

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XFS3

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00842

1. MEDICARE/MEDICAID PROVIDER NO. (L1) <b>245551</b>		3. NAME AND ADDRESS OF FACILITY (L3) <b>CLARKFIELD CARE CENTER</b> (L4) <b>805 FIFTH STREET, BOX 458</b> (L5) <b>CLARKFIELD, MN</b> (L6) <b>56223</b>		4. TYPE OF ACTION: <u>7</u> (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other  8. Full Survey After Complaint	
2. STATE VENDOR OR MEDICAID NO. (L2) <b>908340500</b>		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) <b>01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA</b> <b>02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF</b> <b>03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC</b> <b>04 SNF 08 OPT/SP 12 RHC 16 HOSPICE</b>	
6. DATE OF SURVEY <b>05/02/2016</b> (L34)		8. ACCREDITATION STATUS: <u>    </u> (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		FISCAL YEAR ENDING DATE: (L35) <b>09/30</b>	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10. THE FACILITY IS CERTIFIED AS: <b>X</b> A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements <u>    </u> 2. Technical Personnel <u>    </u> 6. Scope of Services Limit Compliance Based On: <u>    </u> 3. 24 Hour RN <u>    </u> 7. Medical Director <u>    </u> 1. Acceptable POC <u>    </u> 4. 7-Day RN (Rural SNF) <u>    </u> 8. Patient Room Size <u>    </u> 5. Life Safety Code <u>    </u> 9. Beds/Room B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: <b>A*</b> (L12)			
12. Total Facility Beds <b>42</b> (L18)		13. Total Certified Beds <b>42</b> (L17)		14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID <b>42</b> (L37) (L38) (L39) (L42) (L43)	
15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)					

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

17. SURVEYOR SIGNATURE  <u>Jessica Sellner, Unit Supervisor</u> (L19)		Date : 05/02/2016		18. STATE SURVEY AGENCY APPROVAL  <u>Kate JohnsTon, Program Specialist</u> (L20)		Date: 05/20/2016	
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## PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY <b>X</b> 1. Facility is Eligible to Participate <u>    </u> 2. Facility is not Eligible (L21)		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : <u>    </u>	
22. ORIGINAL DATE OF PARTICIPATION <b>01/01/1991</b> (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) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. <b>03001</b> (L28)		30. REMARKS  (L31)	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE <b>04/29/2016</b> (L33)		DETERMINATION APPROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245551  
May 20, 2016

Mr. Murray Finger, Administrator  
Clarkfield Care Center  
805 Fifth Street, Box 458  
Clarkfield, Minnesota 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 May 6, 2016 the above facility is certified for or recommended for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Clarkfield Care Center

May 20, 2016

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Sincerely,

A handwritten signature in cursive script, reading "Kate Johnston". The signature is fluid and includes a long, sweeping horizontal line at the end.

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

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered  
May 20, 2016

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

RE: Project Number S5551026

Dear Mr. Finger:

On March 30, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 17, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 2, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 17, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 17, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 6, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 17, 2016, effective May 6, 2016 and therefore remedies outlined in our letter to you dated March 30, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Clarkfield Care Center

May 20, 2016

Page 2

Sincerely,

A handwritten signature in black ink, reading "Kate Johnston". The signature is fluid and cursive, with a large loop at the end of the last name.

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245551	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 5/2/2016
NAME OF FACILITY CLARKFIELD CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223	

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0356	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.30(e)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/31/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS) JS/KJ	DATE 05/20/2016	SIGNATURE OF SURVEYOR 29249	DATE 05/02/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 3/17/2016

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

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245551	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	DATE OF REVISIT 5/17/2016
NAME OF FACILITY CLARKFIELD CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223	

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0038	05/06/2016	LSC K0048	04/22/2016	LSC K0154	04/22/2016
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC K0155	04/22/2016	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS) TL/KJ	DATE 05/20/2016	SIGNATURE OF SURVEYOR 35482	DATE 05/17/2016
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 3/15/2016

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

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245551	MULTIPLE CONSTRUCTION A. Building 02 - BUILDING TWO B. Wing	DATE OF REVISIT 5/17/2016
NAME OF FACILITY CLARKFIELD CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223	

