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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: VEE8

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/09/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **48** (L18)

13.Total Certified Beds **48** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	48			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Mary Rogers, HFE NE II — 4/22/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 4/22/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/23/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/03/2014
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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,

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245551	A. Building B. Wing	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) Date
ID Prefix **F0162** Reg. # **483.10(c)(8)** LSC	Correction Completed **03/11/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **03/11/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **03/11/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/11/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KJ/PK	4/22/2014	27955	4/9/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/12/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00842	A. Building B. Wing	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	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **03/11/2014**	ID Prefix **21315** Reg. # **MN Rule 4658.0720 Subp. 1 A-** LSC	Correction Completed **03/11/2014**	ID Prefix **21390** Reg. # **MN Rule 4658.0800 Subp. 4 A-** LSC	Correction Completed **03/11/2014**
ID Prefix **21620** Reg. # **MN Rule 4658.1345** LSC	Correction Completed **03/11/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PK/KJ	4/22/2014	27955	4/9/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/12/2014			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245551	A. Building 01 - MAIN BUILDING 01 B. Wing	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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0047	02/13/2014	ID Prefix Reg. # NFPA 101 LSC K0056	04/02/2014	ID Prefix Reg. # NFPA 101 LSC K0073	02/14/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/KJ	Date: 4/22/2014	Signature of Surveyor: 27200	Date: 4/7/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/12/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245551	A. Building B. Wing 02 - BUILDING TWO	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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0056	04/02/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/KJ	Date: 4/22/2014	Signature of Surveyor: 27200	Date: 4/7/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/12/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: VEE8

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/12/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **48** (L18)

13.Total Certified Beds **48** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	48			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Mary Rogers, HPR Social Work Specialist — 03/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 04/2/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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 Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245551	A. BUILDING _____ B. WING _____	02/12/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 162 SS=D	483.10(c)(8) LIMITATION ON CHARGES TO PERSONAL FUNDS The facility may not impose a charge against the personal funds of a resident for any item or services for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.) During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services: Nursing services as required at §483.30 of this subpart.	F 162		3/11/14

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

Electronically 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245551	A. BUILDING _____ B. WING _____	02/12/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 162	Continued From page 1 Dietary services as required at §483.35 of this subpart. An activities program as required at §483.15(f) of this subpart. Room/bed maintenance services. Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry. Medically-related social services as required at §483.15(g) of this subpart. Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid: Telephone. Television/radio for personal use. Personal comfort items, including smoking materials, notions and novelties, and confections. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. Personal clothing. Personal reading matter. Gifts purchased on behalf of a resident.	F 162		

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F 162	Continued From page 2 Flowers and plants. Social events and entertainment offered outside the scope of the activities program, provided under §483.15(f) of this subpart. Noncovered special care services such as privately hired nurses or aides. Private room, except when therapeutically required (for example, isolation for infection control). Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by §483.35 of this subpart. The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident. The facility must not require a resident (or his or her representative) to request any item or services as a condition of admission or continued stay. The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide denture adhesive during a Medicare or Medicaid stay, for 1 of 3 residents (R4) who were reviewed for oral and dental services. Findings include: R4 was re-admitted to the facility after hospitalization for a fall. Her return diagnoses per the hospital discharge summary dated 2/7/14, included dysphasia (difficulty swallowing).	F 162	Tag 0162 Corrective Action: 1. Denture adhesive was obtained for 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 be provided for residents during their stay at the facility as deemed appropriate by Speech Therapy.	

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F 162	Continued From page 3 A speech pathology inpatient progress note dated 2/6/14, revealed R4 had difficulty chewing and propelling food to be swallowed. She was able to eat meat, if cut into small pieces. The progress note included plans for swallowing strategies which included ensuring her upper denture was in place with adhesive prior to oral intake. Additionally, instructions to ensure the upper denture was in place with adhesive were communicated via a Safe Swallow Strategies to be Followed by Patient, Staff and Visitors form dated 2/7/14. The form was copied to the facility dining room board, the nursing assistant (NA) board, as well as to be passed along in report. 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 talked to registered nurse (RN)-A and the adhesive had to be ordered in as there was none	F 162	Corrective Action as it applies to other residents: 1. All residents will receive an oral assessment on admission. Speech Therapy will be referred as deemed appropriate 2. All Therapy recommendations will be added to the care plan and passed on to facility staff for implementation. 3. All recommended assistive devices and interventions will be implemented as ordered. The facility will ensure the items are obtained and/or provided. 4. Nursing staff will be educated on maintaining necessary supplies and communicating need to restock at a Mandatory meeting(s)scheduled for March 10 and March 11, 2014. Reoccurrence will be prevented by: 1 Denture adhesive will be ordered and maintained as a stock supply. 2 DON or Designee will audit resident care plans and ensure that adhesive is available and in place for all residents requiring its use. Correction will be monitored by: 1. DON or designee 2. DON will report the findings to the QA Committee quarterly and PRN.	

