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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Y7H6

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 **01/23/2013** (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 IMR	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 **52** (L18)

13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___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: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	52			
(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 :
Sarah Grebenc, Unit Supervisor 01/25/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 01/25/2013 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/22/2013
(L33)

DETERMINATION APPROVAL

At the time of the standard survey completed on December 6, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On January 23, 2013, the Minnesota Department of Health (by review of the plan of correction) completed a Post Certification Revisit (PCR) and on January 11, 2013 the Minnesota Department of Public Safety completed a PCR and determined that the facility had achieved substantial compliance pursuant to the standard survey completed on December 6, 2012, effective January 15, 2013. Therefore, the remedies outlined in our letter dated December 24, 2012 will not be imposed.

See attached CMS-2567B for the results of the January 11, 2013 and January 23, 2013 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5551

January 25, 2013

Mr. Paul Luitjens, Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, Minnesota 56223

Dear Mr. Luitjens:

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 January 15, 2013 the above facility is recommended for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 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,

Nicole Steege

Nicole Steege, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 25, 2013

Mr. Paul Luitjens, Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, Minnesota 56223

RE: Project Number S5551023

Dear Mr. Luitjens:

On December 24, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 6, 2012. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 23, 2013, the Minnesota Department of Health (by review of your plan of correction) completed a Post Certification Revisit (PCR) and on January 11, 2013 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 December 6, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 15, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 6, 2012, effective January 15, 2013 and therefore remedies outlined in our letter to you dated December 24, 2012, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Sarah Grebenc

Sarah Grebenc, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7365 Fax: (320) 223-7348
Enclosure
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	1/23/2013

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 **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **01/15/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/15/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **01/15/2013**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **01/15/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **01/15/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **12/06/2012**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **01/15/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **01/15/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **01/15/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SG/NCS	1/25/13	28589	1/23/13
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
12/6/2012			

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 A. Building B. Wing	(Y3) Date of Revisit
245551	01 - MAIN BUILDING 01	1/11/2013

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 Reg. # NFPA 101 LSC K0062	Correction Completed 12/10/2012	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/NCS	Date: 1/25/13	Signature of Surveyor: 27200	Date: 1/11/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 12/5/2012		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 02 - BUILDING TWO B. Wing	1/11/2013

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 ____ Reg. # NFPA 101 LSC K0062	Correction Completed 12/10/2012	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed

Reviewed By State Agency	Reviewed By PS/NCS	Date: 1/25/13	Signature of Surveyor: 27200	Date: 1/11/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 12/5/2012		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: Y7H6

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 **12/06/2012** (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 IMR	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 **52** (L18)

13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___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

X 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	IMR
	52			
(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 :
Nicolle Marx, HFE-NEII 01/17/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 01/22/2013 (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 1/22/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

At the time of the standard survey completed on December 6, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed.

See attached CMS-2567 for survey results. Post Certification Revisit after January 15, 2013.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 8489

December 24, 2012

Mr. Paul Luitjens, Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, Minnesota 56223

RE: Project Number S5551023

Dear Mr. Luitjens:

On December 6, 2012, 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>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

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

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

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
Minnesota Department of Health
Midtown Square
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301-4557

Telephone: (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 January 15, 2013, 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 January 15, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter.

Your PoC 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 signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 March 6, 2013 (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 June 6, 2013 (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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Sarah Grebenc, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7365 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245551	A. BUILDING _____ B. WING _____	12/06/2012

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	RECEIVED JAN 0 8 2013 MN Dept of Health St.Cloud	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	1/17/13	

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

Pat Lindgren — Executive Dir — 1-7-13

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.

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

PRINTED: 12/24/2012
FORM APPROVED
OMB NO. 0938-0391

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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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	F 279 1. Corrective Action: R 33 plan of care was developed to identify skin issues related to bruising, fragile skin with use of Coumadin and/or Prednisone. R 1 plan of care developed to address proper positioning with OT assessment.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Dir	1-9-13

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.

Addendum for Clarkfield Care Center MDH Survey Plan of Correction

January 15, 2013, requested by Sarah Grebenc, MSW, HFE Unit Supervisor

F 279: monthly audit or more often if needed

F 282: audit q week x 1 month, then q month or more often if needed

F 309: q week x 1 month, then q month or more often if needed

F 312: q week x 1month, then q month or more often if needed

F 329: q month or more often if needed

F 371: audit q week on going

F 428: monthly audits on going

F 431: weekly audits on-going

F 441: weekly audits x 1 month, the monthly thereafter

Respectfully submitted,

Vonnie Severson, RN/C, DoN

January 17, 2013

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F 279	Continued From page 1 by: Based on observation, interview, and document review the facility failed to ensure 1 of 3 residents (R33), had a care plan developed to identify skin issues related to bruising, fragile skin and the use of Coumadin (an anticoagulant medication) and Prednisone (a steroid medication). In addition, the facility failed to develop a plan of care related to proper positioning for 1 of 3 residents (R1) reviewed in the sample for positioning. Findings include: R33 failed to have a comprehensive care plan developed to identify his skin conditions and risk factors for impaired skin integrity related to bruising and fragile skin. R33 was admitted to the facility on 9/16/12, with diagnoses to include: congestive obstructive pulmonary disease (COPD) and chronic iron deficiency. R33's physician orders dated 10/31/12, identified he received 6 milligrams (mg) of Prednisone every day for pneumonia and 5 mg of Coumadin each Sunday and 2.5 mg of Coumadin the rest of the week. On 12/3/12, at 4:05 p.m. R33 stated he frequently had bruises on his hands and arms, identified the bruises were related to his medications and bumping his arms. R33 stated his skin was thin and he often sustained skin tears due to his fragile skin. R33's care plan did not identify any skin issues, lacked identification of any problems, goals, or interventions to monitor or maintain skin integrity. The care plan also lacked any identification of risk	F 279	**2. Corrective Action as it applies to others:** All residents will be assessed for skin conditions and risk factors for impaired skin integrity related to bruising and fragile skin, upon admission and at least quarterly with individualized plan for identifying risk factors and monitoring/maintaining skin integrity related to use of Coumadin and/or Prednisone. All residents will be assessed for skin integrity including need for positioning or positioning device upon admission and at least quarterly with individualized care plan. **3. Reoccurrence will be by:** Re-education of nursing staff regarding following facility policy of individualized skin assessment and identifying skin issues related to bruising, fragile skin when receiving Coumadin and/or Prednisone.	

