Electronically delivered

March 30, 2021

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

RE: CCN: 245551
Cycle Start Date: March 1, 2021

Dear Administrator:

On March 11, 2021, a survey was completed at your facility by the Minnesota Department of Health 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 14, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 14, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 14, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 14, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Clarkfield Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 14, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 11, 2021 if your facility does not

achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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 _____	C 03/11/2021

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 On 3/10/2021 to 3/11/21, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be NOT in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5551019C (MN70660) and H5551020C (MN70624) with a deficiency citated at F689. 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. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 689	The submission of this plan of correction	4/6/21

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

Electronically Signed | 04/01/2021

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 _____	C 03/11/2021

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 689	Continued From page 1 review, the facility failed to ensure 2 of 3 residents (R1 and R2) were provided appropriate supervision and intervention to prevent falls. This resulted in harm for R2 was not properly supervised, fell, and required emergency services for a head injury requiring staples. Findings include Review of facility report submitted to the State Agency (SA) on 1/22/21 at 10:46 p.m., it was identified R2 sustained a fall resulting in a scalp laceration requiring staples. The report indicated nursing assistant (NA)-D had been in R2's room to assist R2 to stand with a walker from her wheelchair. The report indicated NA-D turned from the resident to put the wheelchair away, when she heard R2 say "help me!" When NA-D turned back around she saw R2 falling and attempted to catch R2, but R2 struck her head on the door. Further, the report indicated licensed practical nurse (LPN)-A who was called to the resident's room, found R2 sitting on the floor in front of her nightstand. R2 was bleeding from a laceration on her scalp and expressed pain rated at an 8 of 10, on a 1 (lowest) to 10 (highest) pain scale. The report also indicated R2 was assessed and denied dizziness, nausea and changes in vision. R2's neurological checks were within normal limits. LPN-A cleansed R2's wound and sent R2 to the emergency department (ED) for evaluation. The report indicated R2 required staples to close the wound. According to the facility's 5 day investigation report submitted to the SA on 1/27/21 at 2:46 p.m., the facility had determined R2 was transferred to a standing position with her walker, and NA-D turned to put the wheelchair away.	F 689	is for regulatory purposes and does not indicate the facility agrees with the findings 1.) How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 1: Had two meetings with family members, Admin, DON, ADON to discuss concerns with falls and trouble shoot fall intervention plans with family. (meeting 1) A benefit/risk assessment was done with family about discharging to a facility that deal with dementia care to better meet resident needs. (meeting 2) Family decided the benefits of staying were greater than the risk and assured us they are extremely happy with the care and wants their mom to remain in the facility. Family and staff came up with new activities to try to keep resident 1 occupied when they are feeling restless. Met with family in residents' room to discuss removing furniture to declutter to improve resident environment. Updated care plan to include a new falls intervention for the resident affected. Resident 2: care plan was not followed at the time of the incident. Staff will be educated on how to read and understand the Kardex. there have been no further falls. And that care plan was reviewed and fall interventions are adequate. Nursing department will be educated on how to read & understand the Kardex (ADLs) on 04/06/2021	

