Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 20, 2020

Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, MN 56223

RE: CCN: 245551
Cycle Start Date: October 7, 2020

Dear Administrator:

On October 7, 2020, a 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 January 7, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by April 7, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

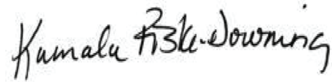
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

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October 20, 2020

Administrator
Clarkfield Care Center
805 Fifth Street, Box 458
Clarkfield, MN 56223

Re: Event ID: T5GJ11

Dear Administrator:

The above facility survey was completed on October 7, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00842	A. BUILDING: ________ B. WING ________	C 10/07/2020

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

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 10/5/20 through 10/7/20, an abbreviated survey was completed at your facility to conduct a complaint investigation related to State Licensure. Your facility was found to be IN compliance with MN state licensure.

The following complaints were found to be

Minnesota Department of Health

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2 000	Continued From page 1 SUBSTANTIATED: H5551016C and H5551017C, however no correction orders were issued.	2 000		

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	245551	A. BUILDING ______ B. WING ______	C 10/07/2020

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F 000	INITIAL COMMENTS On 10/5/20 through 10/7/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5551016C and H5551017C, with a deficieny cited at F574. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 574 SS=D	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this	F 574		10/30/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/30/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 574	Continued From page 1 section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)	F 574		

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F 574	Continued From page 2 (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide contact information to the Ombudsman (resident advocate) and State Agency upon request to 1 of 1 resident (R1). Findings include: R1's 9/23/20, admission Minimum Data Set (MDS) identified R1 had moderate cognitive impairment and documented verbal behavior directed toward others. R1 required extensive assistance from staff with bed mobility, transfers, dressing and toileting. R1 also required limited assistance with personal hygiene, locomotion on the unit and walking in her room. R1's diagnosis list from the electronic medical record (EMR) included hemiplegia (paralysis of one side of the body), hemiparesis (paralysis on 1 side of the body), cognitive social or emotional deficit following brain injury (stroke), generalized	F 574	How Corrective action will be accomplished for those residents found to have been affected by the deficient practice? " Resident has been educated on what the ombudsman is and where to find the contact information. How the facility will identify other residents having the potential to be affected by the same practice will not recur? " The facility interviewed all residents asking if they knew what an ombudsman was and how to contact them or how to find out how to contact the ombudsman. " If resident didn t know the answer to either question resident was educated on Ombudsman services and contact information as well as where and who they could ask for the information again. " All residents have the potential to be	

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F 574	Continued From page 3 weakness, high blood pressure, major depressive disorder, and Parkinsonism. Interview on 10/5/20 at 2:00 p.m. with R1 identified she had been in the facility about 3 months and when asked about the care she received, replied, "not good". R1 stated she was not happy with the care she received from staff, and it was not what she thought it should be with regard to "attitude and how it should be". She stated, she has the feeling she is not wanted here and often expresses she would be irritable with staff because of how she was treated. R1 was unhappy with all the restrictions surrounding COVID-19 but commented she liked it at the facility and had not wanted to leave. She indicated she felt staff's "attitude is the problem". R1 identified she had spoken with the administrator, but it "hadn't helped". R1 reported staff were "irritable lately", and remarked to her they were not getting their days off. R1 reported some nursing assistants would "raise their voice toward her" R1 identified (unknown date) she stated she was left outside for 45 minutes when she went outside to smoke. The unidentified nurses aide (NA) "forgot about her". R1 had her cell phone and would call the facility and someone would come outside to get her. At that time, the NA had told her not to call as no one would answer the phone. She stated it was chilly out and she had been told not to call. After about 45 minutes she telephoned the facility and was told someone would be out to get her. R1 had attempted to transport herself in her wheelchair, but it had rolled back and got stuck. R1 got out of her wheelchair, got up walked to the main door which was locked. She walked back to her chair and pushed it to the main door, where she telephoned again, and demanded someone come	F 574	affected. When interviewed there were 21 other residents who were not aware of the Ombudsman or where to find the contact information. What corrective action was taken to ensure the deficient practice does not recur? " Ombudsman information will continue to be provided in the Admission Packet. Ombudsman contact information will continue to be posted. Ombudsman information will be reviewed in the next Resident Council meeting. Resident education will be provided 10/27/20, 10/28/20, & 10/29/20. Staff education will be completed 11/2/20. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. " The facility will monitor the alleged deficiency by conducting audits once per week for 6 weeks on staff and residents to see if they can explain what an ombudsman is and where to find the contact information. " Information will be reviewed by the QAPI Committee to determine need for frequency of ongoing audits. The date that each deficiency will be corrected: 11/2/20	