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F 279	Continued From page 2 factors for impaired skin integrity related to the use of Prednisone and Coumadin. On 12/4/12, at 2:30 p.m. the registered nurse (RN)-B stated staff were supposed to monitor bruising on a daily basis and to report any new bruising. RN-B verified R33's care plan lacked any skin concerns. R1 was observed on 12/3/12, and on 12/4/12 in her Broda chair, leaning to the left. No positioning device was in place. R1 was admitted to the facility 11/27/00, with diagnoses to include Huntington's chorea. A comprehensive skin assessment dated 11/5/10, indicated a need for a positioning device. The plan of care dated 10/12 (no specific date) did not identify any positioning device or positioning needs for R1 while in the Broda chair. On 12/3/12, at 3:53 p.m. R1 was observed in the day room sitting in front of the television in the Broda chair without a positioning device. She was leaning to the left with her head against the lateral head support. R1 was observed to move her head, but not her trunk. On 12/4/12, at 8:20 a.m. R1 was observed in the Broda chair returning from an activity. Staff placed R1 in the day room in front of the television. R1 again observed to be leaning to the left against the side of the Broda chair without a positioning device. On 12/4/12, at 3:00 p.m. the registered nurse (RN)-A stated the nursing assistants (NA's) were responsible for positioning the residents. RN-A	F 279	Re-education of nursing staff to follow facility policy of individualized skin assessment including need for positioning assistance or positioning device. Periodic audit of completeness of the individualized skin assessment as related to the above concerns. **4. Correction will be monitored by:** a. RNs and DoN b. QA committee will review audit results and provide further direction as needed. **5. Date of completion:** January 15, 2013	

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F 279	Continued From page 3 stated R1 was not able to reposition herself in bed or in her chair. RN-A reported the last formal occupational therapy (OT) assessment for R1 was completed in 2009 and recommended she be placed in a Broda chair. RN-A stated OT did observe the residents and would notify nursing if they noticed any positional changes which needed to be done. On 12/6/12, at 12:30 p.m. the director of nursing (DON) validated the positioning concerns for R1.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow the plan of care for 2 of 3 residents (R35, R22) reviewed in the closed record sample who required hospitalization. In addition, the facility failed to perform oral/dental hygiene as directed by the care plan for 1 of 3 residents (R52) in the sample who were reviewed for oral/dental concerns. Findings include: The plan of care had not been followed for R35 and R22 who had been hospitalized within the first 30 days of admission for an exacerbation of chronic lung problems.	F 282	1. Corrective Action: a. Staff caring for R 52 were counseled by RN and DoN to ensure following individual plan of care and that resident does receive proper personal hygiene assistance per facility policy, including offering oral cares, even if refuses more often than not, he should be re-approached. RN did visual oral assessment on Dec. 6 after being made aware that R 52 had verbalized he had "sores in mouth". RN noted that R 52 had no sores or redness in mouth or signs/symptoms of infection.	

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F 282	Continued From page 4 R35, who was admitted on 8/4/12, with diagnoses to include chronic obstructive pulmonary disease (COPD) and deep vein thrombosis (DVT), required hospitalization from 8/17/12 until 8/24/12, for exacerbation of her COPD. R35 had been hospitalized with bronchitis, shortness of breath, recent bowel surgery and elevated blood sugars prior to the nursing home admission. The plan of care indicated R35 had a problem with ineffective breathing pattern related to anxiety attacks. Care plan approaches includec lung sounds as needed and monitor for respiratory distress. Documentation in the interdisciplinary progress notes lacked assessment of R35's lungs, other than the initial admission nursing note which "noted expiratory wheezes bi-laterally" and "does experience SOB (shortness of breath) with anxiety". A social service note dated 8/15/12, indicated R35 "describes lack of energy due to a cold she now has and states that with the cold she does not always sleep well." The clinical record lacked evidence R35's respiratory status was comprehensively assessed. The note by the hematologist dated 8/16/12, described R35's lungs as having "diffuse wheezing, dyspnea [difficult or labored breathin(with cough and bilateral rhonchi [abnormal whistling or snoring lung sounds]." The clinical record lacked evidence lung sounds were documented, even after the hematologist identified the concern with the lung sounds at tl appointment on 8/16/12. R35 was admitted to the hospital on 8/17/12, subsequent to a clinic visit with the primary physician who documented	F 282	b. (R 35 was discharged to home on 9-15-12. R 22 was hospitalized on 11-28-12 and as of last family contact remained hospitalized.) **2. Corrective Action as it applies to others:** a. Lic. Nurses and DoN have counseled nursing dept. staff on all shifts to re-educate of need to follow facility policy regarding care plans, including offering personal hygiene assistance (oral cares) for all residents as per care plan. Even though, resident may refuse, staff to offer assistance and re-approach if refuses. b. Re-education of licensed nursing staff to follow facility policy for thorough assessing, planning, monitoring, documenting guidelines for post-hospitalization diagnosis and take further action as needed.	

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F 282	Continued From page 5 "chest sounds like a fair number of rales [abnormal crackling lung sounds] on both sides with diagnosis of "probable pneumonitis". On 12/5/12, at 3:00 p.m. the registered nurse (RN)-A confirmed the clinical record lacked any notes by nursing staff on 8/16 and 8/17/12, regarding R35's respiratory status and/or lung sounds as defined on the plan of care. R22 was admitted on 10/30/12, with diagnoses to include severe COPD and steroid dependence, anemia and night time hypoxemia with recommended BIPAP (Bilevel Positive Airway Pressure, a treatment which helps users breathe more easily) at night. The plan of care identified R22 had a problem with ineffective breathing pattern related to COPD and recent respiratory failure. The approaches included: Lung sounds as needed and Monitor for respiratory distress. R22's nursing documentation dated 11/24/12, indicated, "sob [shortness of breath] and has had increase weakness today. c/o [complained of] being sob asked for something for anxiety, gave Tylenol 650 mg [milligrams], appetite is 25-50%. O2 sats [saturation] 97% after nebulizer". The clinical record lacked evidence an assessment related to lung sounds was documented. Documentation by a licensed practical nurse (LPN) on 11/28/12, at 10:18 a.m. indicated: "TMA [trained medication aide] reports this AM that [R22] is at 70% with c-pap [continuous positive airway pressure, a treatment which uses mild air pressure to keep the airways open] on,		**3. Reoccurrence will be prevented by:** a. Lic. nurses will do random direct observation audits of personal hygiene assistance (including oral cares) to ensure proper care plan is being followed. Results will brought to DoN. b. DoN or designee will do random audits to ensure that thorough, comprehensive assessments have been done, documented, care planned, and action taken, if needed, regarding post-hospitalization diagnosis monitoring compliance with policy and guidelines as above.	

