DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		ICARE/MEDICA I - TO BE COM						-		VEE8 ity ID: 00842	
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245551 2.STATE VENDOR OR MEDICAID NO. (L2) 908340500	0.	3. NAME AND ADI (L3) CLARKF (L4) 805 FIFT (L5) CLARKF	FIELD CARI H STREET,	E CEN	158	(L6)	56223	4. TYPE OF 1. Initial 3. Termina 5. Validati 7. On-Site	ntion on	<u>7</u> (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> 13 PTIP	(L7)	22 CLIA		visit vey After Compl		
 6. DATE OF SURVEY 04/0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	9/2014 (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 HOSPI	ICE		FISCAL YEA	R ENDING DA /30	TE: (L35)	
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 	48 (L18) 48 (L17)	 10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On: X_1. Acceptable POC B. Not in Compliance with Program Requirements and/or Applied Waivers: 				And/Or Approved Waivers Of The Following Requirements: 2. Technical Personnel 6. Scope of Services Limit 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 8. Patient Room Size 5. Life Safety Code 9. Beds/Room * Code: A1 *					
14. LTC CERTIFIED BED BREAKDOWN					15. FACILIT	TY MEET	ſS				
18 SNF 18/19 SNF 48 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) ((1) or 186	1 (j) (1):	(L	.15)		
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):								
See Attached Remarks											
17. SURVEYOR SIGNATURE		Date :			18. STATE	SURVEY	Y AGENCY API	PROVAL		Date:	
Mary Rogers, HF			4/22/2014	(L19)	Kate JohnsTon, Enforcement Specialist 4/22/2014 (L20)						
	PART II - TO								4.0570)		
 DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Part <u>2</u>. Facility is not Eligible 	icipate (L21)		PLIANCE WITH CI ITS ACT:	VIL	21.	2. Own		al Solvency (HCF. nterest Disclosure		13)	
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEMEN	T	26. TERM	INATIO	NACTION:		(L30)	
OF PARTICIPATION 01/01/1991	BEGINNING I	DATE	ENDING DATE		<u>VOLUNTA</u> 01-Merger,	Closure	<u>_00</u>	0	NVOLUNTAR	Health/Safety	
(L24)	(L41)		(L25)				/ Reimbursemer y Termination)6-Fail to Meet A	Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATIVI A. Suspension of		(L44)		04-Other Re			0	<u>OTHER</u>)7-Provider Stat)0-Active	us Change	
(L27)											
			(L45)								
28. TERMINATION DATE:	29		30. REMAI	RKS							
	(L28)	(L31)	Posted 04/23/2014 CO.								
31. RO RECEIPT OF CMS-1539	32	OF APPROVAL DAT	E	-							
	(L32)	04/03/2014		(L33)	DETERM	AINATI	ON APPRO	VAL			

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY ID: VEE8 Facility ID: 00842

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

Page 2 Provider Number: 24-5551 Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective April 2, 2014, the facility is certified for 48 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245551

April 22, 2014

Mr. Murray Finger, Administrator Clarkfield Care Center 805 Fifth Street, Box 458 Clarkfield, MN 56223

Dear Mr. Finger:

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

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

Effective April 2, 2014, the above facility is certified for:

48 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 48 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Inston

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-3992 Fax: (651) 215-9697

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.

(Y1) Provider / Supplier / CLIA / Identification Number 245551	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/9/2014
Name of Facility		Street Address, City, State, Zip Code	
CLARKFIELD CARE CENTER		805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223	

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date (Y4) Item	(Y5	i) D	ate
ID Prefix	F0162	Correction Completed 03/11/2014	ID Prefix	F0323	Correction Completed 03/11/2014	ID Prefix	_F0431		Correction Completed 03/11/2014
Reg. # LSC	483.10(c)(8)	-	Reg. # LSC	483.25(h)		Reg. # LSC	483.60(b), (d), (e)		
ID Prefix Reg. # LSC	F0441 483.65	Correction Completed 03/11/2014	Reg. #		Correction Completed	Rea #			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed	Reg. #			Correction Completed
ID Prefix Reg. # LSC		Correction Completed 			Correction Completed				Correction Completed
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			Reg. #			Correction Completed
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:		D	ate:	
State Agency Reviewed By CMS RO		KJ/PK By	4/22/20 Date:	014 Signature of Surve	2795 <u>:</u> yor:	5	D	<u>4/9</u> ate:	/2014
Followup to Survey Completed on: 2/12/2014						eficiencies. Was CMS-2567) Sent	to the Feeility 2	YES	NO

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00842	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/9/2014	
Name	of Facility		Street Address, City, State, Zip Code		
CLARKFIELD CARE CENTER			805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223		

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	ſ	(5) Da	te	(Y4)	ltem	(Y5)	Date	(Y4)	ltem	(Y5) I	Date
ID Prefix	20830	Correc Compl 03/11/2	eted	1	D Prefix	21315	Correction Completed 03/11/2014		ID Prefix	21390		Correction Completed 03/11/2014
0	MN Rule 4658.0520 Sub	p. 1				MN Rule 4658.0720 Subp.	1 A -(MN Rule 4658.08	300 Subp	. 4 A-I
LSC					LSC		_		LSC			_
0	21620 MN Rule 4658.1345	Correc Compl 03/11/2	eted	1	Reg. #				ID Prefix Reg. # LSC			
ID Prefix Reg. # LSC				1	Reg. #				ID Prefix Reg. # LSC			
ID Prefix Reg. # LSC				1	D Prefix Reg. # LSC		Correction Completed 		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC				1	D Prefix Reg. # LSC		_		ID Prefix Reg. # LSC			
Reviewed By State Agency		d By PK/I	KJ	Date	 /22/20	Signature of Surv	eyor: 2795.	5			Date: 4/	/9/2014
Reviewed By	Reviewe	d By		Date	:	Signature of Surv	eyor:				Date:	
CMS RO												
Followup to Survey Completed on: 2/12/2014					Uncorrecte				a Summary of to the Facility?	YES	NO	
STATE FORM	I: REVISIT REPORT	(5/99)				Page 1 of 1				Event ID: V	EE812	

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245551	(Y2) Multiple Constr A. Building B. Wing		N BUILDING 01	(Y3) Date of Revisit 4/7/2014			
Name of Facility		Street Address, City, State, Zip Code						
CLARKFIELD CARE CENTER				805 FIFTH STREET, BOX 458				
				CLARKFIELD, MN 56223				

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

(Y4) I	tem		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	ltem	(Y5)	Date
				Correction					Correction					Correction
	 -			Completed 02/13/2014					Completed 04/02/2014		ID Deefer			Completed 02/14/2014
				02/13/2014					04/02/2014					02/14/2014
	0	NFPA 101 K0047					NFPA 101 K0056					NFPA 101 K0073		_
	130	K0047				130					130	K0073		_
				Correction					Correction					Correction
				Completed					Completed					Completed
ID F	Prefix					ID Prefix					ID Prefix			
R	leg. #					Reg. #					Reg. #			
	LSC					LSC					LSC			_
				Correction					Correction					Correction
ID F	Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
	leg. #			-					-					
						LSC					LSC			
										+				
				Correction					Correction					Correction
				Completed					Completed					Completed
ID F	Prefix					ID Prefix								
	leg. #					Reg. #					Reg. #			
	LSC					LSC					LSC			
				Correction					Correction					Correction
				Completed					Completed					Completed
ID F	Prefix					ID Prefix					ID Prefix			
R	leg. #					Reg. #					Reg. #			
	LSC					LSC					LSC			_
					_									
Review	ed By		Reviewed By			te:	Signature of	Surve	•				Date:	
State A	gency		, I	PS/KJ	4	/22/20	4		2720	0			4/2	7/2014
Review			Reviewed		Da	te:	Signature of	Surve	yor:				Date:	
E Ms R	0		Ву											
Followup to Survey Completed						-				a Summary of				
on:	on: 2/12/2014					Unco	rrecte	d Deficiencies	(CMS	-2567) Sent	to the Facility?	YES	NO	

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245551	(Y2) Multiple Constr A. Building B. Wing		DING TWO	(Y3) Date of Revisit 4/7/2014		
Name of Facility		Street Address, City, State, Zip Code					
CLARKFIELD CARE CENTER				805 FIFTH STREET, BOX 458			
				CLARKFIELD, MN 56223			

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

(Y4) Item	(Y5) Date	(Y4)	ltem	(Y5)	Date	(Y4)	ltem		(Y5)	Date
		Correction				Correction					Correction
ID Drofiv		Completed 04/02/2014		D Drofiv		Completed		ID Drofiv			Completed
•	NFPA 101 K0056	-		Reg. #				Reg. #			
		_					+				_
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix		_		D Prefix		-		ID Prefix			
Reg. #		_		Reg. #				Reg. #			
							<u> </u>	LSC			
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix		_	1	D Prefix		-		ID Prefix			
Reg. #		_		Reg. #				Reg. #			_
LSC		_		LSC				LSC			_
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		Correction Completed				Correction Completed					Correction Completed
ID Prefix			1	D Prefix				ID Prefix			
Reg. #		_		Reg. #				Reg. #			
LSC		-		LSC				LSC			_
Reviewed By			Date):	Signature of Surve	yor:	1			Date:	
State Agency	, ^{By} P	S/KJ	4	/22/2014		27200				4/7/	/2014
Reviewed	Reviewed		Date):	Signature of Surve	yor:				Date:	
Êlis ro	Ву										
Followup to Survey Completed					•	Uncorrected D			-		
on: 2/12/2014					Uncorrecte	d Deficiencies	(CMS-	2567) Sent t	o the Facility?	YES	NO