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F 162	Continued From page 4 available in the facility. ST-G had difficulty feeding R4 her meat due to the dentures being out of R4's mouth, and proceeded to feed her pudding instead. ST-G said with the dentures in, R4 could have chewed her food better. During interview on 2/11/14, at 12:06 p.m. NA-A stated it was the usual procedure to call the pharmacy to have denture adhesive sent for a resident when needed. NA-A verified the facility did not routinely have this in stock for resident use when needed. During interview on 2/12/14, at 8:25 a.m. the director of nursing (DON) said it was the usual procedure to order denture adhesive from the pharmacy for residents that needed it, and that the adhesive was then billed by pharmacy to the resident. The DON indicated that the facility "probably should" have kept some denture adhesive on hand; however, it had "just always been done this way," since she had worked at the facility. During interview on 2/12/14, at 8:40 a.m. the social worker (SW)-A stated that the nursing department ordered personal supplies like denture adhesive. SW-A further stated she thought it was written in the admission agreement that denture adhesive was not covered and was billed to the resident. Review of the facility's undated admission booklet revealed that items such as Kleenex, denture cups, denture cleaner, toothbrushes, and toothpaste were provided. The items covered did not include denture adhesive.	F 162		
F 323	483.25(h) FREE OF ACCIDENT	F 323		3/11/14

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F 323 SS=D	Continued From page 5 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to evaluate and analyze causative factors to minimize the risk for falls, for 1 of 3 residents (R4) reviewed for accidents. 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. Review of R4's fall incident reports and assessments from 5/18/13, through 2/9/14, revealed the following: The first fall report on 5/18/13, at 7:45 a.m. noted	F 323	Corrective Action: 1. Resident #4 care plan was reviewed along with the Functional Safety Assessment and Fall Risk Assessment. All were updated to reflect current and appropriate interventions. Correction as it applies to other residents: 1. All residents will have a Functional Safety and Fall Risk Assessment completed at admission, quarterly, and with any significant change. A Fall Risk will be completed following every fall. Appropriate interventions will be added to the resident□s care plan. 2. A Post Fall Huddle will be initiated following every fall. An Incident Report will be completed in full following every fall including development of an appropriate intervention to prevent further reoccurrence. Interventions will be developed by evaluating the resident□s patterns, toileting patterns, medications, and all other risk factors. The intervention will immediately be added to the resident□s care plan. Incident Reports will include a review after 24 hours by an	

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F 323	Continued From page 6 staff heard R4 hollering for help. She was found sitting on the floor by the end of her bed with her wheelchair (w/c) in front of her. The fall was unwitnessed. R4 said she slid out of the w/c, onto the floor. Comments noted on the report included the following: isolated incident, R4 had no change in physical or psychosocial functioning as a result of her fall, brakes were working on her w/c, observe and reassess quarterly and as needed (PRN). No interventions to minimize the risk for future falls were identified. The second fall report on 9/25/13, at 8:30 a.m. noted R4 was found seated on the floor of her bathroom with her back against the wall. R4 stated she missed the toilet seat. External rotation of the right hip and pain in the right hip were noted. R4 was sent to the emergency room and was admitted for surgical repair. No immediate interventions were implemented as R4 went to the hospital. The registered nurse (RN) assessment and plan of action noted R4 was independent prior to the fall and was at the hospital for repair of her right hip. The plan added, when R4 returned from the hospital, increased assistance would have been necessary. The report indicated R4 was alert and oriented before fall and was aware of her safety needs. The report identified no potential causes for falls or dates of other falls or incidents. No patterns were identified. The report did identify depression as a psychological risk factor for R4. A falls assessment dated 10/8/13, revealed a total risk score of 75 (high risk). Falls risk analysis comments included that R4 lost her balance on 9/25/13. Potential risk factors included forgetfulness of limitations, use of a walker for transfers, impaired gait and balance, and a history of falls. Summary notes indicated R4 was alert, oriented, able to make her needs known,	F 323	RN. All Incident Reports will be reviewed by the Interdisciplinary Team at Stand-up meeting held Monday through Friday. 3. A note will be made on the resident□s Fall Risk Assessment following each fall including an analysis of the risk factors and interventions implemented. Reoccurrence will be prevented by: 1. DON or designee will audit one resident chart weekly X 12 weeks for appropriate fall assessment and intervention. 2. Incident Reports will be reviewed by the Interdisciplinary Team at Stand-up meetings Monday thru Friday. Correction will be monitored by: 1. DON or designee. 2. DON will report audit findings to the QA Committee quarterly and PRN.	

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and used her call-light appropriately to request assistance. No fall precautions were added. The assessment noted to observe, reassess quarterly and PRN.
R4's most recent care area assessment (CAA) dated 10/14/13, indicated R4 had an isolated fall with a hip fracture and was seen by physical and occupational therapy. R4 was identified as alert and called appropriately for assistance. The CAA revealed a referral was not indicated as she was already being seen by therapy and her medication were reviewed routinely by her medical doctor and pharmacy. The CAA instructed to observe, reassess quarterly and PRN.
On 10/24/13, R4's fall assessment scoring was updated with a score of 65 (high risk). Summary notes indicated R4 needed continuous reminding of non-weight-bearing restrictions for her right leg.
The third fall report on 11/18/13, at 4:20 p.m. revealed the staff heard R4 call out for help when she was found sitting in an upright position on the floor, in front of her sink. R4 was interviewed and stated she just slipped out of the chair when she was going to her sink. Interventions included reminding R4 she could not walk alone and to ask for help. An alarm for her chair was noted as an intervention to consider. There was no noted injury with the fall. Risk factors and potential causes for falls included increased confusion, impaired mobility and balance, impaired cognition, and judgment/safety awareness deficit. Dates of other falls/incidents and patterns were not identified. The RN assessment and plan of action noted R4 had no change in physical or psychosocial functioning as a result of the fall. The plan noted R4 was forgetful, but had not had any further incidents. R4 had no further interventions put into place.
A fourth fall was identified in a fall assessment on