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F 282	Continued From page 6 c-pap was loose, repositioned. Upon rechecking, O2 sats remain around 79%. 1st neb [nebulizer] given, sats up to 92% then drop down to 86%. Finished up other 2 nebs and sats remain around 79-82%. TPR [temperature, pulse, respiration] 94.6-100-38". As evidenced by the electronic record, an assessment of lung sounds for worsening dyspnea was lacking in the days prior to the physician examination of R22 on 11/28/12. The physician note dated 11/28/12, revealed the following: "Assessment/Plan: [R22] with severe COPD with worsening dyspnea over the last few days and severe respiratory distress this morning. Ambulance was called for transfer to the emergency room. [R22] is DNR/DNI [do not resuscitate/do not intubate] but apparently is not opposed to hospitalization." On 12/5/12, at 11:00 a.m. RN-A confirmed R22 had a long history of COPD with exacerbations. At 3:00 p.m. RN-A confirmed documentation was lacking to indicate lung sounds had been monitored for R22 as directed by the plan of care. R52 was admitted to the facility on 10/3/12, with diagnoses to include cardiovascular accident with right-sided hemiplegia. During initial interview of R52 on 12/03/12, at 6:53 p.m. R52 stated he was having oral pain related to a sore on his upper gum line and stated he was unable to wear his upper dentures due to the oral cavity discomfort. R52 further stated he did not brush his teeth and stated staff did not assist him with oral cares. On 12/5/12, at 7:05 a.m. the nursing assistants	F 282	**4. Correction will be monitored by:** a. DoN or designee b. Data collected will be reviewed by DoN, reviewed at QA meeting for further recommendations **5. Date of completion:** January 15, 2013	

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F 282	Continued From page 7 (NA)-C and NA-E were observed to assist R52 out of bed to receive a bath. During the observation staff toileted R52 and transferred him into a shower chair. NA-C and NA-E failed to offer or provide any oral cares. R52's care plan dated 10/23/12, identified he needed extensive assistance of one staff with all grooming. The care plan failed to identify R52 with any oral/dental concerns. R52 Functional Safety Assessment dated 10/18/12, identified R52's oral/dental status as having upper dentures and lower partials. The note identified R52 was free of signs or symptoms of infection in his mouth. On 12/5/12, at 2:00 p.m. the registered nurse (RN)-B verified R52's care plan identified he needed extensive assistance of one staff for grooming, which included oral cares. RN-B stated staff should offer to provide oral cares for R52 and if he refused they should wait and attempt again later.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 309		

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F 309	Continued From page 8 review, the facility failed to comprehensively assess the clinical status of 2 of 3 residents (R35, R22) in the closed record sample who required hospitalization. The facility also failed to reassess and initiate interventions for proper positioning for 1 of 3 residents (R1) reviewed in the sample for positioning. Findings include: The clinical status's of R35 and R22 were not comprehensively assessed prior to hospitalization. R35 was admitted on 8/4/12, with diagnoses to include chronic obstructive pulmonary disease (COPD) and deep vein thrombosis (DVT). R35 required hospitalization from 8/17/12, until 8/24/12, for exacerbation of her COPD. R35 had been hospitalized with bronchitis, shortness of breath, recent bowel surgery and elevated blood sugars prior to the nursing home admission. The clinical record indicated on 8/16/12, R35 had a consultation with hematology related to abnormal blood tests noted during the hospital stay before admission on 7/26-8/3/12. The hematologist progress note dated 8/16/12, indicated the following: "chronic myclomonocytic leukemia with anemia and thrombocytopenia, chronic bronchitis and left distal DVT, diffuse wheezing and dyspnea with cough and bilateral rhonchi, chronic status-left leg." Subsequently, the recommendations written by the hematologist included blood work and for the [primary physician] to order CT chest -"bronchiastasis." On 12/5/12, at 11:30 a.m. the registered nurse (RN)-A verified R35 had a scheduled	F 309	**1. Corrective Action:** Staff caring for R 1 were counseled by RN and DoN to ensure following plan of care after addition made regarding positioning/positioning devices and that resident receives proper positioning assistance including use of positioning device. OT assessment for positioning in Broda chair was requested. (R 35 was discharged to home on 9-15-12. R 22 was hospitalized on 11-28-12 and remains hospitalized.)	

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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 309	Continued From page 9 appointment with the primary physician for evaluation on 8/17/12. The primary physician clinic note dated 8/17/12, revealed the following: "Subjective: patient presents with daughter who tells physician [R35] had been hospitalized for ventral hernia with strangulation of the bowel (7/28/12) and the [R35's] platelet counts dropped and likely [R35] has myelodysplasia of some kind; daughter also indicated the hematologist noted [R35] was doing quite a lot of loose coughing and recommended a chest CT scan; currently the patient complains about fatigue, cough, and just weakness; Objective: exam reveals a very ill appearing 86 year old female. The chest sounds like a fair number of rales on both sides. Assessment: probable pneumonitis." Documentation in the interdisciplinary progress notes lacked assessment of R35's lungs, other than the initial admission nursing note which "noted expiratory wheezes bi-laterally" and "does experience SOB (shortness of breath) with anxiety". A social service note dated 8/15/12, indicated R35 "describes lack of energy due to a cold she now has and states that with the cold she does not always sleep well." The clinical record lacked evidence R35's respiratory status was comprehensively assessed. On 12/5/12, at 3:00 p.m. the registered nurse (RN)-A confirmed documentation was lacking in the clinical record to indicate nursing staff had monitored and/or assessed the respiratory status of R35 related to the cold and cough. RN-A verified the record lacked any notes by nursing staff on 8/16/12, and 8/17/12, related to	F 309	**2. Corrective Action as it applies to other residents:** a. Re-education of lic. nursing staff to thoroughly assess positioning for residents requiring assistance and/or use of assistive devices and requesting OT screen or assessment, if needed. b. Re-education of licensed nursing staff to use facility policy charting guidelines to comprehensively assess respiratory status including assessing and monitoring, documenting, lung sounds and take further action as needed. **3. Reoccurrence will be prevented by:** DoN or designee will do random audits to assure that comprehensive assessments have been performed, documented, and acted upon, if needed, including thorough post-hospitalization monitoring and planning regarding hospitalization diagnosis and thorough assessment for proper positioning and interventions initiated.	