DEPARTMENT OF HEAD	LTH AND HUMAN SE	RVICES				CEN	TERS FOR	MEDICARE &	MEDICAII	D SERVICES	
	MED	ICARE/MEDICA	ID CERTIFIC	ATION A	ND TRAN	SMIT	ΓAL		ID: VE	E8	
	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY	AGE	NCY		Facility	ID: 00842	
1. MEDICARE/MEDICAID PROV (L1) 245551 2.STATE VENDOR OR MEDICA (L2) 908340500		^(L4) 805 FIFT	DRESS OF FACILI FIELD CAF FH STREET FIELD, MN	RE CEN F, BOX 4	458	(L6)	56223	4. TYPE OF A 1. Initial 3. Terminatio 5. Validation	2. 1 n 4. 6.	2 (L8) Recertification CHOW Complaint	
5. EFFECTIVE DATE CHANGE	OF OWNERSHIP	7. PROVIDER/SUP	PLIER CATEGOR	Y	02	(L7)		7. On-Site Vis		Other	
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP		22 CLIA	8. Full Survey After Complaint			
 6. DATE OF SURVEY 8. ACCREDITATION STATUS: 	02/12/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC			FISCAL YEAR H	ENDING DATE	: (L35)	
0 Unaccredited 1	TJC Other	04 SNF	08 OPT/SP	12 RHC	16 HOSPI	CE		09/30)		
11LTC PERIOD OF CERTIFICAT	FION	10.THE FACILITY	S CERTIFIED AS:								
From (a):		X A. In Complian						e Following Requiren	nents:		
To (b) :		Program Ree Compliance	2. Technical Personnel6. Scope of Services Limit3. 24 Hour RN7. Medical Director								
12. Total Facility Beds	48 (L18)	X 1. Acceptable POC 4. 7-Day RN (Rural SNF) 5. Life Safety Code						t Room Size			
13. Total Certified Beds	48 ^(L17)		bliance with Program nts and/or Applied V		* Code: B (L12)						
14. LTC CERTIFIED BED BREAK	CDOWN	1			15. FACILI	ΓY MEE	TS				
18 SNF 18/1	9 SNF 19 SNF	ICF	IID		1861 (e)	(1) or 18	61 (j) (1):	(L15)		
	48										
(L37) (I	L38) (L39)	(L42)	(L43)								
16. STATE SURVEY AGENCY R	EMARKS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):								
See Attached Remarks											
17. SURVEYOR SIGNATURE		Date :			18. STATE	SURVE	Y AGENCY AP	PROVAL	D	ate:	
Mary Rogers, HPI	R Social Work Spe	cialist (03/13/2014	(L19)	Kate J	ohns	<u>Ton, Enfc</u>	prcement Sp	ecialist	04/2/2014 (L20)	
	PART II - TO	BE COMPLETEI) BY HCFA RH	EGIONAL	OFFICE	OR SI	NGLE STAT	E AGENCY			
 DETERMINATION OF ELIG 1. Facility is Eligib 			PLIANCE WITH C TS ACT:	IVIL	21.	2. Ow		al Solvency (HCFA-2 nterest Disclosure Str	,	1	
2. Facility is not E	ligible (L21)										
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	ENT	26. TERM	INATIO	NACTION:		(L30)		
OF PARTICIPATION 01/01/1991	BEGINNING	DATE	ENDING DATI	E	<u>VOLUNTA</u> 01-Merger,		00		/OLUNTARY Fail to Meet Hea	lth/Safety	
(L24)	(L41)		(L25)		02-Dissatis	faction W	V/ Reimbursemer	nt 06-	Fail to Meet Agr	eement	
25. LTC EXTENSION DATE:	27. ALTERNATIV	E SANCTIONS					ry Termination	OT	HER		
		04-Other Re	eason for	Withdrawal		Provider Status Active	Change				
(L	27) B. Rescind Sus	pension Date:	(L44)					00-	Active		
			(L45)								
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMA	RKS					
	(7.00)	03001		a an							
	(L28)			(L31)							
31. RO RECEIPT OF CMS-1539	32	DETERMINATION C	F APPROVAL DAT	ГЕ							

(L33)

DETERMINATION APPROVAL

(L32)

CENTERS FOR MEDICARE & MEDICAID SERVICES

Facility ID: 00842

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

C&T REMARKS - CMS 1539 FORM

Page 2 Provider Number: 24-5551 Item 16 Continuation for CMS-1539

At the time of the standard survey completed 02/12/14, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

STATE AGENCY REMARKS



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted February 28, 2014

Mr. Murray Finger, Administrator Clarkfield Care Center 805 Fifth Street, Box 458 Clarkfield, Minnesota 56223

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5551024

Dear Mr. Finger:

The above facility was surveyed on February 9, 2014 through February 12, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Clarkfield Care Center February 28, 2014 Page 2

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

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

When all orders are corrected, the order form should be signed and electronically submitted 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 Sarah Grebenc at (320) 223-7365 or email at: sarah.grebenc@state.mn.us.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Original - Facility Licensing and Certification File

5551s14lic.rtf

Clarkfield Care Center February 28, 2014 Page 3 Clarkfield Care Center February 28, 2014 Page 4

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245551	B. WING			02/	12/2014
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLARKF	IELD CARE CENTER				05 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0	000			
	as your allegation of Department's acce	of correction (POC) will serve of compliance upon the otance. Your signature at the age of the CMS-2567 form will tion of compliance.					
F 162	revisit of your facilit validate that substa regulations has bee your verification. 483.10(c)(8) LIMITA	acceptable POC an on-site y may be conducted to intial compliance with the en attained in accordance with	F 1	62			3/11/14
SS=D	personal funds of a services for which p Medicaid or Medica deductible and coin facility may charge services that are m	impose a charge against the resident for any item or bayment is made under are (except for applicable usurance amounts). The the resident for requested ore expensive than or in services in accordance with					
	charges for items a Medicaid has paid. participation in the who accept, as pay plus any deductible	ct the prohibition on facility nd services for which See §447.15, which limits Medicaid program to providers ment in full, Medicaid payment , coinsurance, or copayment n to be paid by the individual.)					
	Medicaid stay, facil for the following cat	of a covered Medicare or ities may not charge a resident tegories of items and services: s required at §483.30 of this					
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						03/05/2014

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: 03/07/2014

		AND HUMAN SERVICES			FORM	03/07/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245551	B. WING		02 / ⁻	12/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CLARKF	IELD CARE CENTER			805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 162		ige 1 required at §483.35 of this	F 16	52		
	subpart. An activities progra this subpart. Room/bed mainten Routine personal hy required to meet the including, but not lir comb, brush, bath s specialized cleansin treat special skin pr razor, shaving crea denture adhesive, o moisturizing lotion, swabs, deodorant, i supplies, sanitary n towels, washcloths, counter drugs, hair bathing, and basic p Medically-related so §483.15(g) of this s Listed below are ge examples of items a may charge to resid requested by a resi resident that there of payment is not mad Telephone. Television/radio for Personal comfort ite materials, notions a Cosmetic and groot excess of those for Medicaid or Medica Personal clothing. Personal reading m	m as required at §483.15(f) of ance services. ygiene items and services as e needs of residents, mited to, hair hygiene supplies, soap, disinfecting soaps or ng agents when indicated to roblems or to fight infection, m, toothbrush, toothpaste, denture cleaner, dental floss, tissues, cotton balls, cotton incontinence care and apkins and related supplies, hospital gowns, over the and nail hygiene services, personal laundry. ocial services as required at subpart. eneral categories and and services that the facility dents' funds if they are dent, if the facility informs the will be a charge, and if de by Medicare or Medicaid: personal use. ems, including smoking and novelties, and confections. ming items and services in which payment is made under are.				

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/07/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION NG	(X3) DATE	E SURVEY PLETED
		245551	B. WING _		02/ ⁻	12/2014
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
CLARKF	IELD CARE CENTER			805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223		
(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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 162	the scope of the act under §483.15(f) of Noncovered specia privately hired nurse Private room, except required (for exampt control). Specially prepared of instead of the food of facility, as required The facility must no her representative) requested by the re require a resident (or request any item or admission or contin inform the resident requesting an item will be made that the item or service and This REQUIREMEN by: Based on observat review, the facility fa adhesive during a N 1 of 3 residents (R4 and dental services Findings include: R4 was re-admitted hospitalization for a the hospital dischar	entertainment offered outside thivities program, provided this subpart. I care services such as es or aides. of when therapeutically ole, isolation for infection or alternative food requested generally prepared by the by §483.35 of this subpart. t charge a resident (or his or for any item or service not sident. The facility must not or his or her representative) to services as a condition of ued stay. The facility must (or his or her representative) or service for which a charge ere will be a charge for the what the charge will be. NT is not met as evidenced ion, interview and document ailed to provide denture Medicare or Medicaid stay, for by who were reviewed for oral .		62 Tag 0162 Corrective Action: Denture adhesive was obtaineresident #4. Staff was instructed ouse and it was added to the care pl A review of the Facility s Adm policy was reviewed and the facility now purchase stock denture adhesise provided for residents during the at the facility as deemed appropriat Speech Therapy. 	on its lan. ission will sive to eir stay	