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F 323	Continued From page 8 12/25/13, with a risk score of 90 (high risk), a 25-point increase from the previous scoring in 10/13. Summary notes included that R4 had fallen when she tried to open a drawer in her room. R4 was identified with intermittent confusion, with no further attempts to stand. The assessment instructed to continue the current plan, observe and reassess quarterly and PRN. No further fall interventions were implemented. The fifth fall report on 1/5/14, at 1:15 p.m. indicated R4 was found by staff on the floor in front of her dresser. The top dresser was pulled out. R4 was noted to have good range of motion to all extremities and the w/c was six feet from where she fell. R4 stated she was going to her dresser to get something. Interventions to prevent further incidents included reminding R4 to use her walker when in her room and reminding her to use her call light. A pressure alarm (a device that sounded an audible alarm when a resident's weight was lifted) was placed in R4's w/c. Risk factors and potential causes for falls included impaired mobility, activity intolerance, incontinence, impaired cognition, judgement and safety awareness of deficits. No patterns were identified and dates of previous falls included 9/25/13, with fracture of her right hip and 11/18/13. The RN assessment and plan of action noted R4 had recently become full weight bearing, she had a right hip fracture, and she was working with physical therapy for increased strengthening. The sixth fall report on 2/3/14, at 7:25 p.m. identified R4 was found on the floor in a pool of blood, her feet were by the bed with her head pointing toward the opposite side of the room. R4 said she thought she was going to bed. A large gash was noted to the right forehead and temple with profuse bleeding. A pressure dressing and	F 323		

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ice pack were applied and R4 was sent to the hospital for evaluation. The incident report identified risk factors for falls or other incidents as weakness. Dates of other falls and patterns were not identified. Potential risk factors was noted as unknown. The RN assessment and plan of action included pressure alarms and anti-rollback brakes (a device that locked the brakes of a w/c when a resident stood up). The interventions were noted as implemented after R4 returned from the hospital. R4's hospital admission history and physical report, dated 2/3/14, indicated R4 had been leaning forward in her wheelchair when she fell forward, hitting her head and causing a significant laceration.

Review of R4's temporary care plan (post hospitalization), dated 2/7/14, revealed a potential for injury related to a recent fall and weakness. Interventions included adjustment of her bed to the appropriate height, assist of two for transfers, falls precautions (unspecified) as needed, transfer belt with all transfers and assistive devices as needed. The temporary care plan did not identify the use of sensor alarms or anti-rollback brakes.

During interview on 2/10/14, at 1:43 p.m. licensed practical nurse (LPN)-A indicated R4 used a sensor pad in her chair to alert staff if she got up on her own. LPN-A also remarked R4 had been forgetful lately, such as holding papers in her hand and not remembering what to do with them, which started prior to the last fall. LPN-A was unsure if R4 was on a scheduled toileting program. She said RN-A did the falls assessments.

During interview on 2/10/14, at 1:55 p.m. RN-A

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said R4's cognition had been more impaired, and currently, she was "really impaired." She said R4 had been ill just prior to her most recent fall. A fax had been sent to the doctor, requesting to have R4 seen on rounds the next day, but R4 fell and went to the ER prior to being seen by a physician. RN-A said she could not say whether fall assessments were completed each time after a fall. She added, incidents were reviewed with all disciplines Monday through Friday. She indicated that input from those meetings would have been documented in the interdisciplinary progress notes; however, she was not sure this was done consistently. RN-A indicated that she thought staff toileted R4 upon arising and before and after meals. RN-A stated R4 was now a two person assist with transfers. RN-A said R4 had been a one person assist prior to her most recent fall on 2/3/14.

During interview on 2/10/14, at 2:05 p.m. nursing assistant (NA)-A said R4 wore a brief, dribbled a lot between meals and was not on a scheduled toileting program, but staff toileted R4 after meals. NA-A added R4 was on a walking program but could no longer walk the last few days, and needed to be "re-evaluated."

During observation on 2/10/14, at 4:50 p.m. R4 was leaning forward, in a hunched over position in their wheelchair, to reach her newspaper on the floor. R4 stated she was tired. An interview with LPN-E and NA-E on 2/10/14, at 4:50 p.m. identified that R4 had not attempted to self transfer out of her chair or attempted to get up independently since her hospital return.

During interview on 2/11/14, at 7:45 a.m. occupational therapy (OT)-C said R4 was way

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more cognitively impaired since her head injury. OT-C thought they had put R4 in a lower wheelchair back when she was treated for the hip fracture. OT-C added R4 had a new foot pedal.

During interview on 2/11/14, at 11:34 a.m., medical doctor (MD)-E said R4 was at risk for falls due to incontinence and was not a candidate for surgery or medication. MD-E further identified that R4 had a history of falling when reaching for things from their wheelchair, it was their understanding R4 had been doing this when she fell on 2/3/14. R4 was cognitive enough to want to be independent, yet did not always wait for help. MD-E stated R4 had a respiratory infection prior to her last fall, which could have further decreased R4's ability to recognize her limitations. R4 had been more confused for about a month. MD-E had done a CT (computerized topography, a form of x-ray imaging used to create cross-sectional views of the bones and soft tissues) of the head after the fall in January and before the fall in February in attempt to determine the cause of her confusion. The CT came back with no abnormalities.

During interview on 2/11/14, at 2:45 p.m. physical therapy assistant (PTA)-D said R4 was evaluated on 2/10/14, with goals of improving mobility and strength with transfers. PTA-D had worked on similar issues with R4's hip fracture; however, due to impaired cognition, R4 was unable to be independent with transfers.