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	245551	A. BUILDING _____ B. WING _____	12/06/2012

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F 309	Continued From page 10 respiratory status and/or lung sounds. R22 was admitted on 10/30/12, with diagnoses to include severe COPD and steroid dependence, anemia and night time hypoxemia with recommended BIPAP (Bilevel Positive Airway Pressure, a treatment which helps users breathe more easily) at night. R22's nursing documentation dated 11/24/12, indicated, "sob and has had increase weakness today. c/o [complained of] being sob [short of breath] asked for something for anxiety, gave Tylenol 650 mg [milligrams], appetite is 25-50%. O2 sats [saturation] 97% after nebulizer." An interdisciplinary nursing progress note dated 11/26/12, at 6:40 p.m. documented "staff noted increased restlessness, confusion and weakness over the weekend. UA [urinalysis] sent, report returned and faxed to [MD]-wait for UC [urine culture] results-daughter notified." The clinical record lacked evidence R22's lung status, including lung sounds, was assessed. An interdisciplinary progress note from the occupational therapist (OT) dated 11/28/12, at 8:00 a.m. indicated R22, "Reported that she had a 'bad' couple of days over the weekend. Nursing reported the O2 [oxygen] sats [saturation] were in the 90% range however she felt like she could not get her breath. Nursing said it could be anxiety. This am [morning] med assistant reported pt [patient] c-pap [continuous positive airway pressure, a treatment which uses mild air pressure to keep the airways open] was not tight on her face last night and her O2 sats were 79% at 6:30 a.m. And at 8:00 a.m. they were still at 79%. pt. will not be able to be seen on this date	F 309	4. **Correction will be monitored by:** a. DoN or designee b. Data collected will be reviewed by QA committee and further action taken if needed. 5. **Date of correction:** **January 15, 2013**	

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F 309	Continued From page 11 at this time. Pt needs to be in the 90% range to be able to complete therapeutic activities or exercise." A licensed practical nurse (LPN) note on 11/28/12, at 10:18 indicated: "TMA [trained medication aide] reports this AM that [R22] is at 70% with c-pap on , c-pap was loose, repositioned. Upon rechecking, O2 sats [saturation] remain around 79%. 1st neb [nebulizer] given, sats up to 92% then drop down to 86%. Finished up other 2 nebs and sats remain around 79-82%. TPR [temperature, pulse, respiration] 94.6-100-38 BP 110/64. Physician in facility for rounds and ordered transfer to Chippewa County Medical Center ER via ambulance." The physician note dated 11/28/12, revealed the following assessment: "Subjective: nursing asked provider to see [R22] when I was there for routine rounds on other patients. They noted over the last few days she's had increasing shortness of breath which became much worse overnight and again this morning. Objective: O2 sat was between 84% with brief bumps up to 91% on 2 liters with her CPAP on. She is in severe respiratory distress. Pulse was in the 90's. Lungs are diminished bilaterally with the use of accessory muscles. Assessment/Plan: [R22] with severe COPD with worsening dyspnea over the last few days and severe respiratory distress this morning. Ambulance was called for transfer to the emergency room. [R22] is DNR/DNI [do not resuscitate/do not intubate] but apparently is not opposed to hospitalization."	F 309		

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F 309	Continued From page 12 On 12/5/12, at 11:00 a.m. the registered nurse (RN)-A confirmed R22 had a long history of COPD with exacerbations. At 3:00 p.m. RN-A confirmed the clinical record lacked documentation to indicate nursing staff had recorded and/or assessed R22's lung sounds during the time she experienced a change in her clinical status. On 12/3/12 and 12/4/12, R1 was observed to be leaning to the left in her Broda chair. No positioning device was in place. R1 was admitted to the facility 11/27/00, with diagnoses to include Huntington's chorea. The comprehensive skin assessment dated 11/5/10, identified R1's need for a positioning devices. This assessment was reviewed quarterly. The quarterly Minimum Data Set (MDS) dated 10/31/12, indicated R1 had severe cognitive impairment and long/short term memory deficits, required two staff to assist with bed mobility and transfers, and required one staff assistance for locomotion on/off the unit. The MDS indicated R1 was not ambulatory and used a wheelchair for all locomotion. The care area assessment (CAA) dated 8/14/2012, noted R1 was dependent on staff for activities of daily living (ADLs). R1's plan of care dated October 2012 (no specific date) did not address her positioning while in the Broda chair. On 12/3/12, at 3:53 p.m. R1 was observed in the day room sitting in front of the television in the Broda chair without a positioning device. She	F 309		

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F 309	Continued From page 13 was leaning to the left with her head against the lateral head support. R1 was observed to move her head, but not her trunk. On 12/4/12, at 8:20 a.m. R1 was observed in the Broda chair returning from an activity. Staff placed R1 in the day room in front of the television. R1 again observed to be leaning to the left against the side of the Broda chair without a positioning device. On 12/5/12, at 7:50 a.m. R1 was observed to be transferred via Hoyer lift from the bed into the Broda chair by two nursing assistants (NA)-A and NA-C. After placement in the Broda chair, R1 was observed to lean to the left. NA-C assisted R1 with oral care and personal hygiene of her face and hands. R1 continued to lean to the left during these cares and no positioning device was added. When asked on correct positioning of R1, NA-A and NA-C repositioned her and placed her buttocks in the middle of the Broda chair. R1 continued to lean to the left. When asked about R1's position, NA-A and NA-C stated they could put a pillow alongside R1 to help her sit straight in the Broda chair. At 8:50 a.m. R1 was again observed in her room. Her position in the Broda chair was unchanged (continued lean to the left). When asked again about the use of a positioning pillow for R1, NA-C stated she would get it right after they were done feeding R1 breakfast. On 12/4/12, at 2:04 p.m. the trained medical assistant (TMA)-B stated R1 was not able to reposition herself in bed or in her chair. At 2:06 p.m. NA-A stated R1 was not able to reposition herself in her chair. At 2:15 p.m. TMA-A and NA-D stated once R1 was in the Broda chair, she	F 309		

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F 309	Continued From page 14 was stationary. On 12/4/12, at 3:00 p.m. the registered nurse (RN)-A stated the nursing assistants (NA's) were responsible to position the residents. RN-A stated R1 was not able to reposition herself in bed or in her chair. RN-A reported the last formal occupational therapy (OT) assessment for R1 was completed in 2009 and recommended she be placed in a Broda chair. RN-A stated OT did observe the residents and would notify nursing if they noticed any positional changes which needed to be done. On 12/6/12, at 12:30 p.m. the director of nursing (DON) validated the positioning concerns for R1. The Restorative Nursing Manual had a policy (undated) that addressed residents' position. The policy directed staff to screen residents with poor positioning in wheelchairs. The procedure did not specify the procedure for an OT positioning assessment.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary care and services for oral hygiene for 1 of 1	F 312		

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F 312	Continued From page 15	F 312		

resident (R52) in the sample who was depende on staff for grooming and oral cares.

Findings include:

R52 was admitted to the facility on 10/3/12, with diagnoses to include: cardiovascular accident with right-sided hemiplegia.