Facility ID: 00842

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		& MEDICAID SERVICES				0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		245551	B. WING _		02/	12/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	, ZIP CODE	
CLARKF	IELD CARE CENTER			805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
F 162	Continued From pa	ge 3	F 16			
	2/6/14, revealed R4 propelling food to b eat meat, if cut into note included plans which included ensu- place with adhesive Additionally, instruc denture was in plac communicated via a be Followed by Pati dated 2/7/14. The f dining room board, board, as well as to On 2/9/14, at 3:29 p	y inpatient progress note dated had difficulty chewing and e swallowed. She was able to small pieces. The progress for swallowing strategies uring her upper denture was in e prior to oral intake. tions to ensure the upper se with adhesive were a Safe Swallow Strategies to ient, Staff and Visitors form form was copied to the facility the nursing assistant (NA) be passed along in report. o.m. R4 was observed to have ure plate and indicated her		 Corrective Action as it applies to othe residents: 1. All residents will receive an oral assessment on admission. Speec Therapy will be referred as deemed appropriate 2. All Therapy recommendations or added to the care plan and passed facility staff for implementation. 3. All recommended assistive deviand interventions will be implement ordered. The facility will ensure the are obtained and/or provided. 4. Nursing staff will be educated or maintaining necessary supplies and communicating need to restock at a Mandatory meeting(s)scheduled for March 10 and March 11, 2014. 		
	oral cares complete brush her lower tee NA-D proceeded to plate. No denture a dentures prior to R4 On 2/11/14, at 11:42 assisted by speech ST-G began to feed noted that R4's teet she only had molars denture plate, and H lower mouth. ST-G plate and left the ro adhesive to secure ST-G came back to talked to registered	a.m. R4 was observed during ed by NA-D. NA-D cued R4 to th and rinse out her mouth. hand R4 her upper denture adhesive was applied to the 4 putting them in her mouth. 2 a.m. R4 was observed to be therapist (ST)-G. When d R4 bites of her meal, she th were loose and indicated s on the top due to the full had no teeth in the back of her if then removed R4's denture om to inquire about denture the denture plate in place. the room, indicated she nurse (RN)-A and the ordered in as there was none		Reoccurrence will be p 1 Denture adhesive y maintained as a stock y 2 DON or Designee y care plans and ensure available and in place f requiring its use. Correction will be moni 1. DON or designee 2. DON will report the Committee quarterly ar	will be ordered and supply. will audit resident that adhesive is for all residents tored by: e findings to the QA	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/07/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRU	CTION	(X3) DAT	E SURVEY IPLETED
		245551	B. WING _			02/	12/2014
NAME OF F	ROVIDER OR SUPPLIER				RESS, CITY, STATE, ZIP CODE		
CLARKF	ELD CARE CENTER				FREET, BOX 458 _D, MN 56223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECT CH CORRECTIVE ACTION SHOL S-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 162	feeding R4 her mea out of R4's mouth, a pudding instead. S R4 could have chew During interview on stated it was the us pharmacy to have of resident when need did not routinely hav use when needed. During interview on director of nursing (procedure to order pharmacy for reside the adhesive was th resident. The DON "probably should" h adhesive on hand; I been done this way facility. During interview on social worker (SW) department ordered denture adhesive. thought it was writte that denture adhesi billed to the residen Review of the facilit revealed that items cups, denture clear toothpaste were pro- not include denture	lity. ST-G had difficulty at due to the dentures being and proceeded to feed her T-G said with the dentures in, wed her food better. 2/11/14, at 12:06 p.m. NA-A ual procedure to call the denture adhesive sent for a led. NA-A verified the facility we this in stock for resident 2/12/14, at 8:25 a.m. the DON) said it was the usual denture adhesive from the ents that needed it, and that nen billed by pharmacy to the indicated that the facility ave kept some denture however, it had "just always ," since she had worked at the 2/12/14, at 8:40 a.m. the -A stated that the nursing d personal supplies like SW-A further stated she en in the admission agreement ve was not covered and was t. y's undated admission booklet such as Kleenex, denture her, toothbrushes, and ovided. The items covered did adhesive.	F 16				
F 323			F 32	3			3/11/14

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245551	B. WING			02 /1	2/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	IELD CARE CENTER			8	05 FIFTH STREET, BOX 458		
CLANK	IELD GARE GENTER			С	LARKFIELD, MN 56223		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323 SS=D	HAZARDS/SUPER The facility must en environment remain as is possible; and	-	F 3	23			
	by: Based on observat review, the facility fa causative factors to 1 of 3 residents (R4 Findings include: R4's medical record lacked analysis of F 11/18/13, 12/25/13, causative factors, ir meaningful interver implemented lacked needs prior to self-t re-assessment of b evaluation of her er to reach for things, or provision of incre- her impaired cognit Interventions also la effectiveness. Review of R4's fall i assessments from revealed the followi	owel/bladder needs, nvironment to reduce her need evaluation of her medications, eased direct supervision due to ion and safety judgment. acked evaluation for incident reports and 5/18/13, through 2/9/14,			Corrective Action: 1. Resident #4 care plan was rev along with the Functional Safety Assessment and Fall Risk Assessm All were updated to reflect current a appropriate interventions. Correction as it applies to other res 1. All residents will have a Function Safety and Fall Risk Assessment completed at admission, quarterly, with any significant change. A Fall will be completed following every fand Appropriate interventions will be add the resident s care plan. 2. A Post Fall Huddle will be initiated following every fall. An Incident Ref will be completed in full following every including development of an appropri- intervention to prevent further reoccurrence. Interventions will be developed by evaluating the resider patterns, toileting patterns, medicated and all other risk factors. The interv- will immediately be added to the resident s care plan. Incident Ref will include a review after 24 hours	nent. and idents: onal and Risk II. ded to red eport very fall oriate nt s ions, vention ports	

Facility ID: 00842

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PRINTED: 03/07/2014

ALEMENI	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE	SURVEY	
ID PLAN C	F CORRECTION	DENTIFICATION NUMBER:		IG	Сом	PLETED	
		245551	B. WING _		02/-	2/2014	
IAME OF	PROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP COD			
LARKF	IELD CARE CENTER			805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 323	Continued From pa	ae 6	F 32	23			
	staff heard R4 holes sitting on the floor b wheelchair (w/c) in unwitnessed. R4 s onto the floor. Com included the followi no change in physic as a result of her fa w/c, observe and re needed (PRN). No risk for future falls w The second fall rep noted R4 was found bathroom with her b stated she missed rotation of the right were noted. R4 wa and was admitted fo immediate interven went to the hospital assessment and pla independent prior to hospital for repair o added, when R4 rep oriented before fall needs. The report for falls or dates of patterns were ident	aring for help. She was found by the end of her bed with her front of her. The fall was aid she slid out of the w/c, ments noted on the report ng: isolated incident, R4 had cal or psychosocial functioning ill, brakes were working on her eassess quarterly and as interventions to minimize the were identified. ort on 9/25/13, at 8:30 a.m. d seated on the floor of her back against the wall. R4 the toilet seat. External hip and pain in the right hip is sent to the emergency room or surgical repair. No tions were implemented as R4 I. The registered nurse (RN) an of action noted R4 was to the fall and was at the f her right hip. The plan turned from the hospital, ce would have been port indicated R4 was alert and and was aware of her safety identified no potential causes other falls or incidents. No ified. The report did identify ychological risk factor for R4. dated 10/8/13, revealed a total		 RN. All Incident Reports will by the Interdisciplinary Team a meeting held Monday through A note will be made on the Fall Risk Assessment following including an analysis of the risk and interventions implemented Reoccurrence will be prevented DON or designee will aud resident chart weekly X 12 wer appropriate fall assessment ar intervention. Incident Reports will be retthe Interdisciplinary Team at S meetings Monday thru Friday. Correction will be monitored by DON or designee. DON will report audit findir QA Committee quarterly and F 	t Stand-up Friday. resident s g each fall (factors l. d by: it one eks for id viewed by tand-up /:		

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STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	. 0938-039 TE SURVEY MPLETED
		245551	B. WING		02	/12/2014
NAME OF	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	02	
CLARKF	IELD CARE CENTER			805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 323	and used her call-lia assistance. No fall assessment noted and PRN. R4's most recent ca dated 10/14/13, ind with a hip fracture a occupational therap and called appropri revealed a referral already being seen were reviewed rout and pharmacy. The reassess quarterly On 10/24/13, R4's updated with a scon notes indicated R4 of non-weight-bear The third fall report revealed the staff h she was found sittir floor, in front of her stated she just slipp was going to her sin reminding R4 she c for help. An alarm intervention to cons- injury with the fall. causes for falls incl- impaired mobility an cognition, and judg Dates of other falls, not identified. The action noted R4 ha- psychosocial functi- The plan noted R4 any further incident interventions put in	ght appropriately to request precautions were added. The to observe, reassess quarterly are area assessment (CAA) licated R4 had an isolated fall and was seen by physical and by. R4 was identified as alert ately for assistance. The CAA was not indicated as she was by therapy and her medication inely by her medical doctor e CAA instructed to observe, and PRN. fall assessment scoring was re of 65 (high risk). Summary needed continuous reminding ing restrictions for her right leg. on 11/18/13, at 4:20 p.m. eard R4 call out for help when ng in an upright position on the sink. R4 was interviewed and bed out of the chair when she nk. Interventions included could not walk alone and to ask for her chair was noted as an sider. There was no noted Risk factors and potential uded increased confusion, nd balance, impaired ment/safety awareness deficit. /incidents and patterns were RN assessment and plan of d no change in physical or oning as a result of the fall. was forgetful, but had not had s. R4 had no further	F 3	23		

Facility ID: 00842

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CENTEI STATEMENT AND PLAN C		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245551	. ,	S 8		FORM / MB NO. (X3) DATE COMI	03/07/2014 APPROVED 0938-0391 E SURVEY PLETED 12/2014
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	12/25/13, with a risk 25-point increase fr 10/13. Summary ne fallen when she trie room. R4 was iden confusion, with no f assessment instruct plan, observe and r No further fall interv The fifth fall report of indicated R4 was for front of her dresser out. R4 was noted to all extremities an where she fell. R4 dresser to get some prevent further incid use her walker whe her to use her call li device that sounded resident's weight wa w/c. Risk factors an included impaired n incontinence, impai safety awareness o identified and dates 9/25/13, with fractur 11/18/13. The RN a noted R4 had recer bearing, she had a working with physic strengthening. The sixth fall report identified R4 was for blood, her feet were pointing toward the said she thought sh gash was noted to the	lige 8 k score of 90 (high risk), a rom the previous scoring in otes included that R4 had ed to open a drawer in her nutified with intermittent further attempts to stand. The steed to continue the current reassess quarterly and PRN. ventions were implemented. on 1/5/14, at 1:15 p.m. ound by staff on the floor in . The top dresser was pulled to have good range of motion ad the w/c was six feet from stated she was going to her ething. Interventions to dents included reminding ight. A pressure alarm (a d an audible alarm when a as lifted) was placed in R4's and potential causes for falls nobility, activity intolerance, ired cognition, judgement and of deficits. No patterns were s of previous falls included re of her right hip and assessment and plan of action ntly become full weight right hip fracture, and she was cal therapy for increased f on 2/3/14, at 7:25 p.m. bund on the floor in a pool of e by the bed with her head opposite side of the room. R4 he was going to bed. A large the right forehead and temple ng. A pressure dressing and	F	323			

