he desires). R28¿s turr and repositioning program was char from every hour to every two hours in chair and every 1 ¿ hours while ir Heel-lift boots were purchased for F replace the Prevalon boots that wer being utilized, as it seemed that the breakdown on his heels occurred w was up in his wheelchair, rather tha bed. The existing dark area on his r heel has lightened and decreased in significantly since changing to the h boots. The new repositioning sched and pressure reduction boots were implemented and communicated to via Focus Sheet Change Form. The DON or designee will be respon for auditing staff compliance with R2 turning and repositioning schedule a ensure that the pressure reduction devices are used appropriately per plan of care one time weekly for 60 In addition, the DON or designee wi responsible for randomly auditing st compliance with the turning and repositioning schedules and use of pressure relieving devices of differe residents at risk for skin breakdown their plans of care one time weekly days and if results of these audits a positive, they will then be done rand on an as needed basis. Results of t audits as well as any concerns note be discussed at quarterly QA meetin Turning and repositioning schedules be added to Focus Sheets that CNA	nged while bed. 28 to e hen he n in ight n size eel- lift ule staff staff his days. ill be taff ont per for 60 re lomly hese ed will ngs. s will	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		E SURVEY		
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COM	PLETED		
		245573	B. WING		06/	11/2015		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
CLARA (CITY CARE CENTER		1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE		
F 314	Continued From pa	-	F 314					
	pressure reducing ((cushion that has in cushion to wheelch mattress to bed, all refer to certified wo needed, weekly boo prevalon boots (pro- ulcers and foot dro and shear on feet, the foot and separa mattress). The car had a pressure red R28's Tissue Tolera can be used to dete schedule, dated 2/3 risk for pressure ull assist of two with b mechanical lift for t hour turning and re multiple skin conce completed on 5/1/1 determination as th During continuous a.m. until 8:29 a.m. R28 was not repos registered nurse (F (NA)-F repositioned During interview 6/	aure ulcers including a cushion to wheelchair, roho netroconnected air cells) air, pressure reducing ternating pressure mattress, bund nurse, podiatrist as dy audits at bath time, and otection against heel pressure p, minimize pressure, friction heels and ankles. It elevates ating the heel from the e plan further identified R28 ucing mattress to the bed. ance Test (TTT), a tool which ermine a repositioning 8/15, identified R28 was at high cer development, required ed mobility, required a ransfers, and needed a one positioning schedule due to rns. A follow up TTT was 5, with the same ue one completed on 2/3/15. observation 6/10/15, from 7:01 (one hour and 28 minutes) itioned. At 8:29 a.m. N)-D and nursing assistant d R28 to his left side. 10/15, at 8:30 a.m. RN-D one hour turning and		facility will continue to add a Foo Change Form that all direct care responsible to read at the begin their shift (during shift to shift re changes in plans of care for all The Temporary Care Plan for Management of Skin Integrity w included with the Temporary Ca all new admissions until a comp care plan has been completed. or designee will audit 10% of the Sheets weekly until all current th Sheets and Care plans of all cu residents have been audited to that they match the care plan ar care plan has been implemente positive results, the audits will b to quarterly, they will then be do randomly on an as needed basi of these audits and any concerr will be discussed at quarterly Qa meetings. The facility has policies and pro place to ensure that a resident w our facility without pressure ulces clinical condition demonstrates develop ment of pressure ulcers unavoidable, and a resident who pressure ulcers receives the ne treatment and services to prome	e staff are ning of port) for all residents. ill be re Plan for rehensive The DON e Focus rent ensure nd that the d. If e changed ne s. Results is noted A cedures in who enters ers will not their that the was o has cessary			
	reoccurring pressu RN-D stated R28 h buttocks that had re still has a dark area During interview 6/	dule due to he multiple and re ulcers the resident has had. ad a pressure ulcer on his ecently healed on 6/5/15, but a on his right heel. 10/15, at 8:34 a.m. NA-F repositioned R28 at 7:00 a.m.		healing, prevent infection, and p new pressure ulcers from devel These policies were reviewed a updated as well. A policy will be developed regarding the develo implementation of care plans ar reviewed with the RN Managers	oping. nd pment and id			

Facility ID: 00061

If continuation sheet Page 27 of 29

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL	TIPL	E CONSTRUCTION (X3	3) DATE SURVE			
	F CORRECTION	IDENTIFICATION NUMBER:				COMPLETED			
		245573	B. WING			06/11/2015			
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE				
CLARA (CITY CARE CENTER				012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		ETIO		
F 314	Continued From pa	ge 27	F 3	314					
	again at 8:00 a.m., cares and wasn't at a.m.	however, she was busy with ble to reposition R28 until 8:29 6/10/15, at 11:55 a.m. the			with the audits of focus sheets and ca plans as mentioned in the previous paragraph.	ıre			
	director of nursing (assessed to be rep reoccurring and cur ulcers. During interview on reviewed R28's MD change MDS dated have a stage 4 pres stage two pressure unstagable pressur stated after comple facility placed the re turning and repositi multiple, reoccurrin During observation assessed R28's ski pressure ulcer was and the right heel p cm x 0.8 cm of dark	(DON) stated R28 had been ositioned every hour due to rrent skin breakdown/ pressure 6/11/15, at 10:35 a.m. RN-B DS and stated the significant 12/3/15, R28 was noted to ssure ulcer on his buttocks, a ulcer on his right heel, and a re ulcer on his left heel. RN-B ting the TTT on 2/2/15, the esident on an every one hour oning schedule related to the			In order to ensure that residents with pressure ulcers receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing, the DON Wound Nurse will meet monthly with t Registered Dietician to discuss curren residents at nutritional risk as well as residents with current skin issues and possible nutritional interventions. In addition, the DON and Wound Nurse meet weekly to discuss current skin issues and interventions. The WCC R will be available for consultation as needed for worsening skin issues or la of wound healing. The facility will also initiate a form for the physician to fill o when it is felt that a pressure ulcer wa unavoidable to ensure adequate assessment and documentation of this	and the ht will RN ack put as			
	pressure ulcer to hi was not able to be of stated R28's pressu (coccyx) had healed observation. Although R28 was a repositioned every reoccurring pressur observed not being 28 minutes. The Facility policy t Skin Policy and Pro to ensure a residen without pressure ula	s right heel. R28's coccyx observed, however, RN-B ure ulcer on the buttocks d on 6/5/15, 6 days prior to the assessed to be turned and hour related to multiple re ulcers, the resident was repositioned for one hour and itled Clara City Care Center ocedure dated 6/7/12, indicated it who enters the facility cers does not develop ulcers al's clinical condition			Staff education regarding the importar of turning/ repositioning and offloading necessary interventions to maintain current skin integrity and prevent skin breakdown, as well as use of support surfaces will be provided by WCC RN staff meetings scheduled for July 9, 20 Education regarding the same topics of also be provided on a shift to shift bas ensure the information reaches all stat members. The facility employs a Wound Care Nu She is responsible for assessment and	nce g as l at 015. will sis to tff urse.			