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 _____	C 03/11/2021

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 689	Continued From page 2 When NA-D turned away, R2 cried out and fell backwards, striking her head on a door, resulting in a head laceration. R2 was sent to the ED for assessment and received five staples to her scalp. The investigation report indicated R2 required limited assistance of one staff during transfers and indicated R2's care plan, incident report, description of the incident from NA-D, and hospital records were reviewed. After a full review, NA-D was educated on following care plans and definitions of types of transfer assistance for residents including limited assistance. NA-D was educated on how to use the Kardex (part of the care plan) to make sure resident care was provided appropriately. NA-D was also required to view a video on providing resident care, and had to sign an affirmation of understanding. The investigative report identified the resident suffered a laceration and received five staples to the back of her head. The report also indicated R2 had experienced a similar incident on 7/30/20, where the resident had stood up, fallen and required treatment at the ED for staples to her scalp. There was no indication other staff had received any additional education to meet R2's needs due to her impulsiveness and risk for falling. R2's hospital ED report identified on 1/22/21, R2 was treated for a laceration to the back of her head following a fall. The laceration required 5 staples to the resident's scalp. The ED report also indicated R2 had a history of frequent falls. On 1/22/21, a CT scan was performed of R2's head and C-spine, which were negative. R2 was discharged back to the facility with instructions for a return visit in 7 days to remove the staples directions to "ALWAYS use a walker when ambulating".	F 689	2.) How the facility will identify other residents having the potential to be affected by the same deficient practice? The facility has reviewed care plans for all individuals that have fallen in the last 90 days and identified 10 residents with falls during that period. Out of the 10 residents who have fallen 2 were affected by the alleged deficient practice. 3.) What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? The facility updated the falls policy and procedure to be reviewed and updated annually. Implemented new forms & processes to be filled out directly after a fall including Fall Huddles. Implemented RN incident root cause analysis to be filled out the following business day. The nurses were educated on this on 03/31/2021. NAR's & TMA's will be educated on the Kardex on 04/06/2021 4.) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Audits will be conducted by the DON or designee each fall for 1 week, then weekly for 1 month, then monthly for 3 months and quarterly thereafter. Auditing results will be reviewed by the QA committee and brought to QAPI for further evaluation.	

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 _____	C 03/11/2021

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 689	Continued From page 3 R2's quarterly Minimum Data Set (MDS) dated 12/23/21, identified R2's cognition was intact, R2 required limited assistance of one staff for transfers, walking, and locomotion on the unit, required extensive assistance of one staff for toileting, and was unsteady going from a seated to standing position but was able to stabilize with staff assistance. The MDS indicated R2 was not steady during turns and required assistance from staff to stabilize herself, and R2 used a walker and wheelchair for mobility. R2's diagnoses were identified to include left sided hemiparesis (inability to move one side of body), left knee pain, Parkinson's disease, seizure disorder, muscle weakness, and abnormalities of gait and mobility. Staff were to ensure R2's call light was within reach and encourage her to use it, and R2 required prompt response for all request for assistance. R2's care plan, (current at the time of the incident) identified R2 required assistance of 1 staff for bed mobility and transfers, and required use of a mechanical sit-to-stand lift with extensive assistance of two staff. Staff were to encourage R2 to use the call light to call for assistance. R2 had limited physical mobility related to hemiplegia and hemiparesis from a stroke. R2 was to use a walker and limited assistance. R2 had impaired cognitive function and impaired thought process, and her current assessments identified she had moderate cognitive impairments. Staff were to ask yes and no questions to determine R2's needs, cue supervise and reorient as needed. R2 was at high risk for falls related to impaired mobility, and antidepressant and antipsychotic use.	F 689		

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 _____	C 03/11/2021

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 689	Continued From page 4	F 689		

Review of R2's fall incident reports and progress notes identified the following on:
1) 12/11/20, at 9:20 a.m., R2 requested to go outside to smoke. Staff ensured R2 had her phone with her, and assisted R2 outside. Staff had not received a call from R2 to alert them she was done smoking. Staff went to check on R2 and found her halfway up the sidewalk lying in the grass. R2 had a small amount of blood on the left side of her cheek. R2 had a swollen lip, and lacerations on both sides of the bridge of her nose that measured 0.5 centimeters (cm). R2 reported she had forgotten how to access her phone contacts. R2 was educated on how to access her contact list in her cell phone to call for help, and to not use the wheelchair as a walker. There was no indication staff had assessed R2 for decreased cognition. R2's progress notes identified R2's fall was reviewed, and the most recent fall had occurred on 7/30/20. Resident was outside and just finished smoking at the time of the fall. The area was not icy, and the pavement on the sidewalk was even. R2 lost her balance and fell into the grass. R2 was determined to no longer be safe to smoke outside without supervision.