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		AND HUMAN SERVICES				FORM	03/07/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245551	B. WING			02/	12/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CLARKF	IELD CARE CENTER				05 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	ice pack were appli hospital for evaluati identified risk factor weakness. Dates of not identified. Pote unknown. The RN action included press brakes (a device the when a resident sto were noted as imple from the hospital. F and physical report, had been leaning for she fell forward, hitt significant laceratio Review of R4's tem hospitalization), dat for injury related to Interventions includ the appropriate heig falls precautions (un transfer belt with all devices as needed, not identify the use anti-rollback brakes During interview on licensed practical n used a sensor pad got up on her own. been forgetful lately her hand and not re them, which started was unsure if R4 wa program. She said assessments.	ed and R4 was sent to the ion. The incident report rs for falls or other incidents as of other falls and patterns were intial risk factors was noted as assessment and plan of ssure alarms and anti-rollback at locked the brakes of a w/c ood up). The interventions emented after R4 returned R4's hospital admission history , dated 2/3/14, indicated R4 orward in her wheelchair when ting her head and causing a n. porary care plan (post ted 2/7/14, revealed a potential a recent fall and weakness. led adjustment of her bed to ght, assist of two for transfers, nspecified) as needed, I transfers and assistive . The temporary care plan did of sensor alarms or s. 2/10/14, at 1:43 p.m. urse (LPN)-A indicated R4 in her chair to alert staff if she LPN-A also remarked R4 had <i>y</i> , such as holding papers in emembering what to do with d prior to the last fall. LPN-A as on a scheduled toileting	F 3	323			

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CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				FORM. MB NO.	03/07/2014 APPROVED 0938-0391 E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	. ,				PLETED
		245551	B. WING			02/	12/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CLARKF	IELD CARE CENTER				05 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	said R4's cognition currently, she was ' had been ill just price fax had been sent to have R4 seen on ro- and went to the ER physician. RN-A sat fall assessments we a fall. She added, i all disciplines Mond- indicated that input have been docume progress notes; how was done consistent thought staff toileter and after meals. R person assist with to been a one person fall on 2/3/14. During interview on assistant (NA)-A sat lot between meals a toileting program, b meals. NA-A added program but could to days, and needed to During observation was leaning forward in their wheelchair, the floor. R4 stated with LPN-E and NA identified that R4 has transfer out of her co independently since During interview on	age 10 had been more impaired, and 'really impaired." She said R4 or to her most recent fall. A to the doctor, requesting to bunds the next day, but R4 fell prior to being seen by a aid she could not say whether ere completed each time after incidents were reviewed with lay through Friday. She from those meetings would nted in the interdisciplinary wever, she was not sure this ntly. RN-A indicated that she d R4 upon arising and before N-A stated R4 was now a two ransfers. RN-A said R4 had assist prior to her most recent 2/10/14, at 2:05 p.m. nursing id R4 wore a brief, dribbled a and was not on a scheduled but staff toileted R4 after d R4 was on a walking no longer walk the last few o be "re-evaluated." on 2/10/14, at 4:50 p.m. R4 d, in a hunched over position to reach her newspaper on d she was tired. An interview A-E on 2/10/14, at 4:50 p.m. ad not attempted to self chair or attempted to get up e her hospital return. 2/11/14, at 7:45 a.m. by (OT)-C said R4 was way	F 3	23			

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		AND HUMAN SERVICES				FORM	03/07/2014 APPROVED 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245551	B. WING			02 / ⁻	12/2014
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CLARKFI	ELD CARE CENTER				05 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223		
(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
	OT-C thought they wheelchair back wh fracture. OT-C add During interview on medical doctor (MD falls due to incontin for surgery or medic that R4 had a histor things from their wh understanding R4 h fell on 2/3/14. R4 w to be independent, help. MD-E stated prior to her last fall, decreased R4's abi limitations. R4 had about a month. MD (computerized topo imaging used to create the bones and soft fall in January and B attempt to determine The CT came back During interview on therapy assistant (F on 2/10/14, with goas strength with transfe similar issues with F due to impaired cog independent with tra- During interview on director of nursing (procedure for falls w huddle within two here	paired since her head injury. had put R4 in a lower hen she was treated for the hip ded R4 had a new foot pedal. 2/11/14, at 11:34 a.m., 0)-E said R4 was at risk for ence and was not a candidate cation. MD-E further identified ry of falling when reaching for heelchair, it was their had been doing this when she vas cognitive enough to want yet did not always wait for R4 had a respiratory infection which could have further lity to recognize her been more confused for D-E had done a CT graphy, a form of x-ray eate cross-sectional views of tissues) of the head after the before the fall in February in he the cause of her confusion. with no abnormalities. 2/11/14, at 2:45 p.m. physical PTA)-D said R4 was evaluated als of improving mobility and ers. PTA-D had worked on R4's hip fracture; however, gnition, R4 was unable to be	F	323			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/07/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245551	B. WING			02 / ⁻	12/2014
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CLARKF	ELD CARE CENTER				805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223		
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	REGULATORY OR LE Continued From pa trying to eliminate a "Band-Aid" for a fall falls. The DON said filled out after falls a at standup meeting During further interv the DON said thera attend standup meetings Recommendations attend standup (act social work) were to interdisciplinary not the addition of anti- wheelchair were a r The facility's Fall Pr revealed post-fall as review of the causa medication, probab co-morbid (pertainin disorder) conditions sensory aids, the en treatment plan was 483.60(b), (d), (e) D LABEL/STORE DR The facility must en a licensed pharmac of records of receip controlled drugs in s	ge 12 darm usage as they were a l, they did not really prevent d incident reports were to be and the reports were reviewed on weekdays. view on 2/12/14, at 11:15 a.m. py did not always routinely eting, but did attend weekly with nursing. from the disciplines that did ivities, nursing, dietary and be documented in the es. The DON believed that rollback breaks to R4's result of a standup meeting. revention policy revised 9/10, ssessments were to include a tive factors such as le causes of the fall, ng to a disease process or s, mobility aid use, footwear, nvironment, and if the being followed. DRUG RECORDS, UGS & BIOLOGICALS nploy or obtain the services of cist who establishes a system t and disposition of all sufficient detail to enable an	F (CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		
	records are in order controlled drugs is r reconciled.	ion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/07/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245551	B. WING			02/ ⁻	12/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLARKF	IELD CARE CENTER				05 FIFTH STREET, BOX 458 LARKFIELD, MN 56223		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	labeled in accordan professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartmer controls, and permi have access to the The facility must pro- permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distri	ce with currently accepted les, and include the ory and cautionary e expiration date when State and Federal laws, the Il drugs and biologicals in nts under proper temperature t only authorized personnel to keys. ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit bution systems in which the inimal and a missing dose can	F 4	131			
	by: Based on observat review, the facility fa were labeled with th residents (R12), wh observed during the Findings include: On 2/11/14, at 12:3 pen (a prescription blood sugars) was facility's treatment of	NT is not met as evidenced ion, interview and document ailed to ensure insulin pens ne date opened, for 1 of 2 nose insulin pens were a medication storage review. 2 p.m. a Lantus SoloSTAR medication for the control of observed as opened, in the cart and ready for use for R12. abel to indicate the date it was			Corrective Action: 1. Insulin pen for resident #12 was dated and labeled. 2. All insulin pens were observed ensure them as labeled, and dated February 12th, 2014. Corrective Action as it applies to oth residents: 1. The Policy and Procedure for opening, labeling, and dating Insulin Insulin pens was reviewed. 2. All Licensed Nurses received a of the Policy and Procedure.	to her n and	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245551 B. WING 02/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 805 FIFTH STREET. BOX 458 **CLARKFIELD CARE CENTER** CLARKFIELD, MN 56223 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 431 Continued From page 14 F 431 opened. Licensed practical nurse (LPN)-A 3. All Licensed Nurses will be verified there was not a date on the Lantus re-educated on the Insulin Policy and SoloSTAR pen to identify when it was opened. Procedure at a mandatory meeting LPN-A confirmed the insulin pen should have scheduled for March 10 and March 11, been dated when it was opened. 2014. A review of Lantus, Full Prescribing Information revised 10/13, recommended the Lantus Reoccurrence will be prevented by: 1. DON or designee will audit all insulin SoloSTAR pen could remain in use for 28 days, once opened. The Lantus SoloSTAR pen was to and insulin pens weekly X 4 weeks, then be discarded after the 28 days, even if insulin monthly for appropriate labeling and remained in the pen. dating. Reoccurrence will be monitored by: The facility policy for Labeling/Storage of DON or designee 1. Medication revised 9/11, indicated insulin was to DON will report audit findings to the 2. be labeled with the date opened. QA Quarterly and PRN F 441 483.65 INFECTION CONTROL, PREVENT F 441 3/11/14 SS=D SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -(1) Investigates, controls, and prevents infections in the facility: (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to

FORM CMS-2567(02-99) Previous Versions Obsolete

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PRINTED: 03/07/2014

CENTE		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(¥2) MUI	TIPI	FOR OMB NO	D: 03/07/2014 M APPROVED D. 0938-0391 ATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				DMPLETED
		245551	B. WING		02	2/12/2014
NAME OF	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
CLARKF	IELD CARE CENTER				05 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	prevent the spread isolate the resident. (2) The facility musi- communicable dise from direct contact direct contact will tr (3) The facility musi- hands after each di hand washing is inc professional practic (c) Linens Personnel must han transport linens so infection. This REQUIREMEN by: Based on observat review, the facility fa handwashing techn cross-contaminatio observed during ca Findings include: On 2/11/14, at 9:08 was observed to per	of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted ee. ndle, store, process and as to prevent the spread of NT is not met as evidenced tion, interview and document ailed to ensure proper iques to prevent n for 1 of 2 residents (R4)	F 4	141	Corrective Action: 1. NAR-A was given individual education on appropriate hand washing and gloving technique. Corrective Action as it applies to other residents: 1. A handout on proper hand washing technique was given to all nursing staff. 2. All nursing staff will be re-educated and competency tested on hand washing and gloving at a mandatory staff meeting	
	wipe. The incontine NA-A finished to as wearing the soiled or resident's clean brid resident's wheelcha	ear area with an incontinent ence wipe was visibly soiled. sist the resident and while still gloves she pulled up the ef, pants, touched the air, her walker and her transfer loved the soiled gloves and			Reoccurrence will be prevented by: 1. DON or designee will perform random audits of NARs and Nurses for	