Facility ID: 00061

If continuation sheet Page 28 of 29

STATEMENT	OF DEFICIENCIES	KANDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED	
		245573	B. WING _		06/	11/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		00/11/2010	
CLARA	CITY CARE CENTER			1012 NORTH DIVISION STREET PC CLARA CITY, MN 56222	BOX 797	797	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 314	nursing personnel interventions consi family preferences order to create an adherence to the p prevention/mainter treatment plan. Th Impaired mobility, p status, incontinenc	they were unavoidable, and will develop a plan of care with stent with the resident and , goals and abilities, and in environment for the resident's ressure ulcer nance of skin integrity he plan of care should include: pressure relief, nutritional e, skin condition checks, pain ts, interventions, and education	F 31	Management of the skin con- residents in the facility. She completed the Wound Care course. She does intend to in the near future; however WCC (Wound Care Certifie available on the campus for In collaboration with the DO RN (if needed), the Wound responsible for assessing a concerns, development and implementation of policies a procedures, and development implementation of the plan of residents relating to skin iss wound nurse is responsible to the QA committee and ini- monitoring, and assessing a improvement measures bas collected and analysis of su QA committee will then deter root-cause analysis is indicat the data collected and the a such data.	has not yet Certification complete this there is a d) RN consultation. N and WCC Care Nurse is I skin and ent and of care for all ues. The for reporting tiating, and quality sed on data ch data. The ermine if a ated based on		

Facility ID: 00061

If continuation sheet Page 29 of 29

PRINTED:	07/09/2015
FORM	APPROVED
OMP NO	0038-0301

		Ŧ	5	573023		APPROVED 0938-0391
CENTERS FOR MEDICAR STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPL	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATI	E SURVEY PLETED
	245573	B, WING			06/	09/2015
NAME OF PROVIDER OR SUPPLIEF	1		1 · ·	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLARA CITY CARE CENTER				012 NORTH DIVISION STREET PO BOX 7 CLARA CITY, MN 56222	97	
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000 INITIAL COMMEN	ITS	K	000			
FIRE SAFETY						
ALLEGATION OF DEPARTMENT'S SIGNATURE AT 1	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR THE BOTTOM OF THE FIRST MS-2567 WILL BE USED AS OF COMPLIANCE.					
ON-SITE REVISI CONDUCTED TO SUBSTANTIAL O REGULATIONS F	OF AN ACCEPTABLE POC, AN T OF YOUR FACILITY MAY BE OVALIDATE THAT OMPLIANCE WITH THE HAS BEEN ATTAINED IN WITH YOUR VERIFICATION.					
Minnesota Depart Fire Marshal Divis Clara City Care C substantial compli participation in Me Subpart 483.70(a) 2000 edition of Na Association (NFP	e Survey was conducted by the ment of Public Safety, State sion. At the time of this survey, enter was found not in ance with the requirements for edicare/Medicaid at 42 CFR,), Life Safety from Fire, and the ational Fire Protection A) Standard 101, Life Safety oter 19 Existing Health Care.				1	
PLEASE RETURI CORRECTION FO DEFICIENCIES (OR THE FIRE SAFETY			EPCC		
HEALTH CARE F STATE FIRE MAR 444 CEDAR STR ST. PAUL, MN 55	EET, SUITE 145					
ABORATORY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 07/02/2015

Electronically Signed

Service of the service of

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/09/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245573	B, WING			06/0)9/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CLARAC	CITY CARE CENTER			•	012 NORTH DIVISION STREET PO BOX 79 LARA CITY, MN 56222	97	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	K	000			
	By e-mail to: Barbara.lundberg@ and Marian.Whitney@s						
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the defici	what has been, or will be, done ency.					
	2. The actual, or pr	oposed, completion date.					
	3. The name and/o responsible for corr prevent a reoccurre	r title of the person rection and monitoring to ence of the deficiency.					
	The facility was ins buildings:	pected as two separate					
	partial basement. T 5 different times. Th constructed in 1966 Type II(111) constru- was constructed an	nter is a 1-story building with The building was constructed at the original building was 6 and was determined to be of fuction. In 1970, an addition ad was determined to be of					
	was constructed an Type II (111) constr was constructed an Type II(111) constru- new kitchen additio II(111) construction	action. In 1989, an addition ad was determined to be of uction. The 1997 an addition ad was determined to be of uction. The facility added a n in 2010 constructed of type . Because the original building do not met the construction					
		xisting buildings, the facility					

Manager 1

- And Market

Facility ID: 00061

If continuation sheet Page 2 of 4

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/09/2015 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
		245573	B. WING			06/09/2015		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CLARA	CITY CARE CENTER				012 NORTH DIVISION STREET PO BOX 79 CLARA CITY, MN 56222	J 7		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 000	Continued From pa was surveyed as tw	-	K	000				
K 144 SS=F	facility has a fire ala detection in the corr corridors that is mo department notifica capacity of 66 beds time of the survey. The requirement at is NOT MET as evic NFPA 101 LIFE SA Generators are insp	FETY CODE STANDARD bected weekly and exercised binutes per month in	ĸ	144			6/12/15	
	NFPA 101 (2000) L REGULATION - Ge weekly and exercise 30% of the EPS nat per month and shal 99 (1999 edition) ar This STANDARD is Based upon a staff available records, th	s not met as evidenced by: IFE SAFETY CODE SURVEY enerators must be inspected ed under load at not less than meplate rating, for 30 minutes I be in accordance with NFPA nd NFPA 110 (1999 edition). I not met as evidenced by: interview and review of he facility did not perform form 10/16/2014- 06-09-2015			The Maintenance Director or design will perform weekly inspections of t generator to ensure everything is ir working order. These inspections then be recorded on a log and kep maintenance records book for revie This log will be reviewed monthly b Administrator or designee for the n months and if the inspections are b completed and recorded appropria log will be reviewed quarterly there	the will t in the ew. by the lext 3 being tely the		

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Facility ID: 00061

If continuation sheet Page 3 of 4

		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES				1	0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 6 01 - MAIN BUILDING 01		E SURVEY IPLETED	
		245573	B, WING	;		06/	09/2015	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
	ITY CARE CENTER				1012 NORTH DIVISION STREET PO BOX 7	97		
CLARAC	ITT CARE CENTER				CLARA CITY, MN 56222			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
K 144	emergency, this de affect all residents,	generator. In a fire or other ficient practice could adversely staff and visitors. ice was verified by the	K.	144				

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Facility ID: 00061

If continuation sheet Page 4 of 4

PRINTED: 07/09/2015

		AND HUMAN SERVICES & MEDICAID SERVICES	Ŧ	5	573023 01		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPL	E CONSTRUCTION 04 - 2010 KITCHEN ADDITION		E SURVEY IPLETED
		245573	B. WING			06/	09/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 012 NORTH DIVISION STREET PO BOX 79	17	
CLARA	CITY CARE CENTER			-	CLARA CITY, MN 56222		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs	K	000			
	FIRE SAFETY						
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE FO	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST RM CMS-2567 WILL BE ATION OF COMPLIANCE.					
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departm Fire Marshal Divisio time of this survey, Center was found r compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National I (NFPA) Standard 1	Survey was conducted by the nent of Public Safety, State on, on June 09, 2015. At the Building 02 of Clara City Care not to be in substantial e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), ealth Care Occupancies.			EPOC		
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY					
E.	Health Care Fire In State Fire Marshal 445 Minnesota Stre St. Paul, MN 55101	Division eet, Suite 145					
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	_	TITLE		(X6) DATE
Electror	nically Signed						07/02/2015

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.