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

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ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # _____	Completed
LSC K0154	04/22/2016	LSC K0155	04/22/2016	LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS) TL/KJ	DATE 05/20/2016	SIGNATURE OF SURVEYOR 35482	DATE 05/17/2016
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 3/15/2016

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



## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XFS3

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00842

1. MEDICARE/MEDICAID PROVIDER NO. (L1) <b>245551</b>		3. NAME AND ADDRESS OF FACILITY (L3) <b>CLARKFIELD CARE CENTER</b> (L4) <b>805 FIFTH STREET, BOX 458</b> (L5) <b>CLARKFIELD, MN</b> (L6) <b>56223</b>		4. TYPE OF ACTION: <u>2</u> (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other  8. Full Survey After Complaint	
2.STATE VENDOR OR MEDICAID NO. (L2) <b>908340500</b>		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) <b>01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA</b> <b>02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF</b> <b>03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC</b> <b>04 SNF 08 OPT/SP 12 RHC 16 HOSPICE</b>	
6. DATE OF SURVEY <b>03/17/2016</b> (L34)		8. ACCREDITATION STATUS: <u>    </u> (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		FISCAL YEAR ENDING DATE: (L35) <b>09/30</b>	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY IS CERTIFIED AS: <b>X</b> A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements <u>    </u> 2. Technical Personnel <u>    </u> 6. Scope of Services Limit Compliance Based On: <u>    </u> 3. 24 Hour RN <u>    </u> 7. Medical Director <b>X</b> 1. Acceptable POC <u>    </u> 4. 7-Day RN (Rural SNF) <u>    </u> 8. Patient Room Size <u>    </u> 5. Life Safety Code <u>    </u> 9. Beds/Room B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: <b>A1*</b> (L12)			
12.Total Facility Beds <b>42</b> (L18)		13.Total Certified Beds <b>42</b> (L17)		14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF 19 SNF ICF IID 42 (L37) (L38) (L39) (L42) (L43)	
15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)					

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

17. SURVEYOR SIGNATURE  <u>Annette Truebenbach, HFE NE II</u> (L19)	Date : <b>04/05/2016</b>	18. STATE SURVEY AGENCY APPROVAL  <u>Kate JohnsTon, Program Specialist</u> (L20)	Date: <b>04/26/2016</b>
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## PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY  <u>    </u> 1. Facility is Eligible to Participate <u>    </u> 2. Facility is not Eligible (L21)		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : <u>          </u>	
22. ORIGINAL DATE OF PARTICIPATION <b>01/01/1991</b> (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) <b>VOLUNTARY</b> <u>00</u> <b>INVOLUNTARY</b> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. <b>03001</b> (L28)		30. REMARKS  Posted 04/29/2016 Co.	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)		DETERMINATION APPROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered  
March 30, 2016

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

RE: Project Number S5551026

Dear Mr. Finger:

On March 17, 2016, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

**DEPARTMENT CONTACT**

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

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

**OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 26, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

**ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

#### **PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

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

## **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

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

### **Original deficiencies not corrected**

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

### **Original deficiencies not corrected and new deficiencies found during the revisit**

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

### **Original deficiencies corrected but new deficiencies found during the revisit**

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

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

If substantial compliance with the regulations is not verified by June 17, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 17, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

### **INFORMAL DISPUTE RESOLUTION**

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or I IDR of federal deficiencies must be submitted via the web at: [http://www.health.state.mn.us/divs/fpc/profinfo/ltr/ltr\\_idr.cfm](http://www.health.state.mn.us/divs/fpc/profinfo/ltr/ltr_idr.cfm)

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

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

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

**Mr. Tom Linhoff, Fire Safety Supervisor  
Health Care Fire Inspections  
Minnesota Department of Public Safety  
State Fire Marshal Division  
444 Minnesota Street, Suite 145  
St. Paul, Minnesota 55101-5145**

Clarkfield Care Center

March 30, 2016

Page 6

Email: [tom.linhoff@state.mn.us](mailto:tom.linhoff@state.mn.us)

Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script, appearing to read "Kate Johnston".