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F 574	Continued From page 4 to let her in. R1 stated she was upset and told the charge nurse she had been told not to call by the NA. AS-A was reported to have witnessed the event and was "always nice to her". The AP had come to her room while she was talking with AS-A about the incident and was using a" rude tone of voice and had an attitude toward her". R1 stated she had told the AP she didn't appreciate the way they were talking to her. R1 advised the AP she wanted the names and numbers of the (nursing home) board so she could call and talk with them about how she was being treated. The AP replied "there was no one she could talk with" and had refused to provide the number. When R1 asked the AP about the Ombudsman, the AP replied "there was no one she could talk to" and denied her the right to contact information to the SA and the Ombudsman, which caused R1 to become upset. Interview on 10/6/20, at 10:33 a.m. anonymous staff (AS)-A identified The AP overheard the conversation between R1 and a staff member AS-A and entered the room. R1 advised the AP about her feelings of being treated disrespectfully by staff and wanted the names and numbers of attendees of the (nursing home) board so she could call and talk with them about how she was being treated. When R1 asked the AP about the Ombudsman, the AP replied "there was no one she could talk to" and refused to provide contact information for the Ombudsman or SA. The AS-A identified she attempted to report the incident to the Administrator (A) on 10/1/20, at 3:09 p.m. via email with a request for a meeting to discuss the incident. At 4:02 p.m., AS-A identified she had received an email from the administrator with copies to both the AP and social work designee identifying she had made a report to the	F 574		

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F 574	Continued From page 5 administrator of potential abuse or neglect. At 4:24 p.m. that same day, AS-A received a phone call from the administrator and again requested a face to face meeting to discuss the incident. The A was on the phone with the AP in attendance. The administrator "demanded" they discuss the incident at that time over the phone. The AS-A gave the information of events to the A as she had witnessed the incident. AS-A felt intimidated by the A for reporting AP's failure to provide a resident with contact information when requested. Interview on 10/6/20 at 2:15 p.m., with RN-B (social work designee), identified education was routinely provided to all staff on a more than annual basis with regard to Resident Rights, reporting of incidents, and what constituted abuse. During a subsequent interview on 10/7/20 at 11:15 a.m. it was identified she had become aware of an email from the administrator dated 9/30/20, when she had returned to work on 10/5/20. RN-B identified there were several emails back and forth between AS-A and the administrator in which both she and the AP had been included. RN-B identified there had not been any further investigation into the reported incident, and a report had not been submitted to the SA according to the facility policy for abuse. RN-B agreed all allegations of abuse were reportable to the SA. Interview on 10/6/20 at 3:45 p.m. with the AP identified the AP denied knowledge of any problems or conflict in dealing with residents in the facility. When questioned about R1 and her interactions with her she reported R1 verbally abused staff by swearing, giving them the middle finger, and yelling at them to, "get the [expletive] out of her room". The AP identified R1 was	F 574		

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F 574	Continued From page 6 inconsistent in her wants and/or needs, or what bothered her. Attempts to offer interventions had included weekly contact with telehealth for mental health and behavioral issues. The AP identified R1 became upset if she felt she was not responded to as quickly as she wanted or another resident received care ahead of her. The AP would not confirm she had not provided the requested information to R1 for the Ombudsman or SA. Interview on 10/7/20 at 11:47 a.m. with the administrator (A) identified he was aware of the the incident reported to him by AS-A. The A felt R1 had become agitated. The AP had reported to him she had been attempting to explain the reporting method to R1. R1 had multiple complaints and had a history of herself being verbally abusive to staff. The A had not felt the incident of withholding the Ombudsman or SA contact information to R1 was appropriate nor had he investigated the incident to identify if any other requests were made by other residents for attempts to aquire contact information for the Ombudsman or SA. The A had spoken to AS-A who had corroborated R1's story of the AP withholding information, however, the A indicated he did not feel the need for further investigation or re-education to the AP about residents rights. No policy related to resident rights was provided by the end of the survey.	F 574		