During initial observation and interview of R52 on 12/03/12, at 6:53 p.m. R52 stated he was having oral pain related to a sore on his upper gum line and stated he was unable to wear his upper dentures due to the oral cavity discomfort. R52 further stated he did not brush his teeth and stated staff did not assist him with oral cares.

On 12/5/12, at 7:05 a.m. the nursing assistants (NA)-C and NA-E were observed to assist R52 out of bed to receive a bath. During the observation staff toileted R52 and transferred him into a shower chair. NA-C and NA-E failed to offer or provide any oral cares. R52 was transported to the shower room by NA-D.

On 12/5/12, at 11:10 a.m. NA-D stated she had not completed any oral cares during the bathing process and stated R52 refused to do his oral cares frequently.

R52's care plan dated 10/23/12, identified he needed extensive assistance of one staff with all grooming. The care plan failed to identify R52 with any oral/dental concerns. R52 Functional Safety Assessment dated 10/18/12, identified R52's oral/dental status as having upper dentures and lower partials. The note identified R52 was free of signs or symptoms of infection in his

1. Corrective Action:

Staff caring for R 52 were counseled by RN and DoN to ensure following plan of care and that resident does receive proper personal hygiene assistance including offering oral cares, even if refusals more often than not. Noted in care plan.

RN did visual oral assessment on Dec. 6 after being made aware that R 52 had verbalized he had "sores in mouth".

RN noted that R 52 had no sores or redness in mouth or signs/symptoms of infection.

2. Corrective Action as it applies to others:

Lic. Nurses and DoN have counseled nursing dept. staff on all shifts to re-educate of need to follow facility policy regarding care plans, including offering personal hygiene assistance (oral cares) for all residents as per care plan. Even though, this may be refused, it must be offered and re-approached with same offer later.

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F 312	Continued From page 16 mouth. On 12/5/12, at 2:00 p.m. the registered nurse (RN)-B verified R52's care plan identified he needed extensive assistance of one staff for grooming, which included oral cares. RN-B stated staff should offer to provide oral cares for R52 and if he refused they should wait and attempt again later. The facility's Oral Cares policy and procedure dated 5/2011, identified oral cares would be offered to residents at least twice a day with morning and evening cares.		**3. Reoccurrence will be prevented by:** Lic. Nursing staff will do random direct observation audits of personal hygiene assistance (including offering oral cares) to ensure care plan is being followed. Results will brought to DoN. **4. Correction will be monitored by:** a. DoN or designee b. Data collected will be reviewed by DoN, reviewed at QA meeting and further action, if needed. **5. Date of completion:** January 15, 2013	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			

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F 329	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 4 of 10 residents (R2, R7, R18, R33) were free from unnecessary medications; R2's as needed (PRN) Valium and lorazepam (both benzodiazepine medications) did not have identified parameters for PRN use, R7's clobetasol propianate (a cream used to treat vaginitis) was not evaluated for excessive duration of use, R18's Remeron (an antidepressant medication) lacked evaluation for continued use, R33's Prednisone (a steroid medication) and Coumadin (an anticoagulant medication) lacked a system for monitoring side effects and risk factors for ongoing use of the medications. R2 received an as needed Valium (diazepam) and lorazepam (Ativan) and did not have parameters identified for PRN use. R2 had diagnoses which included anxiety state. The most recent physicians orders dated 10/25/12, revealed R2 had orders for the use of Valium and lorazepam both to be used PRN for anxiety. The medication administration record (MAR) dated 11/01/12 - 12/31/12, indicated lorazepam was given daily from 11/10/12 to 11/27/12. The nurse's medication notes for PRN medication lacked documentation of clinical indications for its	F 329	**F 329** **1. Corrective Action:** R 2's physician contacted for parameters for dosing of Valium and Ativan and review of these meds. given regularly. R 7's physician contacted if should continue use of cream for atrophic vaginitis or change plan. R 18's physician and family prefer to not have medication dosing altered. R 33's plan of care changed to identify use of both prednisone and coumadin to monitor side effects regarding skin.	

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F 329	Continued From page 18 use. The MAR indicated from 11/27/12 to 12/03/12, Valium was used daily at 8:00 p.m. The nurse's medication notes for PRN medication lacked documentation of clinical indications for its use. In addition, the clinical record lacked parameters for when to give PRN Valium versus the PRN lorazepam. On 12/06/12, at 8:15 p.m. the registered nurse (RN)-B verified lorazepam and Valium were administered daily although the order was for PRN. RN-B verified there was no documentation as to why these medications were given. RN-B stated she was not aware of these medications being given regularly and if she had been aware of the medications being given regularly, she would have looked into having the orders changed to regularly scheduled. RN-B also stated nurses were to document PRN's given, the reason given and whether relief had occurred. RN-B indicated she kept an "Awakenings-Resident List for Psychotropic Medications" on residents to review use of psychotropic medications with staff and physicians. RN-B added Valium to the "Awakenings-Resident List for Psychotropic Medications" at the time of the interview. RN-B stated she would expect nurses to inform her if a PRN was being used on a regular basis. RN-B indicated the pharmacist and "everyone" should have caught these concerns. On 12/07/12, at 10:30 a.m. the pharmacy consultant stated use of PRN's should be reviewed with the physician for concerns for indications of use. R7 had clobetasol propianate 0.05% cream	F 329	**2. Corrective Action as it applies to others:** a. Lic. nursing staff re-educated to facility policy of addressing GDR or rationale for continued use of medication in effort to be free of un-necessary meds. in accordance with the law. b. Lic. staff re-educated to obtain primary physician follow-up initiated by consulting PharmD. in a timely manner. c. Lic. staff re-educated to provide clinical indications/outcomes for the use of PRN meds and, if given regularly, review with physician for concerns for indications of use.	

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F 329	Continued From page 19 administered beyond the recommended duration of it's use. R7 had a diagnosis of atrophic vaginitis and used a medicated treatment clobetasol propianate 0.05% cream twice daily. Review of MARs dated 04/01/12 to 11/30/12, indicated R7 had received the treatment twice daily since 04/26/12. Documentation review indicated R7 was treated twice daily since 04/26/12. The manufacturer's guidelines for clobetasol propianate indicated the medication was used to reduce the inflammation, redness, swelling, itching and tenderness associated with skin conditions and directed to apply the cream locally on the skin. If no improvement was seen within two weeks, reassessment of diagnosis may be necessary. Treatment with the cream beyond four consecutive weeks was not recommended. On 12/05/12, at 1:00 p.m. the director of nursing (DON) verified the use of this medication for R7, but provided no justification for its extended use. On 12/06/12, at 8:40 a.m. RN-B stated she was aware the clobetasol propianate cream was used, but was unaware of any concern with the ongoing use of clobetasol propionate. RN-B stated the pharmacy consultant and "everyone" should have caught concerns with medication treatment use. On 12/07/12, at 10:30 a.m. the consultant pharmacist stated the benefits of this creams use may outweigh the possible side effects, but the physician should have indicated the need for ongoing use. The pharmacist stated topical use had minimal effect.	F 329	d. Lic. nursing re-educated to do thorough skin assessment, care planning, and on-going monitoring of skin condition/active bruising d/t concurrent use of prednisone and coumadin and potential side effects.	