ALC: NO

and Provident

PRINTED: 07/09/2015

DEPARTMENT OF HEALTH AND HUMAN SERVICES FO CENTERS FOR MEDICARE & MEDICAID SERVICES OMB I								
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED	
	2	245573	B, WING	_		06/0	9/2015	
				10	TREET ADDRESS, CITY, STATE, ZIP CODE 012 NORTH DIVISION STREET PO BOX 797 LARA CITY, MN 56222	,	20	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 000	By eMail to: Marian.Whitney@si THE PLAN OF CON DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the deficie 2. The actual, or pro 3. The name and/or responsible for corr prevent a reoccurre Building 02 of Clara a kitchen addition, o 02 is one-story in he fully fire sprinkler pr to be of Type II(111) addition was added Assisted living with also has a physical has no basement a and smoke detection determined to be a The facility has a fir detection in the corr corridors which is m department notifica	tate.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. If title of the person ection and monitoring to ence of the deficiency. A City Care Center consists of constructed in 2010. Building eight, has no basement, is rotected, and was determined) construction. In 2015, an to this area with a link to as a 2-hour fire wall. This area therapy area. This area also nd is fully sprinkler protected on in corridors, and was Type II (III) construction. The alarm system with smoke ridors and spaces open to the honitored for automatic fire tion. The facility has a f 66 beds and had a census of	ΚO	00				
K 144	NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD	K 1	44			6/12/15	

AT STREET

Facility ID: 00061

If continuation sheet Page 2 of 3

PRINTED: 07/09/2015

		AND HUMAN SERVICES				FORM	07/09/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 04 - 2010 KITCHEN ADDITION		E SURVEY PLETED
		245573	B. WING			06/0	9/2015
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE 012 NORTH DIVISION STREET PO BOX 79	7	
	CITY CARE CENTER				LARA CITY, MN 56222		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 144 SS=F	Continued From pa	ige 2	K	144			
	Generators are ins under load for 30 m accordance with N	pected weekly and exercised ninutes per month in FPA 99. 3.4.4.1.	5				
	NFPA 101 (2000) I REGULATION - Ge weekly and exercis 30% of the EPS na per month and sha 99 (1999 edition) a This STANDARD is Based upon a staff available records, t weekly inspections for the emergency emergency, this de affect all residents,	ice was verified by the			The Maintenance Director or design will perform weekly inspections of the generator to ensure everything is in working order. These inspections we be recorded on a log and kept in the maintenance records book for revior This log will be reviewed monthly be Administrator or designee for the ne months and if the inspections are to completed and recorded appropriation log will be reviewed quarterly there	he n vill then ie ew. ext 3 peing tely the	

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Facility ID: 00061

If continuation sheet Page 3 of 3



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted June 25, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5573024

Dear Mr. Stordahl:

The above facility was surveyed on June 8, 2015 through June 11, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

Clara City Care Center June 25, 2015 Page 2

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

ate Compton

Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulations Division Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

Minneso	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	SURVEY PLETED
		00061	B. WING		06 /1	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CLARA (CITY CARE CENTER		TH DIVISIO	N STREET PO BOX 797 222		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	this Department's s and the following co When corrections a date, make a copy original to the Minno Division of Complia	and 9th, 2015 surveyors of taff, visited the above provider prrection orders are issued. are completed, please sign and of these orders and return the esota Department of Health, nce Monitoring, Licensing and		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	
ABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

Electronically Signed

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If continuation sheet 1 of 30

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00061	B. WING		06/11/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LARA C	CITY CARE CENTER		RTH DIVISIO	N STREET PO BOX 797 222		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	Certification Progra Suite 212, St Cloud	m, 3333 West Division St, , MN 56301.		The assigned tag number and far left column entitled "ID F The state statute/rule out of listed in the "Summary State Deficiencies" column and re Comply" portion of the corre This column also includes the which are in violation of the statement, "This Ru as evidence by." Following the findings are the Suggested I Correction and Time period PLEASE DISREGARD THE THE FOURTH COLUMN W STATES, "PROVIDER'S PLA CORRECTION." THIS APP FEDERAL DEFICIENCIES O WILL APPEAR ON EACH PA THERE IS NO REQUIREME SUBMIT A PLAN OF CORR VIOLATIONS OF MINNESC STATUTES/RULES.	Prefix Tag." compliance is ement of places the "To ction order. he findings state statute ule is not met he surveyors Method of for Correction. HEADING OF HICH AN OF LIES TO DNLY. THIS AGE. ENT TO ECTION FOR	
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			7/21/15
		omprehensive plan of care I personnel involved in the				
	by:	ent is not met as evidenced				
		on, interview, and document iled to follow the care plan for		Corrected		