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

[kate.johnston@state.mn.us](mailto:kate.johnston@state.mn.us)

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

PRINTED: 04/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245551</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLARKFIELD CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.  Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION  The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.  The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356		3/31/16	

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

TITLE

(X6) DATE

Electronically Signed

04/04/2016

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NAME OF PROVIDER OR SUPPLIER  <b>CLARKFIELD CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223</b>		
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F 356	<p>Continued From page 1</p> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the nurse staff posting included the actual hours worked by licensed and unlicensed nursing staff responsible for resident care. This had the potential to affect all 32 residents who currently resided in the facility.</p> <p>Findings include:</p> <p>During initial tour of the facility on 3/14/16, at 3:36 p.m. the facility Clarkfield Care Center Nursing Staff Hours Posting (staff posting) was displayed on the director of nursing's (DON) office door. The posting included the facility name, current date, current census, and the total number of staff and hours worked on the day shift identified as 6:00 a.m. to 2:30 p.m. , the evening shift identified as 2:00 p.m. to 10:30 p.m. and the night shift identified as 10:00 p.m. to 6:30 a.m. The staff included in this were identified as registered nurses (RN), licensed practical nurses (LPN), trained medical assistants (TMA), and nursing assistants (NA).</p> <p>The staff posting dated 3/14/16, indicated on the evening shift from 2:00 p.m.- 9:30 p.m. (a 7.5</p>	F 356	<p>Corrective Action:</p> <p>1. Posted Staff Information Sheet has been corrected to also show the actual hours worked by category.</p> <p>Corrective Action as it applies to other residents:</p> <p>1. Posted Staff Information Sheet will consistently show the actual hours worked by category.</p> <p>Date of Completion:</p> <p>March 31st, 2016</p> <p>Reoccurrence will be prevented by:</p> <p>1. Standard form, including actual hours worked, will be used daily.</p> <p>2. Standard form will be audited weekly for one month, and then every month for six months.</p> <p>Correction will be monitored by:</p> <p>1. DON or designee</p>		

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F 356	<p>Continued From page 2</p> <p>hour shift), there was one RN for a total of 4 hours (did not indicate the actual hours the RN was working), and 3.5 NA's for a total of 28 hours (did not indicate the actual hours the NA's were working). The posting lacked the actual hours, and/ or partial shift the staff was working.</p> <p>During interview on 3/14/16, at 6:39 p.m. DON stated the posting indicated the number of hours worked on the shift, however, it did not identify the actual hours for the partial shifts which were worked.</p> <p>A policy on staff posting was requested but was not provided.</p>	F 356			

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K 000	<p><b>INITIAL COMMENTS</b></p> <p><b>FIRE SAFETY</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or</p> <p>By email to:</p>	K 000			

**EPOC**

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

TITLE

(X6) DATE

Electronically Signed

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K 000	<p>Continued From page 1</p> <p>Marian.Whitney@state.mn.us &lt;mailto:Marian.Whitney@state.mn.us&gt; and Angela.Kappenman@state.mn.us &lt;mailto:Angela.Kappenman@state.mn.us&gt;</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> <li>1. A description of what has been, or will be, done to correct the deficiency.</li> <li>2. The actual, or proposed, completion date.</li> <li>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.</li> </ol> <p>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.</p> <p>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</p>	K 000			

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K 000	Continued From page 2 notification. The facility has a capacity of 42 beds and had a census of 33 at time of the survey.	K 000			
K 038 SS=E	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  FINDINGS INCLUDE:  On facility tour between 9:30 AM and 12:00 PM on 03/15/2016, observation revealed:  1.) The Dining Room Exit Door has a "thumb turn device" on the locking mechanism. 2.) The exit door to the Courtyard adjacent to the Dining Room has a key operated lock on the exit door.  This deficient practice was confirmed with the Facility Maintenance Director.	K 038	The Environmental Services Director will ensure the door exiting the dining room will be replaced. The new door will have the proper exiting devices to allow door access to exit the building at all times. The Environmental Services Director will mount a push-bar exit device on the existing courtyard door. The new push-bar device will allow door access to exit the building at all times.  The Environmental Service Director will ensure the two doors are in compliance on or before 5/6/16.  The Environmental Service Director, or designee, will complete inspections of the facility on a regular basis to ensure there are no doors that do not allow exiting of the building at all times, to assure resident safety.	5/6/16	
K 048 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: There is a written plan for the protection of all	K 048	The Environmental Services Director will	4/22/16	