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F 329	Continued From page 20 R18's continued use of Remeron lacked a physician's evaluation for continued use of the medication. The monthly pharmacy review for R18 dated 9/19/12, identified the following recommendation for physician review: "(1) Problem: dementia, psychotic conditions, depressive disorder, night anxiety; agitation/combative behavior, reactive confusion; (2) Psychoactive medication orders: Paxil 20 mg AM [an antidepressant medication]; Remeron 15 mg PM, Seroquel [an antipsychotic medication] 12.5 mg daily; Ativan 0.25 mg bid [twice daily] + PRN Ativan 0.25 mg x 1/day; (3) Psychotropic Review: It was noted on 9/14/12, that in one week would re-evaluate behaviors to determine if any changes need to be made in her antipsychotic medication Seroquel. When this is done, reevaluation of [R18's] Ativan and Remeron medication should also be done. Please make documentation regarding risk/benefit of continuing current doses and if at minimal effective doses (also receives Paxil but this was just lowered in July)." The physician responded with a dose reduction of Paxil on 9/27/12, the physician also addressed the use of Seroquel and Ativan. However, during review of the physician progress notes dated 10/25/12 and 11/29/12, it was noted there was no mention and/or follow-up in regards to the recommendation to re-evaluate the Remeron for continued use and/or reduction in dosage. On 12/6/12, at 9:30 a.m. the registered nurse (RN)-A confirmed according to the progress notes available in the clinical record, a review of	F 329	**3. Reoccurrence will be prevented by:** a. Random audits will be done to review the above specific concerns. b. Re-education for lic. nursing staff as noted above in *corrective action as applies to others.* c. Audits will be reviewed with QA committee for further recommendations. **4. Correction will be monitored by:** a. Lic. nurses will collect and monitor data b. DoN or designee will do random audits. **5. Date of Completion:** January 15, 2013	

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	245551	A. BUILDING _____ B. WING _____	12/06/2012

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F 329	Continued From page 21 the Remeron had not occurred. R33 failed to have a system in place to monitor the potential side effects and risk factors related to the use of Prednisone and Coumadin. R33 was admitted to the facility on 9/16/12, with diagnoses to include: chronic obstructive pulmonary disease (COPD) and chronic iron deficiency. R33's physician orders dated 10/31/12, identified R33 received Prednisone 6 milligram (mg) daily for pneumonia and Coumadin 5 mg each Sunday and 2.5 mg the other six days of the week. On 12/03/12, at 3:59 p.m. R33 was observed to have discoloration and bruising of the skin on the bilateral upper extremities extending from his hands to above the elbows. On 12/3/12, at 4:05 p.m. R33 stated he frequently had bruises on his hands and arms and identified the bruises were related to his medications when he bumped his arms. R33 stated his skin was thin and he often sustained skin tears due to his fragile skin. R33's Skin Assessment dated 7/27/12, identified R33 had intact skin and no pressure areas. The assessment further identified R33 had fragile skin and identified he sustained skin tears related to his fragile skin. The assessment also identified R33 had multiple bruises on his arms which was normal for him. There was no ongoing monitoring of his skin condition even when he had evidence of active bruising (a potential side effect of Prednisone and Coumadin use). R33's care plan failed to identify any skin issues	F 329		

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F 329	Continued From page 22 or identify any problems, goals, or interventions to monitor or maintain skin integrity. The care plan also lacked identification of the use of Prednisone or Coumadin as risk factors for skin integrity issues. On 12/4/12, at 2:30 p.m. the registered nurse (RN)-B stated staff were supposed to monitor bruises on a daily basis and to report any new bruises. RN-B verified R33's care plan lacked any skin concerns. Although R33 was observed to have bruises on his bilateral upper extremities, RN-B stated there were no current skin monitoring for R33. RN-B verified there was no system to monitor the side effects for the use of Coumadin and Prednisone.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor temperatures of the breakfast items to minimize the risk of food borne illness. This had the potential to affect 40 of 40 residents in the sample. Findings include:	F 371:	Corrective Action: Upon discovery that breakfast hot food temperatures were not checked or documented and tracked, dietary staff was immediately re-educated of this requirement. Corrective Action as it applies to others: Hot foods held on stoves , steam tables, will be kept hot (150 degrees F. or above) and be documented and tracked as per policy.	3

F 371

1. Corrective action:
   Upon discovery that temperatures were not being taken or recorded for the breakfast meal staff were informed to do so.

2. Corrective action as it applies to other residents:
   All breakfast meal temperatures will be taken and recorded.

3. Reoccurrence will be prevented by:
   Dietary staff have been re-educated on policy and procedure to take and record breakfast temperatures daily.

4. Correction monitored by:
   Dietary Manager will do frequent, random audits to assure compliance is being met.

5. Date of correction:
   ~~12/03/12.~~ 12/6/2012

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F 371	Continued From page 23 A review of the Daily Tracking Log for Breakfast and Noon Meals from 8/1/12 through 12/3/12, noted one day (8/3/12) the breakfast cereal that was served had a temperature, all other dates did not include temperatures for the breakfast meal. A review of the menus indicated that hot cereal and eggs were offered on a daily basis. During the initial tour on 12/3/12, at 1:05 p.m. cook-A stated that they do not check the temperatures of the breakfast foods, but acknowledged they should. An interview during the initial tour with certified dietary manager revealed that she was unaware that the cooks did not document or track the temperatures of the breakfast foods that were served, and she did validate this should be documented. The facility's Sanitation Procedure titled Food Preparation, file no: 6003, last dated as reviewed 8/9/93 indicated "Hot foods held on stoves, steam tables or in food carts will be kept hot (150 degrees Fahrenheit or above). Temperatures will be recorded of each steam table."	F 371	Reoccurrence will be prevented by: On Dec. 19 2012, dietary staff were formally re-educated on policy and procedure to check and record breakfast hot food temperatures daily. Correction will be monitored by: Dietary manager will do frequent, Random audits to assure compliance. Date of correction: ~~December 3, 2012~~ 12/6/2012 Per SG. Ml	
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			