If continuation sheet 2 of 30

STATEMEN	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00061	B. WING	B. WING		06/11/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
CLARA	CITY CARE CENTER			STREET PO BOX 797			
			CITY, MN 5622		0000000000		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 2	2 565				
	1 of 3 residents (R28) reviewed for pressure ulcers.						
	Findings include:						
	indicated the reside diabetes mellitus, is	ician Orders dated 6/4/15, ent had diagnoses including schemic heart disease, hip replacement, and kidney					
	risk for pressure uk skin breakdown rel repair, impaired mo coronary artery dise hypertension, eden assistance with act The care plan indic on his upper left bu on 6/5/15, had a cu right heel, and the l discolored. The ca treatment per medi daily skin checks b	ted 6/5/15, indicated he was at cer development, potential for ated to diabetes, recent left hip obility, chronic kidney disease, ease, hypothyroidism, na, and required staff ivity of daily living function. ated R28 had a pressure ulcer uttock cheek which resolved urrent pressure ulcer on the left heel was boggy and are plan listed approaches of cal doctor and wound clinic, y NA's (nursing assistant) with and reposition R28 every one					
	7:01 a.m. until 8:29 minutes) R28 was registered nurse (R (NA)-F repositioned During interview on stated R28 was on repositioning sched	observation on 6/10/15, from a.m. (one hour and 28 not repositioned. At 8:29 a.m. RN)-D and nursing assistant d R28 to his left side. a 6/10/15, at 8:30 a.m. RN-D a one hour turning and dule due to reoccurring and cers. RN-D stated the					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00061	B. WING	B. WING		11/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
CLARA	CITY CARE CENTER		RTH DIVISION CITY, MN 5622	STREET PO BOX 797 2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 565	During interview on stated she had last NA-F stated R28 sh again at 8:00 a.m. a however, she was b able to reposition h Although R28 had o pressure ulcers on follow the individual plan to heal the cur prevent new areas A SUGGESTED MI The director of nurs develop and impler to ensure that resid provide staff educa systems or audit to Report the findings Committee.	6/10/15, at 8:34 a.m. NA-F repositioned R28 at 7:00 a.m. nould have been repositioned according to his plan of care, busy with cares and wasn't im until 8:29 a.m. current and reoccurring his heels, the facility failed to lized interventions on the care rent pressure ulcers and	2 565			
2 900	Ulcers Subp. 3. Pressure comprehensive res of nursing services development of a n provides that: A. a resident wh without pressure si pressure sores unle condition demonstr	5 Subp. 3 Rehab - Pressure sores. Based on the ident assessment, the director must coordinate the ursing care plan which o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and	2 900			7/21/15

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SU COMPLET	
		00061	B. WING		06/11/2	2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CLARA (CITY CARE CENTER	1012 NOF		N STREET PO BOX 797		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE ((X5) COMPLETE DATE
2 900	Continued From pa	ge 4	2 900			
	receives necessary	ho has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: Based on observati review, the facility f (R28) who had had	ent is not met as evidenced on, interview, and document ailed to ensure 1 of 1 resident a history of pressure ulcers, as assessed to prevent the v pressure ulcers.		Corrected		
	Findings include:					
	indicated the reside on 11/21/14, and had diabetes mellitus, is	ician Orders dated 6/4/15, ent was admitted to the facility ad diagnoses including schemic heart disease, hip replacement, and kidney				
	indicated the reside ulcers, had a stage 1/19/15, had a stage unstagable deep tis tissue injury in evol identified the dimer or 4 pressure ulcer (cm) x 2.4 cm x 1.0 tissue type for any p brown, black, or tar the wound bed or u harder then surrour identified R28 had a chair/bed, was on a program, and had r	ange MDS dated 2/3/15, ent was at risk for pressure 2 pressure ulcer dated e 4 pressure ulcer, and one sue, with suspected deep ution. The MDS further usion of the unhealed stage 3 or eschar was 4.0 centimeter cm, and the most severe pressure ulcer had eschar with the tissue that adheres firmly to lcer edges, maybe softer or nding skin. The MDS further a pressure relieving device in a turning repositioning nutrition or hydration ce to manage skin problems.				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00061	B. WING		06/	06/11/2015	
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE ZIP CODE			
				I STREET PO BOX 797			
CLARA (CITY CARE CENTER		CITY, MN 5622				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T		COMPLET DATE	
				DEFICIENC	Y)		
2 900	Continued From pa	iae 5	2 900				
		.90 0					
	D20'a Cara Araa Ar	accoment (CAA) dated					
		ssessment (CAA) dated 28, "Is at high risk for pressure					
		, he is only up for noon					
		t skin concerns. {R28} has					
		ht decline since admission.					
		nt was started on Renal (for					
	-	aily, and zinc supplement (aide					
		x 14 days. {R28} was also	-				
		supplement to aide in healing					
		ally per Nancy Drange NP					
		who is following him for heel					
	and ulcer on left up						
	R28's current care	plan dated 6/5/15, indicated					
	the resident was at risk for pressure ulcer						
		ntial for skin breakdown related	k				
		left hip repair, impaired					
		ney disease, coronary artery					
		idism, hypertension, edema,					
		with activity of daily living					
		plan identified, the pressure					
	ulcer on the upper	left buttock cheek resolved on					
	6/5/15, and had a p	pressure ulcer on right heel					
		boggy and discolored. The					
	care plan listed app	proaches of treatment per					
	medical doctor and	wound clinic, daily skin					
		rsing assistant) with cares,					
		osition every one hour. The					
		up until 6/5/15, R28 was up in					
		noon and supper meal only.					
		d approaches for healing and					
		ure ulcers including a					
		cushion to wheelchair, roho					
		terconnected air cells)					
		air, pressure reducing					
		ernating pressure mattress,					
		und nurse, podiatrist as					
		dy audits at bath time, and					
	prevalon boots (pro	tection against heel pressure					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
	00061	B. WING		06/11/2015	
AME OF PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
LARA CITY CARE CENTER			STREET PO BOX 797		
	CLARA (CITY, MN 5622	22		
REFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES //UST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900 Continued From page	e 6	2 900			
and shear on feet, he the foot and separati mattress). The care had a pressure reduce R28's Tissue Toleran can be used to detern schedule, dated 2/3/ risk for pressure ulce assist of two with be mechanical lift for tra hour turning and repor multiple skin concern completed on 5/1/15, determination as the During continuous of a.m. until 8:29 a.m. (R28 was not repositioned I During interview 6/10 stated R28 is on a or repositioning schedu reoccurring pressure RN-D stated R28 had buttocks that had reo still has a dark area of During interview 6/10 stated she had last re and the resident sho again at 8:00 a.m., he cares and wasn't able a.m. During interview on 6 director of nursing (D	plan further identified R28 cing mattress to the bed. Acce Test (TTT), a tool which mine a repositioning 15, identified R28 was at high r development, required d mobility, required a unsfers, and needed a one ositioning schedule due to is. A follow up TTT was , with the same one completed on 2/3/15. oservation 6/10/15, from 7:01 one hour and 28 minutes) oned. At 8:29 a.m. I)-D and nursing assistant R28 to his left side. I)15, at 8:30 a.m. RN-D he hour turning and le due to he multiple and ulcers the resident has had. d a pressure ulcer on his cently healed on 6/5/15, but				