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		AND HUMAN SERVICES				FORM	03/07/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245551	B. WING	B. WING			12/2014
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLARKF	IELD CARE CENTER				05 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223		
(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 441	During an interview reported they would their hands whenew dirty activities such she should have re her hands between R4's clean items. During an interview director of nursing (should have change peri-care and befor The undated facility Control, stated glow whenever touching	on 2/11/14, at 9:18 a.m. NA-A d change gloves and wash ver going between clean and as peri-care. NA-A confirmed moved her gloves and washed the peri-care and touching on 2/11/14, at 2:25 p.m. the (DON) indicated that staff ed gloves after providing e touching any clean items. v policy, entitled Basic Infection res should be changed something dirty, such as the nen during cares and before	F 4	141	appropriate hand washing and glov weekly X 4 weeks, then monthly x 6 months. Reoccurrence will be monitored by 1. DON or designee 2. DON will report audit findings to QA Committee quarterly and PRN	6 :	

Facility ID: 00842

If continuation sheet Page 17 of 17

		AND HUMAN SERVICES		F5551023	FORM APPRO	
			r		(X3) DATE SURVE	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		6 01 - MAIN BUILDING 01	COMPLETED	
		245551	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	02/12/201	4
	PROVIDER OR SUPPLIER			805 FIFTH STREET, BOX 458		
CLARKF	IELD CARE CENTER			CLARKFIELD, MN 56223		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPL	
K 000	INITIAL COMMENT	rs	K 000			
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENTS A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.				
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.			54 m	
	Minnesota Departm Fire Marshal Divisio Clarkfield Care Cer substantial complia participation in Mec Subpart 483.70(a), 2000 edition of Nat Association (NFPA)	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, neter was found not in ince with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection) Standard 101, Life Safety iter 19 Existing Health Care.		EPOC		
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-	R THE FIRE SAFETY			-	
	HEALTH CARE FIF STATE FIRE MARS 444 CEDAR STRE ST. PAUL, MN 551	SHAL DIVISION ET, SUITE 145			3	
ABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DAT	
	ically Signed				03/05	/20

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	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTI NG 01 - MAIN BUIL		E SURVEY IPLETED		
		245551	B. WING_			02/	12/2014
NAME OF F	ROVIDER OR SUPPLIER		· · · · ·		SS, CITY, STATE, ZIP COE	DE	
CLARKF	ELD CARE CENTER			805 FIFTH STRE CLARKFIELD,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	VIDER'S PLAN OF CORR CORRECTIVE ACTION SI REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	Continued From pa By e-mail to: Marian.Whitney@s		к ос	00			
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the deficient	vhat has been, or will be, done ency.					
	2. The actual, or pro	oposed, completion date.					
		r title of the person ection and monitoring to ence of the deficiency.					
	partial basement. T 4 different times. Th constructed in 1955 Type II(111) constru- constructed and wa II(111) construction. constructed and de constructed and de constructed in 2004 II(111) construction. building and the new	ter is a 1-story building with he building was constructed at ne original building was and was determined to be of action. In 1958 an addition was as determined to be of Type . In 1970, an addition was termined to be of Type II(111) most recent addition was and determined to be of Type . Because the existing w additions are of different on, the facility was surveyed		3 2 2 2 2 2	2	a a	
FORM CMS-22	fire alarm system w corridors and space monitored for autom notification. The fac	sprinklered. The facility has a vith smoke detection in the es open to the corridors, that is natic fire department cility has a capacity of 48 beds of 35 at time of the survey.		Facility ID: 00842	If c	continuation she	et Page 2 of 6

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TEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3 01 - MAIN BUILDING 01) DATE SURVEY COMPLETED	
245551			B. WING		00/10/0011	
		245551		STREET ADDRESS, CITY, STATE, ZIP CODE	02/12/2014	
	PROVIDER OR SUPPLIER			B05 FIFTH STREET, BOX 458		
LARKF	IELD CARE CENTER		(CLARKFIELD, MN 56223		
(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETIO DATE	
K 000	Continued From pa	ge 2	K 000			
		42 CFR, Subpart 483.70(a) is				
K 047	NOT MET as evide	nced by: FETY CODE STANDARD	K 047	,	2/13/14	
SS=C						
		signs are displayed in ction 7.10 with continuous				
		rved by the emergency lighting				
	system. 19.2.10.					
	a.					
		s not met as evidenced by: tion, the facility has failed to		Maintenance replaced the two burned	1 out	
	provide 1 of severa	l operational exit signs that		light bulbs located within the illuminate	ed	
	marks the means of	f egress path in accordance		exit sign located in the east basement		
	with NFPA Life Safe	ety Code 101 (2000 edition), deficient practice could affect		The Environmental Services Director		
	residents, staff and	visitors, if the lack of properly		and/or designee will complete inspect		
		prevented a means of egress		of the facility plant on a regular basis t ensure that all illuminated signs are in		
	emergency situatio	in a timely manner in an n		working order and keep documentation		
				to date.		
	Findings include:					
		veen 10:30 AM and 1:30 PM				
		as observed that the that is located in the east				
		perative due to 2 burnt out				
	light bulbs that are	located within the device.				
	This deficient pract	ice was verified by the				
	Maintenance Supe	rvisor (JB).			A1014.4	
K 056	NFPA 101 LIFE SA	FETY CODE STANDARD	K 056	5	4/2/14	

Facility ID: 00842

		AND HUMAN SERVICES				FORM	03/18/2014 APPROVEI 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED
		245551	B. WING			02/ [,]	12/2014
	PROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE 05 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 056	installed in accorda for the Installation of provide complete of building. The syste accordance with NI Inspection, Testing Water-Based Fire F supervised. There supply for the syste systems are equipp	hatic sprinkler system, it is ance with NFPA 13, Standard of Sprinkler Systems, to overage for all portions of the em is properly maintained in FPA 25, Standard for the , and Maintenance of Protection Systems. It is fully is a reliable, adequate water em. Required sprinkler oed with water flow and tamper e electrically connected to the	K	056			τ
	Based on observa system is not instal accordance with NI Installation of Sprin to maintain the spri with NFPA 13 (99) out of service caus protection system of emergency that wo and staff of the fact Findings include: On facility tour betw 02/12/2014, observ deficient conditions facility's fire sprinkl 1. the spare sprinkl	ween 10:30 AM to 1:30 PM on vations reveled the following s were found affecting the er system: kler head box was not			Maintenance will add additional sp elevated temperature type of sprink heads for the west basement boiler The Fire Sprinkler riser pressure ga will be serviced and replaced withir yeartime frame. This will be docum The Environmental Services Direct insure that the facility plant is equip with at least 2 of every type and sty sprinkler heads that are being used facility and that the fire sprinkler ris pressure gauges will be monitored serviced or replaced as necessary.	ker room. auges a the 5 nented. or will ped d in the er and	
	equipped with at le	ast 2 of every type and style of at are being used in the facility.					

2

Facility ID: 00842

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G 01 - MAIN BUILDING 01	COMPLETED	
		245551	B. WING		02/12/2014	
VAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CLARKF	IELD CARE CENTER			805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223	ž	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE
K 056 K 073 SS=C	The observed miss were the elevated t heads that were loo boiler room. 2. It could not be v gauges located on have were last test This deficient cond Maintenance Super NFPA 101 LIFE SA No furnishings or d	ing spare sprinkler heads emperature type of sprinkler cated in the west basement erified when the sprinkler the main fire sprinkler riser ed or recalibrating.	K 05		1.8	2/14/14
	Based on observation maintain combustition with NFPA Life Safe 19.7.5.4. The failur combustible decoration accordance with NF could allow smoke through the corrido egress capability in residents, visitors at Findings include: On facility tour betw 02/12/2014, observing resident room door paper that is not information	s not met as evidenced by: tions, the facility failed to ble decoration in accordance ety Code 101 (00) section re to treat and maintain the ations throughout the facility in FPA Life Safety Code 101 (00) and fire to rapidly migrate rs and negatively affect the the event of an emergency for nd staff of the facility.		Staff removed the wrapping pap the resident room door #203. The Environmental Services Dire ensure that all decorations used facility will meet Life Safety Code Standards to prevent smoke and rapidly migrate throught the corri negatively affect the egress capa the event of an emergency	ector will in the fire to dors and	

Facility ID: 00842

If continuation sheet Page 5 of 6

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/18/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COM	E SURVEY PLETED	
	245551					02/ [.]	12/2014
NAME OF F	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CLARKF	IELD CARE CENTER				05 FIFTH STREET, BOX 458 LARKFIELD, MN 56223		
(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
K 073	Continued From pa wrapping paper cov residents door on th	ge 5 vered the entire exterior of the ne corridor side of the door.	ĸ	073			
	The deficient practi Maintenance Super	ces were confirmed by the visor (JB).					
						а у П	
	a.						