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F 428	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the consultant pharmacist identified drug irregularities and pharmacy recommendations were acted upon for 3 of 11 residents (R2, R7, R18) reviewed in the sample for unnecessary medications. Findings include: R2 received anti-depressant medications on an as needed (PRN) basis with no parameters. R2 had diagnoses which included anxiety state. Review of most recent physicians orders, dated 10/25/12, revealed R2 had orders for the use of valium (a benzodiazepine) and Lorazepam (a second benzodiazepine) both to be used as needed for anxiety. Review of medication administration record (MAR), dated 11/01/2012-12/31/2012, indicated lorazepam was given daily from 11/10/12 to 11/27/12. There was no documentation in the nurses medication notes for medications used as needed (PRN). The MAR indicated that from 11/27/12 to 12/03/12, valium was used daily at 8:00 p.m. There was no documentation in the nurses medication notes for PRN's, that indicated the need for use. No parameters for the use were given for one PRN versus the other. In an interview on 12/06/12, at 8:15 p.m. registered nurse (RN)-B who verified that lorazepam and valium were used daily although the order was for PRN. RN-B verified that there was no regular documentation as to why these	F 428	**F 428** **1. Corrective Action:** R2's physician contacted for parameters for valium and ativan administration and dosing. R7's physician contacted regarding continuing same medication or changing the plan. R18's family and physician prefer to not have medication & dosing altered. **2. Corrective Action as it applies to others:** a. Lic. nursing staff re-educated to provide clinical indications/outcomes documentation for use of PRN meds. and if given regularly, review with physician for concerns for indications and parameters of use. b. Lic. nursing staff re-educated to facility policy of addressing GDR or rationale for continued of the medication in effort to be free of un-necessary meds. and in accordance with the law. c. Lic. nursing re-educated to obtain primary physician response initiated by consulting PharmD. in a timely manner. d. Reviewed survey findings with consulting PharmD. and surveyors had also consulted with PharmD. by phone.	

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F 428	Continued From page 25 medications were given. RN-B stated she would expect nurses to inform her if a PRN was being used regularly. RN-B indicated that the pharmacist and "everyone" should have caught these concerns. The consultant pharmacist's monthly drug regimen review dated 11/13/12, revealed the pharmacy consultant had reviewed medications for R2 and had no recommendations. During an interview on 12/07/12, at 10:30 a.m. The pharmacy consultant stated that use of PRN's should be reviewed with the physician for concerns for indications of use. R7 received medication for a duration beyond it's limited, recommended duration and the pharmacy consultant did not identify the irregularity. R7 had diagnoses that included atrophic vaginitis. She used a medicated treatment clobetasol propianate 0.05% cream twice daily. Review of MAR dated 04/01/2012 to 11/30/2012 indicated R7 had received this treatment twice daily since 04/26/12. Documentation review indicates R7 was treated twice daily since 04/26/12. Review of manufactures guidelines for clobetasol propianate indicated the medication was used to reduce the inflammation, redness, swelling, itching and tenderness associated with skin conditions and is applied locally on the skin. If no improvement seen within two weeks, reassessment of diagnosis may be necessary. Treatment beyond four consecutive weeks was not recommended.	F 428	e. IDT review of residents receiving psychotropic meds. to address if candidate for GDR with "behavior" interventions (unless clinically contraindicated) in an effort to ultimately discontinue the med. **3. Reoccurrence will be prevented by:** a. re-education of lic. nursing staff as noted above. b. Random audits of medical records of residents receiving psychotropic meds, who are noted to have recommendations by consulting PharmD. will be done to ensure physician has been provided the information and has addressed it in a timely manner following regulation guidelines. c. IDT reviews as described in #2. d. Audits will be reviewed at quarterly QA meeting for further recommendations. **4. Correction will be monitored by:** a. RNs, DoN, or designee **5. Date of Completion:** January 15, 2013	

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F 428	Continued From page 26 The consultant pharmacist's monthly drug regimen review for May until November, revealed the pharmacy consultant had reviewed medications for R7 and had no recommendations in regards to the ongoing use of clobetasol propianate 0.05%. An interview was conducted 12/07/12, at 10:30 a.m. with pharmacy consultant who indicated the benefits of this creams use may outweigh the possible side effects, but that the physician should have indicated the need for ongoing use. The pharmacist stated that topical use had minimal effect. No physician action was taken in response to the irregularity identified by the pharmacist for R18. The monthly pharmacy review for R18 dated 9/19/12, identified the following: (1) Problem: dementia, psychotic conditions, depressive disorder, night anxiety; agitation/combative behavior, reactive confusion; (2) Psychoactive medication orders: Paxil 20 mg AM (antidepressant); Remeron 15 mg PM (antidepressant), Seroquel 12.5 mg daily; Ativan 0.25 mg bid (twice daily) + PRN (as needed)Ativan 0.25 mg x 1/day ; and (3) Psychotropic Review: It was noted on 9/14/12, that in one week would reevaluate behaviors to determine if any changes need to be made in her antipsychotic medication Seroquel. When this is done, could reevaluation of [R18's] ativan and Remeron medication should also be done. Please make documentation regarding risk/benefit of continuing current doses and if at minimal effective doses (also receives Paxil but this was just lowered in July).	F 428		

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F 428	Continued From page 27 The subsequent 9/27/12, physician progress note stated: "there is a pharmacy review questioning her current psychotropic meds. [R18] has had two previous attempts to lower her Seroquel over the last two years. Each time it was unsuccessful. The patient is on a relatively low dose of Ativan and is taking it primarily at bedtime, which I think is probably appropriate. The patient does have UTIs [urinary tract infections], which further complicates our issues with agitation and confusion. I think at this point it might be appropriate to try decreasing the Paxil and see if anything different changes. If it does I would go back to the current dose of 20 mg a day. If it does not I would stay at the new dose of 10 mg daily". During review of the physician progress notes dated 10/25/12 and 11/29/12 it was noted that no mention and/or follow-up regarding the recommendation to re-evaluate the antidepressant medication, Remeron, was evident. Interview with RN-A on 12/6/12 at 9:30 a.m. confirmed that a review of the medication, Remeron, had not yet occurred by the physician according to the progress notes available in the record.	F 428		
F 431 SS=E	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.		**F 431** **1. Corrective Action:** Expired medications and biologic solutions for R8, R14, R33, R36, R38 were immediately removed from accessibility.	