STATE FORM

Minneso	ta Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF OOTHIEOTION	IDENTIFICATION NOWIDER.	A. BUILDING: _		00	
		00061	B. WING	B. WING		11/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
				STREET PO BOX 797		
CLARA (CITY CARE CENTER		CITY, MN 5622			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH		COMPLETE DATE
				DEFICIENCY)	
2 900	Continued From pa	age 7	2 900			
		-				
		0S and stated the significant I 2/3/15, R28 was noted to				
		ssure ulcer on his buttocks, a				
	U	ulcer on his right heel, and a				
		re ulcer on his left heel. RN-B				
		ting the TTT on 2/2/15, the				
	facility placed the re	esident on an every one hour				
	turning and repositioning schedule related to the					
	multiple, reoccurrin					
		on 6/11/15, at 1:43 p.m. RN-B				
	assessed R28's skin. RN-B stated R28's left heel pressure ulcer was scabbed over with no eschar,					
		pressure ulcer measured 1.5				
		k purple, which was eschar, d to be an unstagable				
		is right heel. R28's coccyx				
		observed, however, RN-B				
		ure ulcer on the buttocks				
		d on 6/5/15, 6 days prior to the				
	observation.					
		assessed to be turned and				
		hour related to multiple				
		re ulcers, the resident was				
	28 minutes.	repositioned for one hour and				
		itled Clara City Care Center				
		ocedure dated 6/7/12, indicated	1			
		it who enters the facility				
		cers does not develop ulcers				
	unless the individua	al's clinical condition				
		they were unavoidable, and				
		will develop a plan of care with				
		stent with the resident and				
		goals and abilities, and in				
		environment for the resident's				
	adherence to the prevention/mainten	ressure uicer ance of skin integrity				
		e plan of care should include:				
		pressure relief, nutritional				
		e, skin condition checks, pain				
innesota D	epartment of Health	,, pan	l			

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		00061	B. WING		06/	06/11/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
CLARA	CITY CARE CENTER		TH DIVISION TY, MN 562	N STREET PO BOX 797 22			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	ge 8	2 900				
	infection, treatment of resident, family, a	s, interventions, and education and staff.					
	The director of nurs develop and implem to ensure that resid pressure ulcers rec staff as appropriate systems or audit to	ETHOD FOR CORRECTION: sing (DON) or designee could nent policies and procedures ents with current or at risk for eive timely services; educate ; then develop monitoring ensure ongoing compliance ngs to the Quality Assurance					
	(21) days.	R CORRECTION: Twenty one					
21435	Recreation Program Subpart 1. Genera home must provide recreation program based on each indiv strengths, and need meet the physical, r well-being of each r comprehensive res comprehensive plat 4658.0400 and 468 provided opportunit	al requirements. A nursing an organized activity and . The program must be vidual resident's interests, ds, and must be designed to mental, and psychological resident, as determined by the ident assessment and n of care required in parts 58.0405. Residents must be ies to participate in the opment of the activity and	21435			7/21/15	
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to provide consistent, ngagement for 4 of 5		Corrected			

STATEMEN	Ita Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	- 06/11/2015	
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NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
CLARA (CITY CARE CENTER		RTH DIVISION CITY, MN 5622	STREET PO BOX 797		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
21435	Continued From pa	ige 9	21435			
	residents (R34, R5 activities.	8, R62 and R31) reviewed for				
	Findings include:					
	4/30/2015, indicate cognitive impairme assistance to comp The MDS staff asso indicated R34 prefe newspapers, or ma being around anima with groups of peop activities, and spen	himum Data Set (MDS) dated d the resident had severe nt and required extensive blete activities of daily living. essment of activity preferences erred reading books, agazines, listening to music, als such as pets, doing things ble, participating in favorite iding time outdoors. R34's tified in the MDS, included e.	3			
	communication dat was rarely understo others. The CAA a was unclear and no distracted, was at r	ssessment (CAA) for ed 2/2/22015, identified R34 bod and rarely understands lso indicated R34's speech on-sensical, she became easily isk for not having her needs n, and decreased activity.	,			
	5/6/2015, indicated was, "Reviewed an also indicated R34 to music from the T sensory therapy fro The assessment in	arterly assessment dated the plan of care for activities d remains." The assessment was read to by staff, listened "V, and received music and om activity and hospice staff. structed staff, "Watch for body e unable to understand [R34's]				
	was seated and red in the living room o	on 6/9/2015, at 3:11 p.m. R34 clined in a chair, facing the TV n the secured unit. R34 sat ed, dozing off and not paying				

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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
CLARA C	CITY CARE CENTER		RTH DIVISION CITY, MN 5622	STREET PO BOX 797			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21435	Continued From pa	age 10	21435				
		program. As other residents ntly walked past, R34 n the recliner.					
	prior to the breakfa was reclined with h TV, which was tune Following breakfas ambulate out from R34 into the recline they exited the dinit tuned to the news p 9:15 a.m. activities secured unit, and for the center of the live exercise activity. F recliner and was no activity. At 9:50 a.r concluded the ballo turned music on for area. At 10:02 a.m and ambulated her	on 6/10/2015, at 7:05 a.m. st meal, until 8:01 a.m., R34 er feet up in a chair, facing the ed to a morning news program t, NA-C assisted R34 to the dining room, positioning er chair directly to the left as ng area. The TV was still program during this time. At assistant (AA)-B entered the prmed a circle of residents in ring area, and led balloon R34 remained seated in the bt invited to participate in the m., activities assistant (AA)-B pon exercise activity, and r the residents in the living u., NA-C assisted R34 to stand to another recliner facing the ided no further engagement tion.					
	AA-B stated R34 us activity's, and didn't	n 6/10/2015, at 10:02 a.m., sually doesn't participate in t ask her to join because she the group doing the activity.					
	2015, indicated the music, physical gar reminisce, exercise care, devotions. For	Place Activity Calendar June week day activities included: mes, cognitive stimulation, e, sensory stimulation, beauty or the majority of the activities did not identify specific times were to occur.					

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
CLARA (CITY CARE CENTER		RTH DIVISION	STREET PO BOX 797			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE	
21435	Continued From pa	ige 11	21435				
	unit. During the gro room getting her ha hair care, NA-A sto ambulate from her then assisted R34 if the activity ended a anyone wanted to v and tuned the TV to remained seated in During interview on NA-A stated when I ambulatory" she wo entertainment activ simply watch than p did not participate i group because she recliner watching T R34's activity attend identified a list of act for staff to write a c indicating the reside involvement in an a indicated the follow 1. independent part 2. limited participat 3. extensive assist 4. total dependenc 5. refused 6. not available 7. observed 8. present but not o	 6/11/2015, at 10:01 a.m. R34 was "cognizant and puld often attended numerous ities, but R34 would rather participate. NA-A stated R34 in this morning's exercise espends a lot of time in the V. dance sheet dated June 2015, ctivities, and provided space ode (the numbers 0-9) ent's response to or activity. The numbers ing: rticipation tion ance se engaged 					
	 9. resident choice; 0. done twice 	and					
		ctivity attendance sheets from 2015, indicated R34 had a					