During interview on 2/12/14, at 8:25 a.m. the director of nursing (DON) said the usual procedure for falls was to complete a team huddle within two hours to come up with an immediate intervention. She said the facility was

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F 323	Continued From page 12 trying to eliminate alarm usage as they were a "Band-Aid" for a fall, they did not really prevent falls. The DON said incident reports were to be filled out after falls and the reports were reviewed at standup meeting on weekdays. During further interview on 2/12/14, at 11:15 a.m. the DON said therapy did not always routinely attend standup meeting, but did attend weekly Medicare meetings with nursing. Recommendations from the disciplines that did attend standup (activities, nursing, dietary and social work) were to be documented in the interdisciplinary notes. The DON believed that the addition of anti-rollback breaks to R4's wheelchair were a result of a standup meeting. The facility's Fall Prevention policy revised 9/10, revealed post-fall assessments were to include a review of the causative factors such as medication, probable causes of the fall, co-morbid (pertaining to a disease process or disorder) conditions, mobility aid use, footwear, sensory aids, the environment, and if the treatment plan was being followed.	F 323		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		3/11/14

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 13 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure insulin pens were labeled with the date opened, for 1 of 2 residents (R12), whose insulin pens were observed during the medication storage review. Findings include: On 2/11/14, at 12:32 p.m. a Lantus SoloSTAR pen (a prescription medication for the control of blood sugars) was observed as opened, in the facility's treatment cart and ready for use for R12. The pen lacked a label to indicate the date it was	F 431	Corrective Action: 1. Insulin pen for resident #12 was dated and labeled. 2. All insulin pens were observed to ensure them as labeled, and dated February 12th, 2014. Corrective Action as it applies to other residents: 1. The Policy and Procedure for opening, labeling, and dating Insulin and Insulin pens was reviewed. 2. All Licensed Nurses received a copy of the Policy and Procedure.	

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	245551	A. BUILDING _____ B. WING _____	02/12/2014

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F 431	Continued From page 14 opened. Licensed practical nurse (LPN)-A verified there was not a date on the Lantus SoloSTAR pen to identify when it was opened. LPN-A confirmed the insulin pen should have been dated when it was opened. A review of Lantus, Full Prescribing Information revised 10/13, recommended the Lantus SoloSTAR pen could remain in use for 28 days, once opened. The Lantus SoloSTAR pen was to be discarded after the 28 days, even if insulin remained in the pen. The facility policy for Labeling/Storage of Medication revised 9/11, indicated insulin was to be labeled with the date opened.	F 431	3. All Licensed Nurses will be re-educated on the Insulin Policy and Procedure at a mandatory meeting scheduled for March 10 and March 11, 2014. Reoccurrence will be prevented by: 1. DON or designee will audit all insulin and insulin pens weekly X 4 weeks, then monthly for appropriate labeling and dating. Reoccurrence will be monitored by: 1. DON or designee 2. DON will report audit findings to the QA Quarterly and PRN	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT 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	F 441		3/11/14

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F 441	Continued From page 15 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper handwashing techniques to prevent cross-contamination for 1 of 2 residents (R4) observed during cares. Findings include: On 2/11/14, at 9:08 a.m. nursing assistant (NA)-A was observed to perform peri-care for R4. NA-A cleansed R4's perineal area with an incontinent wipe. The incontinence wipe was visibly soiled. NA-A finished to assist the resident and while still wearing the soiled gloves she pulled up the resident's clean brief, pants, touched the resident's wheelchair, her walker and her transfer belt before she removed the soiled gloves and washed her hands.	F 441	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 scheduled for March 10 and March 11,2014. Reoccurrence will be prevented by: 1. DON or designee will perform random audits of NARs and Nurses for	

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F 441	Continued From page 16 During an interview on 2/11/14, at 9:18 a.m. NA-A reported they would change gloves and wash their hands whenever going between clean and dirty activities such as peri-care. NA-A confirmed she should have removed her gloves and washed her hands between the peri-care and touching R4's clean items. During an interview on 2/11/14, at 2:25 p.m. the director of nursing (DON) indicated that staff should have changed gloves after providing peri-care and before touching any clean items. The undated facility policy, entitled Basic Infection Control, stated gloves should be changed whenever touching something dirty, such as the resident's body or linen during cares and before touching anything clean.	F 441	appropriate hand washing and gloving 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 the QA Committee quarterly and PRN	

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	245551	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/12/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Clarkfield Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

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

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Clarkfield Care Center is a 1-story building with partial basement. The building was constructed at 4 different times. The original building was constructed in 1955 and was determined to be of Type II(111) construction. In 1958 an addition was constructed and was determined to be of Type II(111) construction. In 1970, an addition was constructed and determined to be of Type II(111) construction. The most recent addition was constructed in 2004 and determined to be of Type II(111) construction. Because the existing building and the new additions are of different years of construction, the facility was surveyed as two buildings. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is monitored for automatic fire department notification. The facility has a capacity of 48 beds and had a census of 35 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 047 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation, the facility has failed to provide 1 of several operational exit signs that marks the means of egress path in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.5.2. The deficient practice could affect residents, staff and visitors, if the lack of properly illuminated exit sign prevented a means of egress from being utilized in a timely manner in an emergency situation. Findings include: On facility tour between 10:30 AM and 1:30 PM on 02/12/2014, it was observed that the illuminated exit sign that is located in the east basement was in-operative due to 2 burnt out light bulbs that are located within the device. This deficient practice was verified by the Maintenance Supervisor (JB).	K 047	Maintenance replaced the two burned out light bulbs located within the illuminated exit sign located in the east basement. The Environmental Services Director and/or designee will complete inspections of the facility plant on a regular basis to ensure that all illuminated signs are in working order and keep documentation up to date.	2/13/14
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 056		4/2/14

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K 056	Continued From page 3 If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect all residents, visitors and staff of the facility. Findings include: On facility tour between 10:30 AM to 1:30 PM on 02/12/2014, observations reveled the following deficient conditions were found affecting the facility's fire sprinkler system: 1. the spare sprinkler head box was not equipped with at least 2 of every type and style of sprinkler heads that are being used in the facility.	K 056	Maintenance will add additional spare elevated temperature type of sprinker heads for the west basement boiler room. The Fire Sprinkler riser pressure gauges will be serviced and replaced within the 5 yeartime frame. This will be 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 facility and that the fire sprinkler riser pressure gauges will be monitored and serviced or replaced as necessary.	