Facility ID: 00842

If continuation sheet Page 6 of 6

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		TRUCTION		ATE SURVEY MPLETED
		245551	B. WING			0	2/12/2014
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP	CODE	
CLARKFI	ELD CARE CENTER				H STREET, BOX 458 FIELD, MN 56223		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	c c	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO ROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	K 00	00			
	FIRE SAFETY						
	ALLEGATION OF O DEPARTMENTS A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE CATION OF COMPLIANCE.					
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departn Fire Marshal Divisio Clarkfield Care Cer substantial complia participation in Mec Subpart 483.70(a), 2000 edition of Nat Association (NFPA	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, nter was found not in ance with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection) Standard 101, Life Safety oter 18 New Health Care.					
	DEFICIENCIES (K	R THE FIRE SAFETY			EPO		
	STATE FIRE MAR						

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			ž.	FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 02 - BUILDING TWO		E SURVEY PLETED
		245551	B. WING	_		02/ [,]	2/2014
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CLARKF	IELD CARE CENTER				805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223		
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa By e-mail to: Marian.Whitney@s		КO	00			
÷.,	DEFICIENCY MUS FOLLOWING INFO						
	1. A description of v to correct the deficient	vhat has been, or will be, done ency.					
	2. The actual, or pro	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency.					
	partial basement. T 4 different times. Th constructed in 1955 Type II(111) constru- constructed and wa II(111) construction. constructed and de constructed in 2004 II(111) construction. building and the new	ter is a 1-story building with the building was constructed at the original building was 5 and was determined to be of action. In 1958 an addition was as determined to be of Type . In 1970, an addition was termined to be of Type II(111) most recent addition was I and determined to be of Type . Because the existing w additions are of different on, the facility was surveyed				-144) 14	
	as two buildings. The building is fully fire alarm system w corridors and space monitored for autor notification. The fa	sprinklered. The facility has a with smoke detection in the es open to the corridors, that is natic fire department cility has a capacity of 48 beds of 35 at time of the survey.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00842

If continuation sheet Page 2 of 4

PRINTED: 03/18/2014

		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	M APPROVE <u> D. 0938-039</u> ATE SURVEY MPLETED
ND PLAN O	FCORRECTION	245551	A BUILD		02 - BUILDING TWO	2/12/2014
	ROVIDER OR SUPPLIER	245551	B. WING	-	IREET ADDRESS, CITY, STATE, ZIP CODE	2/12/2014
				80	05 FIFTH STREET, BOX 458	
GLARRE	ELD CARE CENTER			С	LARKFIELD, MN 56223	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETIOI DATE
K 000	Continued From pa	ge 2	ĸ	000		
	The requirement at NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by:				
K 056 SS=F		FETY CODE STANDARD	K)56		4/2/14
	in accordance with Installation of Sprin components, device complete coverage The system is main NFPA 25, Standard and Maintenance o Systems. There is supply for the system	tic sprinkler system, installed NFPA 13, Standard for the kler Systems, with approved es, and equipment, to provide of all portions of the facility. Intained in accordance with for the Inspection, Testing, f Water-Based Fire Protection a reliable, adequate water em. The system is equipped tamper switches which are re alarm system. 18.3.5.				
	Based on observat system is not instal accordance with NF Installation of Sprin to maintain the spri with NFPA 13 (99) o out of service caus protection system of emergency that wo and staff of the faci	s not met as evidenced by: tions, the automatic sprinkler led and maintained in FPA 13 the Standard for the kler Systems (99). The failure nkler system in compliance could allow system being place ing a decrease in the fire capability in the event of an uld affect all residents, visitors lity.			Maintenance will add additional spare elevate temperature type of sprinkler heads for the west basement boiler room The Fire Sprinkler riser pressure gauges will be serviced and or replaced within the 5 year time frame and documented. The Environmental Services Director will insure that the facility plant is equipped with at least 2 of every type and style of sprinkler heads that are being used in the	e
	Findings include: On facility tour betv	veen 10:30 AM to 1:30 PM on	8		facility and that fire sprinkler riser pressure gauges will be monitored and	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00842

If continuation sheet Page 3 of 4

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/18/2014 APPROVED 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 02 - BUILDING TWO		E SURVEY PLETED
		245551	B. WING			02/1	2/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CLARKF	IELD CARE CENTER				05 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223		
(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
	 deficient conditions facility's fire sprinkle the spare sprink equipped with at leas sprinkler heads that The observed miss were the elevated to heads that were loo boiler room. It could not be ver gauges located on thave were last tester 	ations reveled the following were found affecting the er system: ler head box was not ast 2 of every type and style of t are being used in the facility. ing spare sprinkler heads emperature type of sprinkler cated in the west basement erified when the sprinkler the main fire sprinkler riser ed or recalibrating.	K	056	DEFICIENCY)		
FORM CMS-25	567(02-99) Previous Versions	Obsolete Event ID: VEE82	1	Fac	cility ID: 00842 If continu	ation shee	et Page 4 of 4



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered February 28, 2014

Mr. Murray Finger, Administrator Clarkfield Care Center 805 Fifth Street, Box 458 Clarkfield, Minnesota 56223

RE: Project Number S5551024

Dear Mr. Finger:

On February 12, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

<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;

Potential Consequences - 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:

Sarah Grebenc, Supervisor St. Cloud Survey Team B Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health sarah.grebenc@state.mn.us

Phone: (320) 223-7365 Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 9, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 9, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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. Clarkfield Care Center February 28, 2014 Page 4

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 12, 2014 (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

Clarkfield Care Center February 28, 2014 Page 5

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 12, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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) 215-0541 Clarkfield Care Center February 28, 2014 Page 6

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

5551s14.rtf

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00842	B. WING		02/1	2/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CLARKF	IELD CARE CENTER		I STREET, B ELD, MN 56			
(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			
	****ATTE	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				
	You may request a that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	this Department's s and the following lic When corrections a date, make a copy original to the Minne Division of Complia	11 and 12, 2014, surveyors of taff, visited the above provider sensing orders were issued. The 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	
		ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

Electronically Signed

STATE FORM

6899

If continuation sheet 1 of 17

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00842	B. WING		02/1	2/2014
	PROVIDER OR SUPPLIER	805 FIFT	DRESS, CITY, I Street, E Eld, MN 56			
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2 000	Continued From pa	ige 1	2 000			
	Suite 212, St. Cloud Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follor are the Suggested Time period for Con PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC	nent of Health is documenting Correction Orders using ag numbers have been tota state statutes/rules for umber appears in the far left Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.		The assigned tag number apper far left column entitled "ID Pre- The state statute/rule out of co- listed in the "Summary Statemed Deficiencies" column and repla Comply" portion of the correction This column also includes the five which are in violation of the state after the statement, "This Rule as evidence by." Following the findings are the Suggested Me Correction and Time period for PLEASE DISREGARD THE HIT THE FOURTH COLUMN WHIC STATES, "PROVIDER'S PLAN CORRECTION." THIS APPLIE FEDERAL DEFICIENCIES ON WILL APPEAR ON EACH PAGE THERE IS NO REQUIREMENT SUBMIT A PLAN OF CORRECT VIOLATIONS OF MINNESOTA STATUTES/RULES.	fix Tag." mpliance is ent of ices the "To on order. findings te statute is not met surveyors thod of Correction. EADING OF CH OF ES TO LY. THIS iE. T TO CTION FOR	
2 830	Proper Nursing Ca	0 Subp. 1 Adequate and re; General general. A resident must	2 830			3/11/14

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If continuation sheet 2 of 17

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SU COMPLE	
		00842	B. WING		02/12/	2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CLARKF	IELD CARE CENTER		H STREET, I ELD, MN 56			
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2 830	individual needs an the comprehensive	age 2 Ind preferences as identified in the resident assessment and scribed in parts 4658.0400 and	2 830			
	4658.0405. A nurs of bed as much as written order from t	ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident				
	by: Based on observat review, the facility f causative factors to	ent is not met as evidenced ion, interview and document ailed to evaluate and analyze o minimize the risk for falls, for 4) reviewed for accidents.		Corrective Action: 1. Resident #4 care plan was revalong with the Functional Safety Assessment and Fall Risk Assessr All were updated to reflect current	nent.	
	Findings include: R4's medical record was reviewed and the record lacked analysis of R4's falls on 5/18/13, 9/25/13, 11/18/13, 12/25/13, 1/5/14, and 2/3/14, for causative factors, in order to implement meaningful interventions. Interventions implemented lacked attempts to anticipate R4's needs prior to self-transfers through re-assessment of bowel/bladder needs, evaluation of her environment to reduce her need to reach for things, evaluation of her medications, or provision of increased direct supervision due to her impaired cognition and safety judgment. Interventions also lacked evaluation for effectiveness.			 appropriate interventions. Correction as it applies to other rest All residents will have a Function Safety and Fall Risk Assessment completed at admission, quarterly, with any significant change. A Fall will be completed following every fat Appropriate interventions will be active the resident s care plan. A Post Fall Huddle will be initiate following every fall. An Incident R will be completed in full following e including development of an appropriate interventions will be developed by evaluating the resident patterns, toileting patterns, medicate 	and Risk all. dded to ted eport very fall priate	
	assessments from revealed the follow	incident reports and 5/18/13, through 2/9/14, ing: on 5/18/13, at 7:45 a.m. noted		and all other risk factors. The inter will immediately be added to the resident s care plan. Incident Re will include a review after 24 hours	rvention ports	

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		00842	B. WING		02/12	2/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CLARKE	FIELD CARE CENTER		I STREET, E ELD, MN 56			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 3	2 830			
	sitting on the floor b wheelchair (w/c) in unwitnessed. R4 si onto the floor. Com included the followin no change in physic as a result of her fa w/c, observe and re- needed (PRN). No risk for future falls w The second fall rep noted R4 was found bathroom with her b stated she missed to rotation of the right were noted. R4 wa and was admitted fa immediate intervent went to the hospital assessment and pla independent prior to hospital for repair of added, when R4 re- increased assistant necessary. The rep oriented before fall needs. The report for falls or dates of patterns were ident depression as a psi A falls assessment risk score of 75 (hig comments included 9/25/13. Potential r forgetfulness of limit transfers, impaired history of falls. Sur alert, oriented, able	ering for help. She was found by the end of her bed with her front of her. The fall was aid she slid out of the w/c, meents noted on the report ng: isolated incident, R4 had cal or psychosocial functioning II, brakes were working on her eassess quarterly and as interventions to minimize the were identified. ort on 9/25/13, at 8:30 a.m. d seated on the floor of her back against the wall. R4 the toilet seat. External hip and pain in the right hip s sent to the emergency room or surgical repair. No tions were implemented as R4 . The registered nurse (RN) an of action noted R4 was to the fall and was at the f her right hip. The plan turned from the hospital, be would have been bort indicated R4 was alert and and was aware of her safety identified no potential causes other falls or incidents. No ified. The report did identify ychological risk factor for R4. dated 10/8/13, revealed a total gh risk). Falls risk analysis I that R4 lost her balance on risk factors included itations, use of a walker for gait and balance, and a nmary notes indicated R4 was to make her needs known, ght appropriately to request		 RN. All Incident Reports will be by the Interdisciplinary Team at meeting held Monday through F 3. A note will be made on the real Fall Risk Assessment following including an analysis of the risk and interventions implemented. 4. Training meeting scheduled 10th and 11th, 2014. Reoccurrence will be prevented 1. DON or designee will audit resident chart weekly X 12 weel appropriate fall assessment and intervention. 2. Incident Reports will be revi the Interdisciplinary Team at Sta meetings Monday thru Friday. Correction will be monitored by: 1. DON or designee. 2. DON will report audit finding QA Committee quarterly and PF 	Stand-up riday. resident s each fall factors for March by: one (s for and-up gs to the	