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				STREET PO BOX 797		
CLARA	CITY CARE CENTER	CLARA C	ITY, MN 5622	22		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21435	Continued From pa	age 12	21435			
	total of 489 recorded interactions, and her activity participation was as follows: "was read to, cognitive stimulant" 48 times "provided music by staff or peer or special music" 23 times "tape/CD/radio and music therapy" 32 times "outdoors/swing, garden/plants" 8 times "small group social, therapy" 11 times "therapy/rehab/physical games" 18 times "self-directed act" [activity] 78 times "TV/movie" 29 times "massage therapy, beauty shop, manicure" 8 times "sensory stimulant,b' day,coffee" 22 times "lobby" 90 times "Church service/communion" 10 times "pastoral, animal or baby visit" 13 times "One - one program & family visits" 13 times "pop visit" 68 times "hospice visits" 18 times					
	the majority of R34 "lobby," (90 times c	or 18%) ties (78 times or 16%)				
	activities director (A need due to her dia to provide for her. cognitively declining was upon admissio enjoyed music, goin small groups, and b	AD) stated R34 had an activity agnosis, and it was challenging The AD stated R34 was g, and not as engaged as she on. The AD stated R34 always ng outside, engaging her in batting the balloon. AD stated e simple "greetings" to				

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CLARA	CITY CARE CENTER		RTH DIVISION CITY, MN 5622	STREET PO BOX 797		
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21435	residents, which inc eye, and telling ther interactions lasting directed activity was his or her own, with "A resident going up waving their arms. The AD stated there documentation of R and stated R34 spe lobby time, because the stimulation in th activity staff spend Caring Place (secur calendar is only sug staff may go on the if it doesn't work, th residents want to do chose not to particip activity staff should some kind of individ over. The AD state one visits and R34 always be invited to activities During interview on activities assistant (usually two or three each staff member one hour on the Ca which meant the se three hours of direc staff typically worke to 9:30 a.m., from 3:30 to about 5 p.m	sluded "looking them in the m 'hello, which were brief a minute or two. The self s anything a resident did on out staff involvement such as, o and down the hall, and They're getting exercise."	t			

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	Continued From pa	-	21435				
	pretty good idea wh	AA-A stated staff, "Had a nat they [the residents] liked in resident had care planned					
	nursing assistant (I shift, activities in th suggested by the re have anything plan activities' staff work Thursdays for BINO place outside the s about 3 residents for play. NA-B stated play BINGO, and a and toileting, "Ther	v on 6/11/2015 at 2:52 p.m., NA)-B stated during the p.m. e secured unit were what was esidents, and the NA's don't ned. NA-B also stated the ked later on Mondays and GO, however, the BINGO took ecured unit, and usually only rom the secured unit went to R34 did not go off the unit to side from usual cares, eating, e really are no organized irred unit after supper."					
	averaged nearly 16 nearly half (48%) o interactionspop vi lobby timerequire with the resident. F consistent, organiz activity engagement as no evidence of o engagement follow	ivity record indicated she 50 contact interactions monthly, f the documented activity sists, self-directed activities and d little or no staff engagement Further, there was a lack of a ed resident invitation and at on the secured unit, as well opportunity of a structured ing the evening meal on the forded to residents elsewhere					
	updated 11/20/12, i "to provide individ programming for re	aring Place Activity Program," indicated the facility policy was dualized activity based esidents with cognitive tructured environment, on a					
	R31's quarterly MD	S dated 5/25/15, indicated					

INNESOTA DEPARTMENT OF H ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
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ME OF PROVIDER OR SUPPLIEF	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
LARA CITY CARE CENTER		RTH DIVISION CITY, MN 5622	STREET PO BOX 797			
REFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21435 Continued From p	age 15	21435				
dependent on staf locomotion on and and personal hygin R31's cognitive sk were severely imp made decisions. I in the MDS, includ Disease (a disorde that affects mover R31's annual MDS activity preference preferred reading magazines, listeni groups of people, activities, spending participating in reli R31's care plan da for R31 was, "Will (Life Enrichment fe visits, massage ar weekly and other of up for small group R31's Activities Qu 6/10/15, identified remained the sam level hasn't chang (Assessment Refe continues to move contact at times, a deeper breath as I takes in the fresh	uarterly Assessment dated "Activities attendance has the (to 0-7) also the participation ed much since the last ARD prence Date). He [R31] this arms about, will make eye a rare smile or a word, and a he is taken outdoors as he					

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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CLARA	CITY CARE CENTER		RTH DIVISION CITY, MN 5622	STREET PO BOX 797		
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21435	Continued From pa	ige 16	21435			
	against one anothe	r and against his abdomen.				
	was in bed lying on was in constant mo down and back and hitting the other. A lying on his right sid swinging his right a forth, often hitting h	on 6/10/15, at 6:59 a.m. R31 his left side. His right arm ovement, swinging up and d forth and often one arm was t 9:26 a.m. R31 was in his bed de with his eyes closed rm up and down and back and his other arm. At 12:25 p.m. in the dining room and staff unch.				
		on 6/11/15, at 1:14 p.m. R31 neelchair outside of his room.				
	stated the staff do n NA-D stated she be in bed because, "W do?" NA-D stated f for residents who h but R31 had severe isn't a lot of activity R31 does not have	6/10/15, at 12:57 p.m. NA-D not do much activity with R31. elieved R31 spent a lot of time /hat else is there for him to the facility had a lot of activities ave no cognitive impairment, e cognitive impairment so there for him to do. NA-D stated a TV (television), and stated rep him off his bottom, so he y activities.				
	stated she was not activities, and state	6/10/15, at 2:07 p.m. NA-E aware of R31 attending any d R31 cannot do anything with no cognitive ability to go to any				
	from March 2015, t identified a list of a staff to document "	dance Sheet were reviewed hrough May 2015, which ctivities and provided space for codes" for each one to identify vement in the activity as				

S5IN11

If continuation sheet 17 of 30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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CLARA CITY CARE CENTER			STREET PO BOX 797		
		CITY, MN 5622			
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21435 Continued From pa	age 17	21435			
following activities 1 2015:	ation, tance, ce, Engaged, e, ed R31 had attended the from March 2015, through Ma	y			
"Taped Stories" one engaged; "Crafts/Art" attende "Dining Music" atte "Special Music" atte "Staff/Peer Music" at "Tape/CD/Radio" at "Music Therapy" at "Outdoors/Swing" a "Small Group Thera "Small Group Socia "Intergenerational" "Intervention" atten "Self-Directed Act"	led one time; ion" attended one time; e time, present but not ed one time; nded 19 times; ended two times; attended four times; tended 13 times; attended two times; apy" attended eight times; al" attended one time; attended one time; ded five times;				
"Bird Watching" att "Massage Therapy "Sensory Stimulatio	ended one time; " attended 13 times; on" attended 11 times; ended two times, extensive				