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K 056	Continued From page 4 The observed missing spare sprinkler heads were the elevated temperature type of sprinkler heads that were located in the west basement boiler room. 2. It could not be verified when the sprinkler gauges located on the main fire sprinkler riser have were last tested or recalibrating. This deficient condition was confirmed by the Maintenance Supervisor (JB).	K 056		
K 073 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain combustible decoration in accordance with NFPA Life Safety Code 101 (00) section 19.7.5.4. The failure to treat and maintain the combustible decorations throughout the facility in accordance with NFPA Life Safety Code 101 (00) could allow smoke and fire to rapidly migrate through the corridors and negatively affect the egress capability in the event of an emergency for residents, visitors and staff of the facility. Findings include: On facility tour between 10:30 AM to 1:30 PM on 02/12/2014, observations reveled that the resident room door was covered with wrapping paper that is not inherently fire retardant nor was it treated with any fire retardant treatment. The	K 073	Staff removed the wrapping paper from the resident room door #203. The Environmental Services Director will ensure that all decorations used in the facility will meet Life Safety Code Standards to prevent smoke and fire to rapidly migrate throught the corridors and negatively affect the egress capability in the event of an emergency	2/14/14

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K 073	Continued From page 5 wrapping paper covered the entire exterior of the residents door on the corridor side of the door. The deficient practices were confirmed by the Maintenance Supervisor (JB).	K 073		

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Electronically 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.

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Clarkfield Care Center is a 1-story building with partial basement. The building was constructed at 4 different times. The original building was constructed in 1955 and was determined to be of Type II(111) construction. In 1958 an addition was constructed and was determined to be of Type II(111) construction. In 1970, an addition was constructed and determined to be of Type II(111) construction. The most recent addition was constructed in 2004 and determined to be of Type II(111) construction. Because the existing building and the new additions are of different years of construction, the facility was surveyed as two buildings. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is monitored for automatic fire department notification. The facility has a capacity of 48 beds and had a census of 35 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect all residents, visitors and staff of the facility. Findings include: On facility tour between 10:30 AM to 1:30 PM on	K 056	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 facility and that fire sprinkler riser pressure gauges will be monitored and	4/2/14

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K 056	Continued From page 3 02/12/2014, observations reveled the following deficient conditions were found affecting the facility's fire sprinkler system: 1. the spare sprinkler head box was not equipped with at least 2 of every type and style of sprinkler heads that are being used in the facility. The observed missing spare sprinkler heads were the elevated temperature type of sprinkler heads that were located in the west basement boiler room. 2. It could not be verified when the sprinkler gauges located on the main fire sprinkler riser have were last tested or recalibrating. This deficient condition was confirmed by the Maintenance Supervisor (JB).	K 056	serviced or replaced as necessary.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and
Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

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.

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

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

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00842	A. BUILDING: _____ B. WING _____	02/12/2014

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CLARKFIELD CARE CENTER	805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On, February 9,10,11 and 12, 2014, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Certification Program; 3333 West Division St, Suite 212, St. Cloud, MN 56301-4557. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on	2 830		3/11/14

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2 830	Continued From page 2 individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to evaluate and analyze causative factors to minimize the risk for falls, for 1 of 3 residents (R4) reviewed for accidents. 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. Review of R4's fall incident reports and assessments from 5/18/13, through 2/9/14, revealed the following: The first fall report on 5/18/13, at 7:45 a.m. noted	2 830	Corrective Action: 1. Resident #4 care plan was reviewed along with the Functional Safety Assessment and Fall Risk Assessment. All were updated to reflect current and appropriate interventions. Correction as it applies to other residents: 1. All residents will have a Functional Safety and Fall Risk Assessment completed at admission, quarterly, and with any significant change. A Fall Risk will be completed following every fall. Appropriate interventions will be added to the resident□s care plan. 2. A Post Fall Huddle will be initiated following every fall. An Incident Report will be completed in full following every fall including development of an appropriate intervention to prevent further reoccurrence. Interventions will be developed by evaluating the resident□s patterns, toileting patterns, medications, and all other risk factors. The intervention will immediately be added to the resident□s care plan. Incident Reports will include a review after 24 hours by an	

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2 830	Continued From page 3 staff heard R4 hollering for help. She was found sitting on the floor by the end of her bed with her wheelchair (w/c) in front of her. The fall was unwitnessed. R4 said she slid out of the w/c, onto the floor. Comments noted on the report included the following: isolated incident, R4 had no change in physical or psychosocial functioning as a result of her fall, brakes were working on her w/c, observe and reassess quarterly and as needed (PRN). No interventions to minimize the risk for future falls were identified. The second fall report on 9/25/13, at 8:30 a.m. noted R4 was found seated on the floor of her bathroom with her back against the wall. R4 stated she missed the toilet seat. External rotation of the right hip and pain in the right hip were noted. R4 was sent to the emergency room and was admitted for surgical repair. No immediate interventions were implemented as R4 went to the hospital. The registered nurse (RN) assessment and plan of action noted R4 was independent prior to the fall and was at the hospital for repair of her right hip. The plan added, when R4 returned from the hospital, increased assistance would have been necessary. The report indicated R4 was alert and oriented before fall and was aware of her safety needs. The report identified no potential causes for falls or dates of other falls or incidents. No patterns were identified. The report did identify depression as a psychological risk factor for R4. A falls assessment dated 10/8/13, revealed a total risk score of 75 (high risk). Falls risk analysis comments included that R4 lost her balance on 9/25/13. Potential risk factors included forgetfulness of limitations, use of a walker for transfers, impaired gait and balance, and a history of falls. Summary notes indicated R4 was alert, oriented, able to make her needs known, and used her call-light appropriately to request	2 830	RN. All Incident Reports will be reviewed by the Interdisciplinary Team at Stand-up meeting held Monday through Friday. 3. A note will be made on the resident□s Fall Risk Assessment following each fall including an analysis of the risk factors and interventions implemented. 4. Training meeting scheduled for March 10th and 11th, 2014. Reoccurrence will be prevented by: 1. DON or designee will audit one resident chart weekly X 12 weeks for appropriate fall assessment and intervention. 2. Incident Reports will be reviewed by the Interdisciplinary Team at Stand-up meetings Monday thru Friday. Correction will be monitored by: 1. DON or designee. 2. DON will report audit findings to the QA Committee quarterly and PRN.	