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED		
		00842	B. WING		02/	12/2014		
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE				
CLARKF	FIELD CARE CENTER		H STREET, BO IELD, MN 562					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLET DATE
2 830	Continued From pa	age 4	2 830					
	assessment noted and PRN. R4's most recent c dated 10/14/13, inc with a hip fracture a occupational theray and called appropri- revealed a referral already being seen were reviewed rout and pharmacy. Th reassess quarterly On 10/24/13, R4's updated with a sco notes indicated R4 of non-weight-bear The third fall report revealed the staff h she was found sittli floor, in front of her stated she just slipp was going to her si reminding R4 she of for help. An alarm intervention to cons injury with the fall. causes for falls incl impaired mobility a cognition, and judg Dates of other falls not identified. The action noted R4 ha psychosocial functi The plan noted R4 any further incident interventions put in A fourth fall was ide 12/25/13, with a ris	fall assessment scoring was re of 65 (high risk). Summary needed continuous reminding ing restrictions for her right leg on 11/18/13, at 4:20 p.m. neard R4 call out for help when ng in an upright position on the sink. R4 was interviewed and ped out of the chair when she nk. Interventions included could not walk alone and to ask for her chair was noted as an sider. There was no noted Risk factors and potential luded increased confusion, nd balance, impaired ment/safety awareness deficit. /incidents and patterns were RN assessment and plan of d no change in physical or oning as a result of the fall. was forgetful, but had not had ts. R4 had no further						

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00842	B. WING		02/	12/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
CLARKF	IELD CARE CENTER		H STREET, BC IELD, MN 562			
(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 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	10/13. Summary n fallen when she trie room. R4 was iden confusion, with no f assessment instruc- plan, observe and r No further fall interv The fifth fall report of indicated R4 was for front of her dresser out. R4 was noted to all extremities an where she fell. R4 dresser to get some prevent further incid use her walker whe her to use her call I device that sounder resident's weight w w/c. Risk factors ar included impaired r incontinence, impai safety awareness of identified and dates 9/25/13, with fractu 11/18/13. The RN noted R4 had recer bearing, she had a working with physic strengthening. The sixth fall report identified R4 was for blood, her feet were	otes included that R4 had d to open a drawer in her titified with intermittent further attempts to stand. The ted to continue the current eassess quarterly and PRN. ventions were implemented. on 1/5/14, at 1:15 p.m. bund by staff on the floor in . The top dresser was pulled to have good range of motion ad the w/c was six feet from stated she was going to her ething. Interventions to dents included reminding R4 to m in her room and reminding ight. A pressure alarm (a d an audible alarm when a as lifted) was placed in R4's nd potential causes for falls nobility, activity intolerance, red cognition, judgement and if deficits. No patterns were s of previous falls included re of her right hip and assessment and plan of action notly become full weight right hip fracture, and she was cal therapy for increased on 2/3/14, at 7:25 p.m. bund on the floor in a pool of e by the bed with her head		DEFICIENC	SY)	
	The sixth fall report identified R4 was for blood, her feet were pointing toward the said she thought sh gash was noted to with profuse bleedin ice pack were appli	ound on the floor in a pool of	1			

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CLARKF	IELD CARE CENTER		H STREET, BO IELD, MN 562			
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2 830	Continued From pa	age 6	2 830			
	not identified. Pote unknown. The RN action included pre brakes (a device th when a resident sto were noted as impl from the hospital. and physical report had been leaning for she fell forward, hit significant laceration Review of R4's terr hospitalization), da for injury related to Interventions include the appropriate heif falls precautions (ut transfer belt with all devices as needed not identify the use anti-rollback brakes	nporary care plan (post ted 2/7/14, revealed a potentia a recent fall and weakness. ded adjustment of her bed to ght, assist of two for transfers, inspecified) as needed, Il transfers and assistive . The temporary care plan did of sensor alarms or s.				
	licensed practical r used a sensor pad got up on her own. been forgetful lately her hand and not re them, which started was unsure if R4 w program. She said assessments.	n 2/10/14, at 1:43 p.m. hurse (LPN)-A indicated R4 in her chair to alert staff if she LPN-A also remarked R4 had y, such as holding papers in emembering what to do with d prior to the last fall. LPN-A vas on a scheduled toileting I RN-A did the falls n 2/10/14, at 1:55 p.m. RN-A				
	said R4's cognition currently, she was had been ill just pri	had been more impaired, and "really impaired." She said R4 or to her most recent fall. A to the doctor, requesting to				

	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00842	B. WING		02/	12/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CLARKF	FIELD CARE CENTER		H STREET, BC ELD, MN 562			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 830	have R4 seen on ro and went to the ER physician. RN-A sa fall assessments we a fall. She added, i all disciplines Mond indicated that input have been docume progress notes; how was done consister thought staff toilete and after meals. R person assist with t been a one person fall on 2/3/14. During interview on assistant (NA)-A sa lot between meals a toileting program, b meals. NA-A addee program but could n days, and needed t During observation was leaning forward in their wheelchair, the floor. R4 stated with LPN-E and NA identified that R4 ha transfer out of her co independently since During interview on occupational therap more cognitively im OT-C thought they wheelchair back wh	ge 7 punds the next day, but R4 fell prior to being seen by a uid she could not say whether ere completed each time after ncidents were reviewed with lay through Friday. She from those meetings would nted in the interdisciplinary wever, she was not sure this ntly. RN-A indicated that she d R4 upon arising and before N-A stated R4 was now a two ransfers. RN-A said R4 had assist prior to her most recent 2/10/14, at 2:05 p.m. nursing id R4 wore a brief, dribbled a and was not on a scheduled ut staff toileted R4 after d R4 was on a walking no longer walk the last few o be "re-evaluated." on 2/10/14, at 4:50 p.m. R4 d, in a hunched over position to reach her newspaper on d she was tired. An interview -E on 2/10/14, at 4:50 p.m. ad not attempted to get up e her hospital return. 2/11/14, at 7:45 a.m. by (OT)-C said R4 was way paired since her head injury. had put R4 in a lower nen she was treated for the hip led R4 had a new foot pedal.				

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CLARKE	FIELD CARE CENTER		H STREET, BO			
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2 830	Continued From pa	ge 8	2 830			
	medical doctor (MD falls due to incontin for surgery or media that R4 had a histor things from their wh understanding R4 h fell on 2/3/14. R4 w to be independent, help. MD-E stated prior to her last fall, decreased R4's abi limitations. R4 had about a month. MD (computerized topo imaging used to cre- the bones and soft fall in January and R attempt to determin The CT came back During interview on therapy assistant (F on 2/10/14, with go strength with transfe similar issues with F due to impaired cog independent with tra- buring interview on director of nursing (procedure for falls w huddle within two he immediate intervent trying to eliminate a "Band-Aid" for a fall falls. The DON said	graphy, a form of x-ray eate cross-sectional views of tissues) of the head after the before the fall in February in ite the cause of her confusion. with no abnormalities. 2/11/14, at 2:45 p.m. physical PTA)-D said R4 was evaluated als of improving mobility and ers. PTA-D had worked on R4's hip fracture; however, gnition, R4 was unable to be ansfers. 2/12/14, at 8:25 a.m. the DON) said the usual was to complete a team ours to come up with an tion. She said the facility was larm usage as they were a l, they did not really prevent d incident reports were to be and the reports were reviewed				

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00842	B. WING		00/	10/0014
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		02/	12/2014
		805 FIFT	H STREET, BC	DX 458		
(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
2 830	During further inter the DON said thera attend standup me Medicare meetings Recommendations attend standup (ac social work) were to interdisciplinary not the addition of anti- wheelchair were a The facility's Fall Pr revealed post-fall a review of the causa medication, probab co-morbid (pertaini disorder) conditions sensory aids, the e treatment plan was SUGGESTED MET The director of nurs develop policies an resident falls are co identify patterns an Meaningful interver investigation results reduce the resident director of nursing all appropriate staff procedures. The di designee could dev ensure ongoing con	view on 2/12/14, at 11:15 a.m. apy did not always routinely eting, but did attend weekly with nursing. from the disciplines that did tivities, nursing, dietary and o be documented in the tes. The DON believed that rollback breaks to R4's result of a standup meeting. revention policy revised 9/10, assessments were to include a ative factors such as ble causes of the fall, ng to a disease process or s, mobility aid use, footwear, nvironment, and if the being followed. THOD OF CORRECTION: sing or her designee could id procedures to ensure ponsistently investigated to d/or causative factors. ntions based on the s could be implemented to t's risk for future falls. The or her designee could educate f on these policies and rector of nursing or her velop an auditing system to				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
		00842	B. WING	0	2/12/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE	
CLARKF	IELD CARE CENTER		H STREET, B IELD, MN 56		
(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) COMPLET DATE
21315	Continued From pa	age 10	21315		
21315	MN Rule 4658.072 Oral Care	0 Subp. 1 A-C Providing Daily	21315		3/11/14
	resident consistent comprehensive res A. A resident's indicate whether or teeth or wears rem must also indicate maintain oral hygie supervision, or is d B. A nursing ho with the supplies an carry out the reside supplies must inclu- toothbrushes, fluori dental floss, dentur denture cleaning pr products. C. A nursing ho care plan available each checkup, and	daily oral care plan must not the resident has natural ovable dentures or partials. It whether the resident is able to ne independently, needs ependent on others. One must provide a resident nd assistance necessary to ent's daily oral care plan. The de at a minimum: ide toothpaste, mouth rinses, re cups, denture brushes, roducts, and denture adhesive ome must make the daily oral to the attending dentist before must modify the plan entist's, dental hygienist's, or			
	by: Based on observat	ent is not met as evidenced ion, interview and document		1. Denture adhesive was obtained for	
	adhesive during a l	ailed to provide denture Medicare or Medicaid stay, for 4) who were reviewed for oral 5.		resident #4. Staff was instructed on its use and it was added to the care plan. 2. A review of the Facility s Admission policy was reviewed and the facility will now purchase stock denture adhesive to	
	Findings include:			be provided for residents during their sta at the facility as deemed appropriate by	