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K 048	Continued From page 3 patients and for their evacuation in the event of an emergency. 19.7.1.1  FINDINGS INCLUDE:  During documentation review between 9:30 AM and 12:00 PM on 03/15/2016, observation revealed the Fire Emergency Plan did not contain all the required items needed for a Health Care Fire Emergency Plan.  This deficient practice was confirmed with the Facility Maintenance Director.	K 048	revise the current Emergency Evacuation Plan to add all required items for a Health Care Emergency Plan.  The Environmental Services Director will complete this on or before 4/22/16.  The Environmental Services Director, or designee, will monitor emergency plans to ensure resident safety.		
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1  Findings include:  During documentation review between 9:30 AM and 12:30 PM on 3/15/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the	K 154	The Environmental Services Director will write and implement an out of service plan for the fire sprinkler system.  The Environmental Services Director will have this completed on or before 4/22/16.  The Environmental Services Director, or designee, will monitor out of service plan for the fire sprinkler system to ensure resident safety.	4/22/16	



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K 154	Continued From page 4 fire sprinkler system.	K 154			
K 155 SS=D	<p>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Findings include:</p> <p>During documentation review between 9:30 AM and 12:30 PM on 3/15/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system.</p> <p>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.</p>	K 155	<p>The Environmental Services Director will write and implement an out of service plan for the fire alarm system.</p> <p>The Environmental Services Director will have this completed on or before 4/22/16.</p> <p>The Environmental Services Director, or designee, will monitor out of service plan for the fire alarm system to ensure resident safety.</p>	4/22/16	

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

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NAME OF PROVIDER OR SUPPLIER  <b>CLARKFIELD CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223</b>		
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K 000	<p><b>INITIAL COMMENTS</b></p> <p><b>FIRE SAFETY</b></p> <p>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.</p> <p>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.</p> <p>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 18 New Health Care Occupancies.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or</p> <p>By email to:</p>	K 000			

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245551</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - BUILDING TWO</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/15/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLARKFIELD CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>805 FIFTH STREET, BOX 458 CLARKFIELD, MN 56223</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	<p>Continued From page 1</p> <p>Marian.Whitney@state.mn.us &lt;mailto:Marian.Whitney@state.mn.us&gt; and Angela.Kappenman@state.mn.us &lt;mailto:Angela.Kappenman@state.mn.us&gt;</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> <li>1. A description of what has been, or will be, done to correct the deficiency.</li> <li>2. The actual, or proposed, completion date.</li> <li>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.</li> </ol> <p>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.</p> <p>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</p>	K 000			

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

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K 000	Continued From page 2 notification. The facility has a capacity of 42 beds and had a census of 33 at time of the survey.	K 000			
K 154 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1. This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1  Findings include:  During documentatation review between 9:30 AM and 12:30 PM on 3/15/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system.  This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 154	The Environmental Services Director will write and implement an out of service plan for the fire sprinkler system.  The Environmental Services Director will have this completed on or before 4/22/16.  The Environmental Services Director, or designee, will monitor out of service plan for the fire sprinkler system to ensure resident safety.		4/22/16
K 155	NFPA 101 LIFE SAFETY CODE STANDARD	K 155			4/22/16

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K 155 SS=D	<p>Continued From page 3</p> <p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Findings include:</p> <p>During documentatation review between 9:30 AM and 12:30 PM on 3/15/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system.</p> <p>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.</p>	K 155	<p>The Environmental Services Director will write and implement an out of service plan for the fire alarm system.</p> <p>The Environmental Services Director will have this completed on or before 4/22/16.</p> <p>The Environmental Services Director, or designee, will monitor out of service plan for the fire alarm system to ensure resident safety.</p>		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted  
March 30, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5551026

Dear Mr. Finger:

The above facility was surveyed on March 14, 2016 through March 17, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Clarkfield Care Center

March 30, 2016

Page 2

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script, appearing to read "Kate Johnston", written in black ink.