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2 830	Continued From page 4	2 830		

assistance. No fall precautions were added. The assessment noted to observe, reassess quarterly and PRN.
R4's most recent care area assessment (CAA) dated 10/14/13, indicated R4 had an isolated fall with a hip fracture and was seen by physical and occupational therapy. R4 was identified as alert and called appropriately for assistance. The CAA revealed a referral was not indicated as she was already being seen by therapy and her medication were reviewed routinely by her medical doctor and pharmacy. The CAA instructed to observe, reassess quarterly and PRN.
On 10/24/13, R4's fall assessment scoring was updated with a score of 65 (high risk). Summary notes indicated R4 needed continuous reminding of non-weight-bearing restrictions for her right leg.
The third fall report on 11/18/13, at 4:20 p.m. revealed the staff heard R4 call out for help when she was found sitting in an upright position on the floor, in front of her sink. R4 was interviewed and stated she just slipped out of the chair when she was going to her sink. Interventions included reminding R4 she could not walk alone and to ask for help. An alarm for her chair was noted as an intervention to consider. There was no noted injury with the fall. Risk factors and potential causes for falls included increased confusion, impaired mobility and balance, impaired cognition, and judgment/safety awareness deficit. Dates of other falls/incidents and patterns were not identified. The RN assessment and plan of action noted R4 had no change in physical or psychosocial functioning as a result of the fall. The plan noted R4 was forgetful, but had not had any further incidents. R4 had no further interventions put into place.
A fourth fall was identified in a fall assessment on 12/25/13, with a risk score of 90 (high risk), a 25-point increase from the previous scoring in

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2 830	Continued From page 5 10/13. Summary notes included that R4 had fallen when she tried to open a drawer in her room. R4 was identified with intermittent confusion, with no further attempts to stand. The assessment instructed to continue the current plan, observe and reassess quarterly and PRN. No further fall interventions were implemented. The fifth fall report on 1/5/14, at 1:15 p.m. indicated R4 was found by staff on the floor in front of her dresser. The top dresser was pulled out. R4 was noted to have good range of motion to all extremities and the w/c was six feet from where she fell. R4 stated she was going to her dresser to get something. Interventions to prevent further incidents included reminding R4 to use her walker when in her room and reminding her to use her call light. A pressure alarm (a device that sounded an audible alarm when a resident's weight was lifted) was placed in R4's w/c. Risk factors and potential causes for falls included impaired mobility, activity intolerance, incontinence, impaired cognition, judgement and safety awareness of deficits. No patterns were identified and dates of previous falls included 9/25/13, with fracture of her right hip and 11/18/13. The RN assessment and plan of action noted R4 had recently become full weight bearing, she had a right hip fracture, and she was working with physical therapy for increased strengthening. The sixth fall report on 2/3/14, at 7:25 p.m. identified R4 was found on the floor in a pool of blood, her feet were by the bed with her head pointing toward the opposite side of the room. R4 said she thought she was going to bed. A large gash was noted to the right forehead and temple with profuse bleeding. A pressure dressing and ice pack were applied and R4 was sent to the hospital for evaluation. The incident report identified risk factors for falls or other incidents as	2 830		

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2 830	Continued From page 6	2 830		

weakness. Dates of other falls and patterns were not identified. Potential risk factors was noted as unknown. The RN assessment and plan of action included pressure alarms and anti-rollback brakes (a device that locked the brakes of a w/c when a resident stood up). The interventions were noted as implemented after R4 returned from the hospital. R4's hospital admission history and physical report, dated 2/3/14, indicated R4 had been leaning forward in her wheelchair when she fell forward, hitting her head and causing a significant laceration.

Review of R4's temporary care plan (post hospitalization), dated 2/7/14, revealed a potential for injury related to a recent fall and weakness. Interventions included adjustment of her bed to the appropriate height, assist of two for transfers, falls precautions (unspecified) as needed, transfer belt with all transfers and assistive devices as needed. The temporary care plan did not identify the use of sensor alarms or anti-rollback brakes.

During interview on 2/10/14, at 1:43 p.m. licensed practical nurse (LPN)-A indicated R4 used a sensor pad in her chair to alert staff if she got up on her own. LPN-A also remarked R4 had been forgetful lately, such as holding papers in her hand and not remembering what to do with them, which started prior to the last fall. LPN-A was unsure if R4 was on a scheduled toileting program. She said RN-A did the falls assessments.

During interview on 2/10/14, at 1:55 p.m. RN-A said R4's cognition had been more impaired, and currently, she was "really impaired." She said R4 had been ill just prior to her most recent fall. A fax had been sent to the doctor, requesting to