STATE FORM

VEE811

If continuation sheet 11 of 17

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00842	B. WING		02/1	2/2014
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CLARKF	IELD CARE CENTER		I STREET, E ELD, MN 56			
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21315	Continued From pa	ge 11	21315			
	the hospital dischar included dysphasia A speech pathology 2/6/14, revealed R4 propelling food to b eat meat, if cut into note included plans which included ens place with adhesive Additionally, instruct denture was in plac communicated via be Followed by Pat dated 2/7/14. The dining room board, board, as well as to	a fall. Her return diagnoses per rge summary dated 2/7/14, (difficulty swallowing). / inpatient progress note dated 4 had difficulty chewing and e swallowed. She was able to small pieces. The progress a for swallowing strategies uring her upper denture was in e prior to oral intake. tions to ensure the upper e with adhesive were a Safe Swallow Strategies to ient, Staff and Visitors form form was copied to the facility the nursing assistant (NA) b be passed along in report.		Corrective Action as it applier residents: 1. All residents will receive assessment on admission. Therapy will be referred as appropriate 2. All Therapy recommender added to the care plan and facility staff for implementat 3. All recommended assis and interventions will be implementat 3. All recommended assis and interventions will be implementat 4. Nursing staff will be edu maintaining necessary supple communicating need to resident Mandatory meeting March 12014.	receive an oral ssion. Speech ed as deemed nmendations will be n and passed on to nentation. I assistive devices be implemented as will ensure the items rovided. be educated on y supplies and to restock at a	
	 On 2/9/14, at 3:29 p.m. R4 was observed to have a loose upper denture plate and indicated her teeth bothered her. On 2/11/14, at 9:14 a.m. R4 was observed during oral cares completed by NA-D. NA-D cued R4 to brush her lower teeth and rinse out her mouth. NA-D proceeded to hand R4 her upper denture plate. No denture adhesive was applied to the dentures prior to R4 putting them in her mouth. On 2/11/14, at 11:42 a.m. R4 was observed to be assisted by speech therapist (ST)-G. When ST-G began to feed R4 bites of her meal, she noted that R4's teeth were loose and indicated she only had molars on the top due to the full denture plate, and had no teeth in the back of her lower mouth. ST-G then removed R4's denture plate and left the room to inquire about denture adhesive to secure the denture plate in place. ST-G came back to the room, indicated she 			Reoccurrence will be preven 1 Denture adhesive will b maintained as a stock supp 2 DON or Designee will a care plans and ensure that available and in place for all requiring its use. Correction will be monitored 1. DON or designee 2. DON will report the find Committee quarterly and Pf	e ordered and ly. udit resident adhesive is I residents d by: ings to the QA	

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CLARKE	IELD CARE CENTER		I STREET, BC ELD, MN 562			
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21315	talked to registered adhesive had to be available in the faci feeding R4 her mea out of R4's mouth, pudding instead. S R4 could have chew During interview on stated it was the us pharmacy to have or resident when need did not routinely ha use when needed. During interview on director of nursing of procedure to order pharmacy for reside the adhesive was th resident. The DON "probably should" ha adhesive on hand; been done this way facility. During interview on social worker (SW) department ordered denture adhesive. thought it was writte that denture adhesis billed to the resider Review of the faciliti revealed that items cups, denture clear	 nurse (RN)-A and the ordered in as there was none lity. ST-G had difficulty at due to the dentures being and proceeded to feed her T-G said with the dentures in, wed her food better. 2/11/14, at 12:06 p.m. NA-A the denture adhesive sent for a ded. NA-A verified the facility we this in stock for resident 2/12/14, at 8:25 a.m. the (DON) said it was the usual denture adhesive from the ents that needed it, and that then billed by pharmacy to the I indicated that the facility have kept some denture however, it had "just always t," since she had worked at the 2/12/14, at 8:40 a.m. the -A stated that the nursing d personal supplies like SW-A further stated she en in the admission agreement ive was not covered and was tt. ty's undated admission booklet such as Kleenex, denture how over and booklet such as Kleenex, denture how over a did booklet. 				

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CLARKF	FIELD CARE CENTER		STREET, BC			
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21315	SUGGESTED MET director of nursing of facility policies, pro- contracts regarding necessary to carry of care plan, including toothbrushes, fluori dental floss, dentur- denture cleaning pr products. The direct could implement au needed are availab at the facility's expe- provided for all pers	HOD OF CORRECTION: The or her designee could revise cedures, and/or admission the provision of supplies out each resident's daily oral	21315			
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service ed prevention and con E. a resident he immunization progr defined in part 465 procedures of resid the prevention and F. the developm	D Subp. 4 A-I Infection Control and procedures. The infection ist include policies and provide for the following: based on systematic data r nosocomial infections in detection, investigation, and s of infectious diseases; d precautions systems to mission of infectious agents; ducation in infection trol; ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; nent and implementation of olicies and infection control	21390			3/11/14

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		TE SURVEY MPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
CLARKE	FIELD CARE CENTER		I STREET, E ELD, MN 56				
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE	
21390	practices, including defined in part 4658 G. a system for products which affe disinfectants, antise incontinence produce I. methods for for current standards of This MN Requirement by: Based on observation review, the facility for handwashing technic cross-contamination observed during ca Findings include: On 2/11/14, at 9:08 was observed to per cleansed R4's perion wipe. The incontine NA-A finished to as wearing the soiled go resident's clean brid resident's wheelchat belt before she remi- washed her hands. During an interview reported they would their hands wheney dirty activities such she should have refine the store the store of the store of the store of the store of the store of the store of the store of the store of the store of t	a tuberculosis program as 3.0815; r reviewing antibiotic use; r review and evaluation of ect infection control, such as eptics, gloves, and cts; and maintaining awareness of f practice in infection control. ent is not met as evidenced on, interview and document ailed to ensure proper iques to prevent n for 1 of 2 residents (R4)	21390	 NAR-A was given individual on appropriate hand washing and technique. Corrective Action as it applies to oresidents: A handout on proper hand wastechnique was given to all nursing All nursing staff will be re-edu and competency tested on hand wand gloving at a mandatory staff r March 10th and 11th, 2014. Reoccurrence will be prevented billing to the properties of the propert of the properties of the	gloving other ashing y staff. located washing meeting n es for oving ny: to the		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
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21390	Continued From pa	ige 15	21390			
	director of nursing should have chang	on 2/11/14, at 2:25 p.m. the (DON) indicated that staff ed gloves after providing to touching any clean items.				
	Control, stated glow whenever touching	/ policy, entitled Basic Infection res should be changed something dirty, such as the inen during cares and before clean.	ו			
	The director of nurs or revise policies at infection control teo care and handwash designee (s) could to these policies an nursing or designed	THOD FOR CORRECTION: sing or designee(s) may review nd procedures related to chniques in regards to peri ning. The director of nursing o provide an in-service in regard d procedures. The director of e(s) could conduct audits to and procedures are being	r			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one	9			
21620	MN Rule 4658.134	5 Labeling of Drugs	21620			3/11/14
	Drugs used in the r in accordance with	nursing home must be labeled part 6800.6300.				
	by: Based on observat review, the facility f were labeled with th residents (R12), wh	ent is not met as evidenced ion, interview and document ailed to ensure insulin pens ne date opened, for 1 of 2 nose insulin pens were e medication storage review.		 Insulin pen for resident #12 dated and labeled. All insulin pens were observe ensure them as labeled, and date Corrective Action as it applies to residents: 	ed to ed	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		S:		URVEY ETED
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	PROVIDER OR SUPPLIER	STREET AL 805 FIFT	DDRESS, CITY, H STREET, B IELD, MN 56	3OX 458		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
21620	Findings include: On 2/11/14, at 12:3 pen (a prescription blood sugars) was of facility's treatment of The pen lacked a la opened. Licensed verified there was n SoloSTAR pen to ic LPN-A confirmed th been dated when it A review of Lantus, revised 10/13, reco SoloSTAR pen coul once opened. The be discarded after t remained in the per The facility policy for Medication revised be labeled with the SUGGESTED MET The director of nurs review appropriate safe storage of med cart. Pertinent emp on these policies ar labeling of opened i could be completed designee, or the ph ongoing compliance	2 p.m. a Lantus SoloSTAR medication for the control of observed as opened, in the cart and ready for use for R12. abel to indicate the date it was practical nurse (LPN)-A not a date on the Lantus dentify when it was opened. the insulin pen should have was opened. Full Prescribing Information mmended the Lantus Id remain in use for 28 days, Lantus SoloSTAR pen was to the 28 days, even if insulin the compared of 9/11, indicated insulin was to date opened. THOD FOR CORRECTION: sing or her designee could policies and procedurees for dications in the medication poloyees could be re-educated and procedures, to include the insulin pens. Random audits d by the director of nursing, her parmacy consultant to ensure		 The Policy and Procedu opening, labeling, and dating Insulin pens was reviewed. All Licensed Nurses rece of the Policy and Procedure. All Licensed Nurses will re-educated on the Insulin Poly Procedure at a mandatory m 10th and 11th, 2014. Reoccurrence will be prevent DON or designee will au and insulin pens weekly X 4 monthly for appropriate label dating. Reoccurrence will be monitot DON or designee DON will report audit find QA Quarterly and PRN 	Insulin and eived a copy be olicy and eeting March ted by: Idit all insulin weeks, then ing and red by:	