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21435	Continued From pa	age 18	21435			
	"B/day/Coffee Party" attended one time; "Lobby" attended 74 times; "Special/Holiday Party" attended one time; "Bible Study" attended three times; "Church Service" attended four times; "LEEP" attended 16 times; "One-One Program" attended nine times; "One-One Social" attended two times; "Pop Visits" attended 25 times; "Med Visit In or Out" attended 3 times. The March 2015, through May 2015, attendance					
	at activities was "S	e majority of R31's attendance elf-Directed Acts" which ng his arms up and down, isits".				
	stated R31 had mc R31's arm moveme exercise and docur activity on R31's ac are unsure if R31's	n 6/10/15, at 2:18 p.m. AD-A ostly bedside activities, and ents are considered an mented as a self-directed ctivity log. AD-A stated they a activities are effective, s not communicate.				
	resident had seven was understood an others, had difficult was legally blind wi frequently incontine required assistance R58 had behaviors disorganized thinki	dated 9/22/14, indicated the e cognitive impairment, usually dusually able to understand ty putting sentences together, ith a visual field deficit, ent of bowel and bladder, and e for all activities of daily living. s including inattention, ng, physical behavior toward care, and wandering.				
	Assessment dated interests included of	are Center Activity Interest 5/18/13, indicated R58's cards and games, baking, d sewing, dancing, baseball, a				

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21435	Continued From pa	age 19	21435				
	church, concerts, v movies, news, and	ps to the casino, parades, isiting family and peers, comedies. R58's vision was aired indicating she could only					
	behavioral symptom paranoid statement aggression, wande planned goals for F agitation, physical a paranoid statement transfers through th Avoid over-stimulat Divert behavior by: activities." R58's ca 9/30/14, identified s preferences as May resident goes back confused. The resid cards, dominoes, b dancing, baseball, t and socials. The ca R58 will participate ability related to vis impairments at larg attends each day. S the resident goes b from young child he children. Staff was	ted 10/10/2013, indicated ns exhibited by delusions, ts, physical and verbal ring, and rummaging. Care 858 was to, "Exhibit decreased and verbal aggression, ts, exit seeking, and self ne following approaches: tion (e.g., noise, crowding), providing meaningful are plan for activities dated strengths, needs and cular degeneration, and and forth in time, and is dent enjoyed in the past bingo, taking, knitting, sewing, music, reading, church, TV, are planned goals included in activities to the best of her ion, cognitive, and mobility ge and small groups that she Staff was directed to provide ance to and from her de prompts and cues for both e impairments, and be aware to read to her and turn on mes for her to listen to.					
	Sheets reviewed fro	are Center Activity Attendance om March 2015, to June 2015, larly participated in the					

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21435	Continued From pa	ge 20	21435			
	days. Sitting in the lobby days. Self directed activity While R58's assess listening to the Minn evidence this activity During observation residents on the un unit, and no activitie time. During observation activities staff was p engaging residents was pacing the unit activity. During observation activities were in pr residents on the un wandering around t engagement with si unit. During observation activities on the un wandering around t engagement with si unit.	listening to a compact disc 36 (common area on unit) 75 y 77 days. sment indicated she enjoyed nesota Twins, there was no ty was offered. on 6/9/15, at 3:55 p.m., all it were sitting or pacing the es were in progress at this on 6/10/15, at 9:22 a.m., oresent on the secured unit in a balloon toss game. R58 and was not participating in on 06/10/15, at 2:32 p.m., no ogress on the unit. All the it were sitting in chairs or he unit with no direction or taff. R58 was pacing on the on 6/10/15, at 2:33 p.m. R58 ir in the day room, facing the a cooking show on the TV, looking straight ahead and not				
	was pacing around wiping the window s	on 06/10/15, at 2:38 p.m. R58 the common area of unit, sill and table with her hands. p of coffee, and R58				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00061	B. WING		06/11/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CLARA (CITY CARE CENTER		RTH DIVISION CITY, MN 5622	STREET PO BOX 797		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21435	Continued From par immediately walked full coffee cup on to to pace the unit. During observation entered the secured room where the res morning meal, and residents in the dini completed in four m left the unit. During observation (AA)-C entered the exercise group. R5 activity. At 9:18 a.m after completing ac in the common area During interview on stated Activity staff hour every morning about three hours of through Saturday, t hitting the balloon, p and going outside. AA-B stated anythir is considered a self wandering on the u During interview on stated R58 did not p unit. She stated on cognitive stimulatio residents try to finis	ge 21 d over to the piano, placed the op of the piano, and continued on 6/11/15, at 8:41 a.m. AA-C d unit, went in to the dining idents were eating their read devotions to the ing room. This activity was ninutes at which time (AA)-C on 6/11/15, at 8:54 a.m., unit and led a video taped a did not participate in the a., activity aide left the unit tivity. R58 was sitting in a chai a, not engaged in the activity. 6/10/15, at 2:22 p.m. (AA)-B go to the secured unit for an , and are usually in the unit laily. AA-B stated on Monday hey do activities including olaying kick ball, doing trivia, For self directed activities, ng a resident is doing willingly directed activity, including	21435 r			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00061	B. WING		06/	06/11/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
CLARA	CITY CARE CENTER		RTH DIVISION	STREET PO BOX 797			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21435	Continued From pa	age 22	21435				
	During interview on 06/11/15, at 1:21 p.m. NA-C stated R58 likes to dance, enjoys doing memory games, folding and cleaning, enjoys music, will bat the balloon, ball toss, ball kick, likes to sit outside, and likes animals.						
	to 6/11/15, the resident to 6/11/15, the residence of the participating in any	servations of R58 from 6/8/15, dent was not observed of the activities she was according to the activity staff.					
	stated R58 will do a	n 06/11/15, at 3:44 p.m. AD activities if she is in the the activity staff will go back					
	resident had severe required assistance living, had minimal impaired vision, ha	dated 4/13/15, indicated the e cognitive impairment, e with all activities of daily difficulty with hearing, highly d behaviors including verbal n of care, and wandering daily.					
	Initial Assessment expressed interest puzzles, baking, ne sewing, dancing, va gardening, parades	are Center Activity Long Term dated 1/29/14, indicated R62 in cards and games, jig saw eedle work, quilting and arious music, books, s, wheeling outside, watching sion, liked dogs and cats, and peers.					
	had moderate to se periods of crying, a hallucinations, refu of cares with interv	ed 9/30/2014, indicated R62 evere cognitive impairment with gitation, delusions, sal of medications, and refusal entions including to avoid .g., noise, crowding), provide					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00061	B. WING		06/	06/11/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
CLARA (CITY CARE CENTER		RTH DIVISION	STREET PO BOX 797			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21435	Continued From pa	age 23	21435		1)		
21433	restlessness. Resid likes to have her pu is seated where co observation is poss psychosocial well-b the resident enjoye to, reminiscing, sm sensory, and social was to stay in group time and to socializ peers. Care planne provide prompts, cu make simple concis time for compreher encourage favorite to one to keep her 10 minutes.	es as appropriate to decrease dent enjoyed sorting things, urse, and ensure the resident nstant or near constant sible. R62's care plan for being and activities indicated d music, visiting, being read all groups, physical games, I activities. The activity goal p activities for 10 minutes at a te appropriately with staff and d interventions include: ues and redirection as needed se statements, provide extra nsion and response, group activities, and work one interest in group activities for	,				
	Attendance Sheet I June 2015, indicate following activities: Being read to 26 da Staff/peer music or days. Sitting in the lobby days.	listening to a compact disc 22 (common area of unit) 60	2				
	was sitting in her w common area of th						
	During observation was in her wheel cl	on 6/10/15, at 9:22 a.m. R62 nair sitting in the common area d there were no activities in					