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F 431	Continued From page 28 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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 and interview the facility failed to ensure expired medications and biologic solutions were not accessible for use for 5 of 40 residents (R8, R14, R33, R36, R38) whose medications were stored in the medication room and medication carts. Findings include: During observation on 12/05/12, at 8:30 a.m. in	F 431	**2. Corrective Action as it applies to others:** a. Nursing staff will check med. carts, treatment carts, med. storage room on weekly basis to ensure no expired meds. or labeling problems. This is performed weekly to remove the damaged, outdated, or discontinued medications when found and then discarded. **3. Reoccurrence will be prevented by:** a. Re-education of lic. nursing staff and TMA staff to follow policy and perform weekly checks on medication carts, treatment carts, and east med./storage room for open, dated, and expired meds. to be removed and then discarded. b. Checklist for weekly audits implemented c. Current guide implemented with listing of medications that must be dated when opened. d. The above listings will be given to supervisor or DoN weekly.	

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F 431	Continued From page 29 the east medication storage room, disac-evac suppositories were found for 2 residents (R8 and R14) and were noted to be expired. The suppositories for R8 had expired 06/30/12, and the suppositories for R14 had expired 09/12/12. Licensed practical nurse (LPN)-C was present and acknowledged that they should have been removed. An interview was conducted on 12/05/12, at 9:00 a.m. with the director of nursing (DON) who stated the expired suppositories should have been removed and discarded. During observation on 12/05/12, at 11:05 a.m. of the treatment cart, triamcinolone 0.1% ointment was found to be expired for resident R33 and nystatin cream was found to be expired for resident R36. The triamcinolone 0.1% ointment had expired 05/25/12, and the nystatin cream had expired 08/16/12. LPN C was present and acknowledged that these medicated treatments should have been removed. During observation on 12/05/12, at 1:55 p.m. of the west medication cart, ipratropium 0.02% solution was found to be expired for resident R38. The ipratropium 0.02% solution had expired 08/12. Trained medication aide (TMA)-D was present and acknowledged the expiration dates and that inhalation treatment should be removed. The pharmaceutical services policy and procedure manual (December 2005 revision) was reviewed and it noted that nurses shall inspect the medication room and/or medication cart for damaged, outdated, or discontinued medications weekly and shall remove such medications when found.	F 431	**4. Correction will be monitored by:** a. DoN or designee b. Data collected will be reviewed with QA committee and further action taken if needed. **5. Date of Correction:** January 15, 2013	

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F 431	Continued From page 30 An interview was conducted on 12/07/12, at 10:30 a.m. with the pharmacist; who stated she checked the medication carts and medication rooms quarterly for expired medications and treatments. She was unsure of facility policy to destroy medicated treatments. She stated expired medications and treatments should be removed from use.	F 431		
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 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	F 441		

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F 441	Continued From page 31 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 and interview the facility staff failed to change their gloves and wash their hands after direct resident contact while cares were provided for 1 of 1 residents (R25) reviewed in the sample for activities of daily living. Findings include: During observation of morning cares on 12/5/12, at 7:43 a.m. nursing assistant (NA)-C was observed in R25's room and assisted her to get up for the day. At 7:50 NA-E entered the room and assisted NA-C. R25 was transferred into the bathroom and assisted to sit on the toilet. Prior to placing R25 on the toilet NA-E donned gloves and removed R25's incontinent brief, which was saturated. NA-E continued to use the same gloves while she assisted R25 with a new incontinent brief. NA-C and NA-E stood R25 with use of gait belt and handrail and NA-E performed perineum cares for R25 and continued to use the same gloves. NA-E used a sanitary wipe to wash R25's perineum and then threw the wipe into the garbage but did not remove her gloves. NA-E was observed to touch R25's pants, sweater, transfer belt, wheelchair handles, and door knob	F 441	**F 441** **1. Corrective Action:** Nursing Assistant –E was counseled regarding proper use of gloves and infection control as per facility policy. NA-E expressed understanding and said knew proper procedure, but was very nervous while being observed by surveyors. **2. Corrective Action as it applies to others:** a. Clarkfield Care Center has an organizational commitment to proper Infection Control. b. Re-education of nursing staff in Infection Control basic concepts, including hand-washing and use of gloves.	

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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 441	Continued From page 32 with same gloved hands she used to provide perineum care. NA-E was observed to remove her gloves and throw them in the garbage can after assisting R25 back in her chair. During interview with registered nurse (RN)-B on 12/5/12, at 2:00 p.m. she stated that NA-E should have removed her gloves after she provided perineum care for R25 and washed her hands. RN-B verified the facility policy for hand washing directed staff to change gloves after coming in contact with bodily fluids.	F 441	**3. Reoccurrence will be prevented by:** a. Random audits will be done to monitor for proper hand-washing, and safe glove use. b. Audit results will be presented to QA committee **4. Correction will be monitored by:** a. RNs and DoN b. QA committee will review audit results and provide further recommendations as needed. **5. Date of completion:** January 15, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245551	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/05/2012

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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. 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	RECEIVED JAN 9 2013 MINNESOTA DEPARTMENT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok 1-9-13	

DC: 01.15.13

EXIT: 12.06.12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paul [illegible]	Executive Dir	1-7-13

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
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K 000	Continued From page 1 By e-mail to: Barbara.lundberg@state.mn.us and 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	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 2 monitored for automatic fire department notification. The facility has a capacity of 52 beds and had a census of 44 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 LSC (00) section 19.7.6, 4.6.12. This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 44 residents, staff and visitors. Findings include: On facility tour between 2:00 PM to 4:00 PM on 12/05/2012, a review of documentation and interview with Chief Building Engineer (JB), revealed the facility failed to provide current annual fire sprinkler system test documentation. The last record that the facility had was able to provide was dated 04/06/2011. The sprinkler riser was tagged as having receive an annual test on 04/02/2012, a date that was not supported by	K 062	K 062 **Completion date:** **December 10, 2012** Environmental Service Director (JB) has obtained the current 2012 annual fire sprinkler system test documentation from the Clarkfield Care Center's billing files. A copy of the 2012 annual fire sprinkler system test is now in maintenance files. Completion of filing the annual fire sprinkler system test for 2012 was don on December 10th, 2012 by Environmental Service Director Jeff Bailey. The Environmental Service Director will insure that annual fire sprinkler system test documentation is up to date and on file for further observation.	

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K 062	Continued From page 3 a complete annual test report beyond the inspection tag. This was confirmed by the Chief Building Engineer (JB).	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245551	A. BUILDING 02 - BUILDING TWO B. WING _____	12/05/2012

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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. 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. 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	RECEIVED JAN 9 2013 MINNESOTA DEPARTMENT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok PB 1-9-13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paul Lentz — TITLE: Executive Dir. — (X6) DATE: 1-7-13

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