2) 12/21/20 at 8:10 p.m., R2 was found sitting on the floor by her bed. The report identified R2 stated she slid out of bed and hit her left knee and buttocks as she slid out of bed. R2 had no injuries and was assisted back to bed. The report made no mention of any new interventions having been implemented after the fall to prevent future falls. R2's progress notes identified on 12/24/20, the IDT team had reviewed R2's fall. No injuries were noted from the fall. Staff had instructed R2 not to sit at the edge of the bed, and since R2 had short legs, the bed was to be placed in the

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 _____	C 03/11/2021

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 689	Continued From page 5	F 689		

lowest position.

3) 12/25/20, R2 was found sitting on the floor with her back against the bed and legs in front of her. R2 had her call light in her hand, but had not activated it. R2 was fully clothed and wearing her walking shoes. The fall was unwitnessed, and she had no injuries, R2's walker was out of her reach. The notes indicated R2 had decided to walk to her recliner on her own without the use of her walker. R2 felt unsteady and attempted to step back to sit on her bed but did not make it and fell. R2 landed on her bottom. The report identified the factors related to the fall included R2's walker was out of reach, and R2 had not called for assistance. The report did not identify any revised interventions to help prevent future falls.

According to the interdisciplinary team (IDT) notes dated 1/2/21, the IDT team reviewed R2's fall from 12/11/20, and identified R2 had no new illnesses and was stable. The review indicated R2 had been on isolation related to COVID exposure, but had no changes to her medications and environmental issues were not a concern. The IDT identified R2 required assistance of one staff and was able to transfer independently according to her wishes. As a result of the review, a sign was placed in R2's room to remind her to ask for assistance.

According to the IDT notes dated 1/26/21 at 10:20 a.m., the IDT reviewed R2's falls from 12/21/20, 12/25/20, and R2's fall from 7/30/20. R2's risk factors were identified to include R2 was unsteady and used the wheelchair for mobility. R2 required limited assistance for transfers and ambulation, and had complained of being dizzy at

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 _____	C 03/11/2021

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 689	Continued From page 6	F 689		

times. R2's orthostatic vitals were being monitored for three days. The IDT determined medications and environment had not contributed to R2's fall. Education was provided to NA-D regarding use of the Kardex and how to ensure provision of assistance required by resident care plans.

4) 1/30/21 at 4:40 p.m., 8 days after R2 had fallen, requiring staples to her scalp, R2 was found on the floor in the center of her room. R2 reported to staff she'd attempted to transfer to the bathroom and lost her balance. R2 denied hitting her head and sustained no injuries. R2's post-fall assessment identified R2 had limited mobility and gait imbalance. R2 had bladder incontinence and had used her walker without assistance to get to the bathroom. After the fall, R2 was reminded to use the call light to call staff for assistance. A post fall review by the IDT dated 2/3/21 at 10:20 a.m., indicated the IDT had reviewed R2's fall and those from 1/22/21, 12/25/20, and 12/21/20, but found no specific patterns to the falls. As a result of the IDT review, R2 was to be reminded to ask for assistance. There was no indication the facility identified R2 required increased supervision.

5) 2/1/21 at 1:15 a.m., R2 was found sitting on the floor by her bed. R2 reported she had a nightmare and slid out of bed. R2 was assisted back to bed after assessment revealed no injuries were found. A fall mat was then placed at her bedside, and the bed was placed in the lowest position.

On 2/3/21 at 10:25 a.m., the IDT team reviewed R2's fall with her previous falls. The IDT identified R2 required limited assistance with transfers and had severe arthritis in her right knee, but found no

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 _____	C 03/11/2021

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 689	Continued From page 7	F 689		

specific patterns to R2's falls. The IDT identified R2 frequently used the call light for assistance, had no new medications, and there were no environmental factors contributing to the falls. R2 had no injuries and orthostatic vitals were completed for three days. There was no indication staff had identified the need for increased supervision.

R1's 12/30/20, Minimum Data Set (MDS) identified R1 had poor cognition. R1 had delusions and hallucinations and wandered. R1 required extensive assistance of one staff for bed mobility, transfers, walking in her room, hallways, and corridors. R2 also required supervision while moving through the facility. R1 used a walker and wheelchair. She was unsteady and only able to stabilize with staff assistance to stand from a seated position and while turning to face the opposite direction while walking. R1 was able to walk without human assistance. R1's diagnoses included Alzheimer's disease, Major Depressive Disorder, dementia, osteoporosis, repeated falls, and type 2 diabetes with neuropathy.