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

Enclosure(s)

cc: Original - Facility  
Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00842</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>03/17/2016</b>
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p><b>NH LICENSING CORRECTION ORDER</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b> You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a> The State licensing orders are delineated on the attached Minnesota</p>	2 000		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/04/16

Minnesota Department of Health

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2 000	<p>Continued From page 1</p> <p>Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.</p> <p>On March 14, 15, 16th, and 17th, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.</p> <p>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.</p> <p>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.</p> <p>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.</p>	2 000		



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2 000	Continued From page 2  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train  ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503  (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care.  (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section.  This MN Requirement is not met as evidenced by:	2 302		4/25/16



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2 302	<p>Continued From page 3</p> <p>Koch, Michelle</p> <p>Based on interview and document review, the facility failed to ensure consumers were provided written or electronic information regarding training staff had received for dementia and/ or Alzheimer's care. This had the potential to affect all 32 current residents family members, and/ or guardians, and consumers.</p> <p>Findings include:</p> <p>A review of the staff training program titled Awakenings, which included training for all staff and volunteers on providing care for residents with dementia and/ or Alzheimer's was completed by all staff on 10/29/15, 12/10/15, and 1/28/16.</p> <p>During interview on 3/17/16, at 11:00 a.m. social service (SS)-A stated staff training for dementia and/ or Alzheimer's was last reviewed at Family Council on 11/5/14, and all staff were trained on dementia care upon hire and annually. SS-A stated there was no notification provided to consumers, family members, and/ or guardians either via written or electronic notification of staff training regarding Alzheimer's or dementia care.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator or designee could review its process to ensure: Alzheimer's training is timely completed by both facility and contracted nursing staff; and residents and interested others are made aware that dementia training is provided to staff, who received training, the frequency of training, and a description of the training topics.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	2 302	Corrected	

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21426	<p>MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control</p> <p>(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.</p> <p>(b) Written compliance with this subdivision must be maintained by the nursing home.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a system was in place to screen for tuberculosis (TB) symptoms and/ or complete a step-one skin testing (TST) within 90 days prior to resident care for 3 of 5 employees (licensed practical nurse (LPN)-A, registered nurse (RN)-B, nursing assistant NA-A) reviewed for TB.</p> <p>Findings include:</p> <p>LPN-A's hire date was 3/3/16. LPN-A's employee</p>	21426	Corrected	4/25/16

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21426	<p>Continued From page 5</p> <p>record lacked evidence of a TB symptom screen, and LPN-A had not had a TST completed within 90 days prior to resident care.</p> <p>RN-B's hire date was 2/9/16, and the first day of providing resident care was 2/9/16. Although RN-B began to provide patient cares on 2/9/16, a TB symptoms screen was not completed until 2/10/16, and a step- one TST was completed on 2/10/16, and was read on 2/12/16.</p> <p>NA-A's hire date was 3/1/16, with the first day of providing resident care 3/4/16. NA-A's employee record lacked a completed TB symptoms screen. NA-A's employee record indicated the employee had a step-one TST given on 2/26/16, however, there were no recorded results of the TST.</p> <p>During interview on 3/17/16, at 3:17 p.m. the director of nursing (DON) stated LPN-A worked at a neighboring facility and had a TST test completed on 8/18/15, so the facility did not complete another TST test. DON stated LPN-A did not have a TB symptom screening completed, and stated RN-B's TB symptom screen and step -one TST were completed after she had already been providing direct resident care. DON also stated NA-A did not have a TB symptom screen completed, and although NA-A had received the TST, there was no documentation the TST was read to determine if it was negative or positive.</p> <p>The facility policy and procedure titled Tuberculosis (TB) Prevention and Control dated 6/14, indicated all employees of the facility would be tested prior to employment. "Baseline TB screening consists of two components: 1) assessing for current symptoms of active TB disease and 20 testing for the presence of infection with Mycobacterium tuberculosis by</p>	21426		

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21426	Continued From page 6  administering either a two-step TST or a single TB blood test."  SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the assessment process for employees to be sure the documentation of the tuberculin screens and tests are completed, the administrator or designee could monitor for compliance.  TIME PERIOD FOR CORRECTION: Twenty one (21) days	21426			