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2 830	Continued From page 7 have R4 seen on rounds the next day, but R4 fell and went to the ER prior to being seen by a physician. RN-A said she could not say whether fall assessments were completed each time after a fall. She added, incidents were reviewed with all disciplines Monday through Friday. She indicated that input from those meetings would have been documented in the interdisciplinary progress notes; however, she was not sure this was done consistently. RN-A indicated that she thought staff toileted R4 upon arising and before and after meals. RN-A stated R4 was now a two person assist with transfers. RN-A said R4 had been a one person assist prior to her most recent fall on 2/3/14. During interview on 2/10/14, at 2:05 p.m. nursing assistant (NA)-A said R4 wore a brief, dribbled a lot between meals and was not on a scheduled toileting program, but staff toileted R4 after meals. NA-A added R4 was on a walking program but could no longer walk the last few days, and needed to be "re-evaluated." During observation on 2/10/14, at 4:50 p.m. R4 was leaning forward, in a hunched over position in their wheelchair, to reach her newspaper on the floor. R4 stated she was tired. An interview with LPN-E and NA-E on 2/10/14, at 4:50 p.m. identified that R4 had not attempted to self transfer out of her chair or attempted to get up independently since her hospital return. During interview on 2/11/14, at 7:45 a.m. occupational therapy (OT)-C said R4 was way more cognitively impaired since her head injury. OT-C thought they had put R4 in a lower wheelchair back when she was treated for the hip fracture. OT-C added R4 had a new foot pedal.	2 830		

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2 830	Continued From page 8 During interview on 2/11/14, at 11:34 a.m., medical doctor (MD)-E said R4 was at risk for falls due to incontinence and was not a candidate for surgery or medication. MD-E further identified that R4 had a history of falling when reaching for things from their wheelchair, it was their understanding R4 had been doing this when she fell on 2/3/14. R4 was cognitive enough to want to be independent, yet did not always wait for help. MD-E stated R4 had a respiratory infection prior to her last fall, which could have further decreased R4's ability to recognize her limitations. R4 had been more confused for about a month. MD-E had done a CT (computerized topography, a form of x-ray imaging used to create cross-sectional views of the bones and soft tissues) of the head after the fall in January and before the fall in February in attempt to determine the cause of her confusion. The CT came back with no abnormalities. During interview on 2/11/14, at 2:45 p.m. physical therapy assistant (PTA)-D said R4 was evaluated on 2/10/14, with goals of improving mobility and strength with transfers. PTA-D had worked on similar issues with R4's hip fracture; however, due to impaired cognition, R4 was unable to be independent with transfers. During interview on 2/12/14, at 8:25 a.m. the director of nursing (DON) said the usual procedure for falls was to complete a team huddle within two hours to come up with an immediate intervention. She said the facility was trying to eliminate alarm usage as they were a "Band-Aid" for a fall, they did not really prevent falls. The DON said incident reports were to be filled out after falls and the reports were reviewed at standup meeting on weekdays.	2 830		

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2 830	Continued From page 9 During further interview on 2/12/14, at 11:15 a.m. the DON said therapy did not always routinely attend standup meeting, but did attend weekly Medicare meetings with nursing. Recommendations from the disciplines that did attend standup (activities, nursing, dietary and social work) were to be documented in the interdisciplinary notes. The DON believed that the addition of anti-rollback breaks to R4's wheelchair were a result of a standup meeting. The facility's Fall Prevention policy revised 9/10, revealed post-fall assessments were to include a review of the causative factors such as medication, probable causes of the fall, co-morbid (pertaining to a disease process or disorder) conditions, mobility aid use, footwear, sensory aids, the environment, and if the treatment plan was being followed. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure resident falls are consistently investigated to identify patterns and/or causative factors. Meaningful interventions based on the investigation results could be implemented to reduce the resident's risk for future falls. The director of nursing or her designee could educate all appropriate staff on these policies and procedures. The director of nursing or her designee could develop an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 830		

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21315	Continued From page 10	21315		
21315	MN Rule 4658.0720 Subp. 1 A-C Providing Daily Oral Care Subpart 1. Daily oral care plan. A nursing home must establish a daily oral care plan for each resident consistent with the results of the comprehensive resident assessment. A. A resident's daily oral care plan must indicate whether or not the resident has natural teeth or wears removable dentures or partials. It must also indicate whether the resident is able to maintain oral hygiene independently, needs supervision, or is dependent on others. B. A nursing home must provide a resident with the supplies and assistance necessary to carry out the resident's daily oral care plan. The supplies must include at a minimum: toothbrushes, fluoride toothpaste, mouth rinses, dental floss, denture cups, denture brushes, denture cleaning products, and denture adhesive products. C. A nursing home must make the daily oral care plan available to the attending dentist before each checkup, and must modify the plan according to the dentist's, dental hygienist's, or other dental practitioner's directions. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide denture adhesive during a Medicare or Medicaid stay, for 1 of 3 residents (R4) who were reviewed for oral and dental services. Findings include: R4 was re-admitted to the facility after	21315	1. Denture adhesive was obtained for 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 be provided for residents during their stay at the facility as deemed appropriate by Speech Therapy.	3/11/14

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21315	Continued From page 11 hospitalization for a fall. Her return diagnoses per the hospital discharge summary dated 2/7/14, included dysphasia (difficulty swallowing). A speech pathology inpatient progress note dated 2/6/14, revealed R4 had difficulty chewing and propelling food to be swallowed. She was able to eat meat, if cut into small pieces. The progress note included plans for swallowing strategies which included ensuring her upper denture was in place with adhesive prior to oral intake. Additionally, instructions to ensure the upper denture was in place with adhesive were communicated via a Safe Swallow Strategies to be Followed by Patient, Staff and Visitors form dated 2/7/14. The form was copied to the facility dining room board, the nursing assistant (NA) board, as well as to be passed along in report. 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	21315	Corrective Action as it applies to other residents: 1. All residents will receive an oral assessment on admission. Speech Therapy will be referred as deemed appropriate 2. All Therapy recommendations will be added to the care plan and passed on to facility staff for implementation. 3. All recommended assistive devices and interventions will be implemented as ordered. The facility will ensure the items are obtained and/or provided. 4. Nursing staff will be educated on maintaining necessary supplies and communicating need to restock at a Mandatory meeting March 10th and 11th, 2014. Reoccurrence will be prevented by: 1 Denture adhesive will be ordered and maintained as a stock supply. 2 DON or Designee will audit resident care plans and ensure that adhesive is available and in place for all residents requiring its use. Correction will be monitored by: 1. DON or designee 2. DON will report the findings to the QA Committee quarterly and PRN.	