Review of the 3/4/21 at 9:42 a.m., report filed to the SA identified R1 was found on the floor of her room on 3/3/21, at 11:45 p.m. R1 sustained injuries of a 4 centimeter (cm) by 1 cm laceration above her left eyebrow, and large hematoma (bruise with swelling) on her forehead. The nurse immediately contacted the emergency department (ED), and was instructed to provide ice to the hematoma, and monitor R1's neurological status, and vital signs through the night. R1 was assisted to bed with the bed in the lowest position with mattress was placed next to the bed. R1's neurological status was monitored, and safety checks were completed every 15

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 _____	C 03/11/2021

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 689	Continued From page 8	F 689		

minutes. The next morning, R1 was transferred to the ED the morning of 3/4/21, for evaluation of her head injury.

Review of the 3/8/21 at 4:17 p.m., 5-Day investigation report submitted to the SA identified R1's nurse notes, incident report, reporting policies, physician orders, diagnoses, and ER report were reviewed. R1's care plan was noted to have been followed at the time of the incident. The cause was determined to be R1 had attempted to transfer without assistance. R1 fell, and struck her head resulting in a 4 cm x 1 cm laceration above her left eye. R1 neurological status, vital signs were assessed, and the ED contacted. Instructions given by the ED were to continue monitoring R1's neurological status and vital signs and apply ice to the hematoma. During the night, R1 refused ice packs, and R1's facial swelling worsened. R1 was sent to the ED on the morning of 3/4/21, to evaluate excessive swelling. R1 received an order for scheduled Tylenol for pain management. R1 had a history of falls with similar incidents on 10/10/2020, which resulted in a thumb fracture, and on 10/19/20, R1's fall resulted in a head injury that was evaluated at the ED.

R1's 3/4/21, ED report identified R1 sustained no fractures from the fall.

R1's Risk management reports identified between 9/1/20 and 3/10/21, R1 had 19 falls. On 10/19/20, R1 had one fall resulting in major injury.

R1's 3/10/21, care plan identified R1 had a history of falls, dementia, and impaired cognition. R1 was at high risk for falling. R1 required limited assistance of one staff, a gait belt, and a walker

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 _____	C 03/11/2021

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 689	Continued From page 9	F 689		

to ambulate, toilet, transfer, and toilet. R1's fall interventions included to have staff have one to one observation with nursing staff was restless, and one to one with activities. Staff were to provide safety checks approximately every 15 minutes. R1 was to remain in line of sight in the dining room. R1 had anti-back brakes on the wheelchair. Staff were to assure R1's brakes were unlocked when in the wheelchair. R1's call light was to be kept in reach, clipped directly to her shirt, not the wheelchair. R1 was to have adequate lighting, and her room door always open. When R1 was restless, staff were to attempt distraction techniques, offer word search books, to find a show on R1's sensory screen, engage in conversation, and offer R1 an activity blanket. R1 required assistance of one staff to stand. Staff were to assist R1 to stretch and toilet hourly while awake and, ambulate R1 in the hallway. R1 was able to have compassionate care visits. While in bed, R1 wore gripper socks. R1's bed was to be in the lowest position with a fall mattress at the bedside. Staff were to toilet R1 at 11:30 p.m., 12:30 a.m., 2:30 a.m., and 4:30 a.m.

Observation and interview on 3/10/21 at 3:17 p.m., of R1 identified R1 was in her room seated in her wheelchair. R1 had anti-back brakes on the back of her wheelchair. R1's call light was fastened to the arm of the wheelchair. R1's face had blotches of purple bruises with yellow margins scattered across her forehead and cheeks. Purple discoloration was observed in her laugh lines and along her jaw line. A scabbed area was identified on her left eyebrow. R1 was calm and alert. A bedside table was placed in front of her with a magazine and word find book. R1's television was on. R1 was unable to recall

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 _____	C 03/11/2021

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 689	Continued From page 10	F 689		

falling and was unsure why she had bruises on her face.