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COM	PLETED	
	00061		B. WING		06/	11/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CLARA	CITY CARE CENTER		RTH DIVISION CITY, MN 5622	STREET PO BOX 797		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21435	Continued From pa	age 24	21435			
		on 6/10/15, at 9:27 a.m., R62 rch off the unit by an activity				
	was seated in her warea of the secured shirt and had her secured	on 6/10/15, at 2:33 p.m. R62 wheel chair in the common d unit and was pulling on her weater pulled off. There was on during this observation.				
	AA-C entered the c and read the daily c	on 6/11/15, at 8:41 a.m., lining room of the secured unit devotions during the breakfast vas completed at 8:45 a.m., 4 AA-C left the unit.				
	entered the unit an group. R62 did not	on 6/11/15, at 8:54 a.m. AA-C d led a video taped exercise participate in the activity, and e activity and left the unit at				
	was sitting in the ha her wheel chair and herself down to the there facing the exi 5 minutes. During t were observed wall	on 6/11/15, at 2:45 p.m. R62 allway of the secured unit in d was crying. R62 propelled end of the hall and remained t door crying for an additional his time, three staff members king past her, however, no ntervene or engage R62 in any	,			
	stated R62 attends the birthday party o balloon and particip memory games. Sh unable to participat	a 6/11/15, at 9:37 a.m. NA-C mass on Wednesday, goes to f the month, will bat the bate in ball toss, and does ne stated sometimes R62 is e. Staff offer to bring her to e secured unit and sometimes				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00061	B. WING		06/	11/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
CLARA	CITY CARE CENTER		RTH DIVISION XITY, MN 5622	STREET PO BOX 797		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21435	she doesn't want to back due to agitation During interview on stated, R62 cries, "u give her blankets, h stated R62 enjoys h likes to dig through rummage through of During interview on stated R62 had bee crying since staff go stated staff will try to give her medication however, she was n resident enjoyed or distract her when sl During interview on stated R62 had bee from her nap about unsure what staff co upset, and was una enjoyed or what inte appropriate. During interview on stated R62 liked bir when she was adm the resident was no activities anymore. directed activities in take things from on up to residents and	 go, or she goes and comes on. 6/11/15, at 1:16 p.m. NA- A Quite a bit," and staff try to heat pads, and food. NA-A having her back scratched and her purse and loves to drawers. 6/11/15, at 2:45 p.m. NA-B en wandering in the hallway of her up from her nap. NA-B or repositon the resident and her sure what activities the what could be tried to try to 		DEFICIENC	Υ)	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED			
		00061	B. WING		06/	06/11/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
CLARA C	CITY CARE CENTER		RTH DIVISION CITY, MN 5622	STREET PO BOX 797 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21435	Continued From pa	ge 26	21435				
	Activity Department 6/22/10: "It is the po Center to have an of that shall be design residents for occup maintenance." The outlined in the polic create a normal livi compatible with the residents, The resid involved in his own activity program that	abeled Clara City Care Center t Policy And Procedure, dated blicy of the Clara City Care organized activities program hed to meet the needs of all ation, diversion and following procedures are by: The activities program shall ng environment that is a needs and interests of the dent shall be encouraged to be care through a purposeful at allows him to function at his mental, social and emotional					
	6/24/10, included, " Care Center to serv and those who do r	tled 1-1 Program, dated It is the policy of the Clara City ve low functioning residents not come to group activities, o]., preferences, disease, bed	,				
	The director of nurs inservice staff rega offered their preferr	THOD OF CORRECTION: sing or designee could rding ensuring residents are red activities and being provide d them, then audit to ensure	9				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
22000		6.557 Subd. 14 (a)-(c) tment of Vulnerable Adults	22000			7/21/15	
		prevention plans. (a) Each e health agencies and					

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DAT	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		00061	B. WING		06/	11/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
	CITY CARE CENTER	1012 NOF	RTH DIVISION	STREET PO BOX 797		
		CLARA C	ITY, MN 5622	2		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From pa	ge 27	22000			
		dant services providers, shall				
		ce an ongoing written abuse				
		ne plan shall contain an				
	assessment of the	physical plant, its				
	environment, and its population identifying					
	factors which may encourage or permit abuse,					
	and a statement of specific measures to be taken					
	to minimize the risk of abuse. The plan shall comply with any rules governing the plan					
	promulgated by the licensing agency.					
	(b) Each facility, including a home health care					
	agency and personal care attendant services					
	providers, shall develop an individual abuse					
	prevention plan for each vulnerable adult					
	residing there or receiving services from them.					
	The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other					
	vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the					
		t person and other vulnerable				
		poses of this paragraph, the				
	term "abuse" includ	es self-abuse.				
	(c) If the facility,	except home health agencies				
		attendant services providers,				
	knows that the vulnerable adult has committed a					
	violent crime or an act of physical aggression					
		ndividual abuse prevention				
		e measures to be taken to				
		at the vulnerable adult might				
		ected to pose to visitors to the outside the facility if				
	facility and persons outside the facility, if unsupervised. Under this section, a facility knows					
		It's history of criminal				
		sical aggression if it receives				
	such information fro	om a law enforcement				
	authority or through					

Minnesc	ta Department of He	alth						
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00061	B. WING		06/11/20	015		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
CLARA (CITY CARE CENTER		RTH DIVISION STREET PO BOX 797 CITY, MN 56222					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE CC	(X5) DMPLETE DATE		
22000	Continued From pa	ge 28	22000					
		ther health care provider, or gassessments of the						
	by: Based on interview facility failed to imp policy to ensure bac completed and curr	ent is not met as evidenced and document review, the lement the abuse prohibition ckground studies were rent for 1 of 5 new employees records reviewed for		Corrected				
	Findings include:							
	Center Abuse Previndicated measures risk of abuse, inclue background check "Employees shall n	ty policy titled Clara City Care ention Plan dated 9/08, to be taken to minimize the ding all employees to have a initiated at hire, and directed, ot have direct contact with he outcome of the background						
	6/11/15, indicated D a background Stud however, the result were not received b orientation in the fa working in the facili background study s During interview on Business office ass	6/11/15, at 1:35 p.m. ociate (BA)-A stated (DA)-A's						
	background check	was never submitted to the						
Minnesota D	epartment of Health							