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21315	Continued From page 12	21315		

talked to registered nurse (RN)-A and the adhesive had to be ordered in as there was none available in the facility. ST-G had difficulty feeding R4 her meat due to the dentures being out of R4's mouth, and proceeded to feed her pudding instead. ST-G said with the dentures in, R4 could have chewed her food better.

During interview on 2/11/14, at 12:06 p.m. NA-A stated it was the usual procedure to call the pharmacy to have denture adhesive sent for a resident when needed. NA-A verified the facility did not routinely have this in stock for resident use when needed.

During interview on 2/12/14, at 8:25 a.m. the director of nursing (DON) said it was the usual procedure to order denture adhesive from the pharmacy for residents that needed it, and that the adhesive was then billed by pharmacy to the resident. The DON indicated that the facility "probably should" have kept some denture adhesive on hand; however, it had "just always been done this way," since she had worked at the facility.

During interview on 2/12/14, at 8:40 a.m. the social worker (SW)-A stated that the nursing department ordered personal supplies like denture adhesive. SW-A further stated she thought it was written in the admission agreement that denture adhesive was not covered and was billed to the resident.

Review of the facility's undated admission booklet revealed that items such as Kleenex, denture cups, denture cleaner, toothbrushes, and toothpaste were provided. The items covered did not include denture adhesive.

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21315	Continued From page 13 SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could revise facility policies, procedures, and/or admission contracts regarding the provision of supplies necessary to carry out each resident's daily oral care plan, including at a minimum: toothbrushes, fluoride toothpaste, mouth rinses, dental floss, denture cups, denture brushes, denture cleaning products, and denture adhesive products. The director of nursing or her designee could implement audits to ensure the supplies needed are available and offered for resident use, at the facility's expense. Training could be provided for all personnel to ensure compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21315		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control	21390		3/11/14

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21390	Continued From page 14 practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper handwashing techniques to prevent cross-contamination for 1 of 2 residents (R4) observed during cares. Findings include: On 2/11/14, at 9:08 a.m. nursing assistant (NA)-A was observed to perform peri-care for R4. NA-A cleansed R4's perineal area with an incontinent wipe. The incontinence wipe was visibly soiled. NA-A finished to assist the resident and while still wearing the soiled gloves she pulled up the resident's clean brief, pants, touched the resident's wheelchair, her walker and her transfer belt before she removed the soiled gloves and washed her hands. During an interview on 2/11/14, at 9:18 a.m. NA-A reported they would change gloves and wash their hands whenever going between clean and dirty activities such as peri-care. NA-A confirmed she should have removed her gloves and washed her hands between the peri-care and touching R4's clean items.	21390	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 March 10th and 11th, 2014. Reoccurrence will be prevented by: 1. DON or designee will perform random audits of NARs and Nurses for appropriate hand washing and gloving weekly X 4 weeks, then monthly. Reoccurrence will be monitored by: 1. DON or designee 2. DON will report audit findings to the QA Committee quarterly and PRN	

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21390	Continued From page 15 During an interview on 2/11/14, at 2:25 p.m. the director of nursing (DON) indicated that staff should have changed gloves after providing peri-care and before touching any clean items. The undated facility policy, entitled Basic Infection Control, stated gloves should be changed whenever touching something dirty, such as the resident's body or linen during cares and before touching anything clean. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee(s) may review or revise policies and procedures related to infection control techniques in regards to peri care and handwashing. The director of nursing or designee (s) could provide an in-service in regard to these policies and procedures. The director of nursing or designee(s) could conduct audits to ensure the policies and procedures are being implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure insulin pens were labeled with the date opened, for 1 of 2 residents (R12), whose insulin pens were observed during the medication storage review.	21620	1. Insulin pen for resident #12 was dated and labeled. 2. All insulin pens were observed to ensure them as labeled, and dated Corrective Action as it applies to other residents:	3/11/14

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21620	Continued From page 16 Findings include: On 2/11/14, at 12:32 p.m. a Lantus SoloSTAR pen (a prescription medication for the control of blood sugars) was observed as opened, in the facility's treatment cart and ready for use for R12. The pen lacked a label to indicate the date it was opened. Licensed practical nurse (LPN)-A verified there was not a date on the Lantus SoloSTAR pen to identify when it was opened. LPN-A confirmed the insulin pen should have been dated when it was opened. A review of Lantus, Full Prescribing Information revised 10/13, recommended the Lantus SoloSTAR pen could remain in use for 28 days, once opened. The Lantus SoloSTAR pen was to be discarded after the 28 days, even if insulin remained in the pen. The facility policy for Labeling/Storage of Medication revised 9/11, indicated insulin was to be labeled with the date opened. SUGGESTED METHOD FOR CORRECTION: The director of nursing or her designee could review appropriate policies and procedurees for safe storage of medications in the medication cart. Pertinent employees could be re-educated on these policies and procedures, to include the labeling of opened insulin pens. Random audits could be completed by the director of nursing, her designee, or the pharmacy consultant to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21620	1. The Policy and Procedure for opening, labeling, and dating Insulin and Insulin pens was reviewed. 2. All Licensed Nurses received a copy of the Policy and Procedure. 3. All Licensed Nurses will be re-educated on the Insulin Policy and Procedure at a mandatory meeting March 10th and 11th, 2014. Reoccurrence will be prevented by: 1. DON or designee will audit all insulin and insulin pens weekly X 4 weeks, then monthly for appropriate labeling and dating. Reoccurrence will be monitored by: 1. DON or designee 2. DON will report audit findings to the QA Quarterly and PRN	