Observation and interview on 3/11/21, at 11:45 a.m., with NA-C and R1 identified R1 was in the dining room being assisted to eat by NA-C. R1 was tired and nodding off during the meal. NA-C assisted her to her room and assisted R1 to bed. R1's bed was lowered to the floor and the mattress was placed at bedside. R1's call light was placed on the mattress next to R1. An interview with NA-C identified R1 had episodes when she was very active, trying to pick things off the floor and wandering, and times when she was completely lethargic.

Interview on 3/11/21 at 12:57 p.m., with LPN-B identified R1 was up very early. R1 had been active for the past few days. Staff tried to regulate her sleep cycle, but R1 only became agitated. R1 sometimes became agitated when staff were with her one to one, if one to one's agitated her, staff were to keep her in line of sight. R1 was supposed to have one to one and distance supervision, staff tried to communicate with each other to ensure R1 had appropriate supervision, however, when the TMA was passing medications and supervising R1, R1 was left outside the door when passing meds. It was not a perfect situation, but staff worked with what they had, and TMA-A felt R1's care was covered.

Interview on 3/11/21 at 1:30 p.m., with LPN-A identified on 3/3/21, he worked the night shift with two nursing assistants (NA)-A and NA-B. Each NA was assigned to a separate wing. During the shift, R1 was her usual self. She was confused, active, talkative, and picking at magazines. R1 was active, wheeling herself around the hallway

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 _____	C 03/11/2021

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 689	Continued From page 11	F 689		

looking for children. When the NAs were busy, R1 was placed at the East wing nurse's station with LPN-A to try to keep her in line of sight. Prior to the fall, several call lights were on. NA-A and NA-B were in rooms with residents. LPN-A remained at the with R1. NA-A needed assistance in an unidentified resident's room. NA-B was in the other hallway assisting residents. LPN-A was the only staff available to assist NA-A. LPN-A left R1 unsupervised, outside the unidentified resident's room and closed the door. LPN-A asked R1 to wait outside the door. When LPN-A left the room to get linen, R1 was no longer waiting at the door. LPN-A passed R1's room to get linen and observed R1 sitting in her wheelchair by her dresser behind the door. LPN-A passed R1's room a second time and had not observed R1 because the door blocked his view. LPN-A returned to the nurse desk. LPN-A did not check on R1 or bring her back to the nurse's station. Between 5 and 10 minutes later, NA-B reported R1 was on the floor. LPN-A had not checked to see if R1 was offered the toilet. R1 had a hematoma on her forehead and a laceration on her eyebrow. LPN-A assessed R1's neurological status and cleansed the wound and immediately called the ED. LPN-A was instructed to apply ice to R1's hematoma and to continue to monitor her neurological status through the night. R1 was brought to the nurse station An ice pack was applied to the hematoma, and R1 was monitored. R1 was assisted to bed around midnight. R1 refused to allow ice packs, during the night. R1's swelling worsened, and she was sent to the ED in the morning. Historically, R1 had times of restlessness, and she would wander the hallways, and enter other resident's room. R1 had a history of falls. Many interventions were attempted such as 1:1 supervision when she was

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 _____	C 03/11/2021

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 689	Continued From page 12	F 689		

restless. R1 refused one to one interaction sometimes. When R1 was not receptive to 1:1 supervision, staff were to keep R1 with the nurse at the nurses' desk or with the person passing medications. When all staff were pulled into resident rooms, R1 was not always directly supervised.

Interview with on 3/11/21 at 2:45 p.m., with trained medication aid (TMA)-A, identified R1 was frequently restless, and hallucinated. When she was alert, she was often active and attempted to transfer without assistance and pick items up off the floor. R1 had many interventions, including keeping her within staff's line of sight when she was restless. Staff also were to monitor her every 15 minutes, when she was restless, R1 was placed with the TMA on the med cart or with the nurse when NAs were busy. R1 was often left unsupervised while passing meds. Staff did what they could to keep R1 in line of sight, but when passing meds, sometimes R1 was not always in line of sight when they had to enter rooms.

Interview on 3/11/21 at 3:05 p.m., with registered nurse (RN)-A identified she had investigated the R1 and R2's falls. R1 had an extensive history of falls. All investigation notes were provided with the SA reports and IDT follow-ups were included in the nurse notes in the electronic medical records. R2's fall investigation identified NA-D had not provided appropriate supervision for R2 at the time of the fall and was provided re-education regarding resident assistance and following the care plan. R2. R2 had a history of not calling and not using her walker to ambulate at the time of her falls. R2 was supposed to use her walker according to her care plan. R2's falls were evaluated during IDT meetings. NA-B

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 _____	C 03/11/2021

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 689	Continued From page 13	F 689		

agreed no patterns were identified regarding R2's falls. RN-A agreed a more thorough investigation of the falls could determine staff had no ensured R2's walker was within reach. R1 had fallen in October 2020, and fractured her thumb. R1 was a busy lady and had a history of wandering. Many interventions were implemented, and supervision was the most effective intervention. R1 was not always receptive to one-to-one supervision, so staff were to keep R1 in their line of sight. Review of the circumstances of R1's fall on 3/4/21, identified R1 was left unsupervised during care for another resident, and had not checked on R1 before returning to the nurses' desk. RN-A had not included this information in the investigation report and agreed staff could have checked R1 in her room before returning to the nurse desk, offered her the toilet, and brought her to the desk for closer observation. She also agreed R1's care plan was not followed during the time of the fall, and IDT had not identified this as a factor of R1's falls. Review of the staff education documentation with RN-A identified education was not provided to all staff after any of R1 or R2's falls.

Interview on 3/11/21 at 3:14 p.m., with the administrator identified falls were reviewed at the weekly interdisciplinary team meetings (IDT). R1 had an extensive history of falls and had fallen less recently. R1 had sustained injuries from her falls and had interventions in place to ensure R1's safety. Review of R1's fall on 3/4/21, identified staff had left R1 out of line of sight while providing another resident's care. After providing care, and before returning to the nurse station, staff had not observed R1 to see if she was still restless. The administrator was unsure what else could have been done at the time R1 fell but agreed staff should have checked on R1 after cares before

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 _____	C 03/11/2021

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 689	Continued From page 14	F 689		

returning to the nurse desk to see if R1 was restless, and if she was, staff should have continued to supervise R1 at the nurses' desk. The administrator agreed the IDT fall reviews had not identified any other instances of the care plan not being followed and agreed a more thorough root cause analysis during IDT was needed to identify fall trends. When trends were identified, education should be provided to all staff.

Review of the March 2019, Fall Prevention policy identified the policy purpose was to provide a systematic way for the IDT to prevent, monitor, and assess resident falls in the facility. A post-fall analysis was to occur by the IDT to determine the cause of a fall to prevent future falls. The policy suggested several modifiable fall risks to consider but made no mention of staff supervision as a modifiable risk. There was no indication the policy was reviewed annually.

Review of the facility's policy, Accidents and Incidents-Investigating and Recording policy dated 3/21/19, identified the charge nurse, department supervisor, or director must conduct a fall scene investigation including the circumstances surrounding the incident, corrective action taken, and follow-up information.

Review of the facility's undated policy, Falls-Clinical Protocol, identified as part of the assessment and recognition; staff were to define possible causes for the fall within 24 hours of the fall. Causes referred to factors associated to or directly resulting in a fall. There may be multiple factors in varying degrees contributing to a falling problem. Staff were to evaluate, and document falls and include when and where the fall occurred and any observations of the events. The

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 _____	C 03/11/2021

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 689	Continued From page 15 facility staff and physician were to continue to collect and evaluate information until either the cause of falls was identified, or it was determined no cause was able to be found, or that finding a cause would not change the outcome or the management of falling and fall risk. When underlying causes were not readily identified or corrected, staff were to try various relevant interventions, based on the resident's fall assessments until falling reduces or stops, or until a reason was identified for its continuation. There was no indication whether the policy was reviewed annually.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 30, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: FTW711

Dear Administrator:

The above facility was surveyed on March 10, 2021 through March 11, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

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