

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 17, 2021

Administrator Clara City Care Center 1012 North Division Street PO Box 797 Clara City, MN 56222

RE: CCN: 245573

Cycle Start Date: September 23, 2021

Dear Administrator:

On October 21, 2021, we informed you of imposed enforcement remedies.

On October 26, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey/revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effectiveDecember 5, 2021, will remain in effect.
- Directed plan of correction, Federal regulations at 42 CFR § 488.424 Please see electronically attached documents for the DPOC.

This Department continues to recommend that CMS impose a 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.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 5, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 5, 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.

As we notified you in our letter of October 21, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 5, 2021.

### ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

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

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

### **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:

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health

12 Civic Center Plaza, Suite #2105 Mankato, Minnesota 56001

Email: <u>elizabeth.silkey@state.mn.us</u>

Office: (507) 344-2742 Mobile: (651) 368-3593

#### 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 December 23, 2021 (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.

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/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: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm">https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</a>

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: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>

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

Kumalu Fishe Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 11/22/2021 FORM APPROVED OMB NO. 0938-0391

| I' '                     |                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                   | (X2) MULTIF<br>A. BUILDING | (X3) DATE SURVEY<br>COMPLETED                                                                            |                        |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------------------------------------------|------------------------|
|                          |                                                                                                                                                                                                                                                                                                                                                                                 | 245573                                                                                                                                                                                                                                                                               | B. WING                    |                                                                                                          | C<br><b>10/26/2021</b> |
|                          | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                      |                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1012 NORTH DIVISION STREET PO BOX 79<br>CLARA CITY, MN 56222    |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLÉTION          |
| F 000                    | INITIAL COMMENT                                                                                                                                                                                                                                                                                                                                                                 | ΓS                                                                                                                                                                                                                                                                                   | F 000                      |                                                                                                          |                        |
| F 689                    | abbreviated survey Your facility was for with the requirement Requirements for L.  The following comp SUBSTANTIATED: a deficiency cited at The facility's plan or as your allegation of Departments accepenrolled in ePOC, yat the bottom of the form. Your electronibe used as verificate Upon receipt of an onsite revisit of you validate that substate regulations has been | f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required it first page of the CMS-2567 ic submission of the POC will tion of compliance.  acceptable electronic POC, an refacility may be conducted to intial compliance with the | F 689                      |                                                                                                          | 11/23/21               |
| SS=D                     | CFR(s): 483.25(d)(<br>§483.25(d) Acciden<br>The facility must en<br>§483.25(d)(1) The I                                                                                                                                                                                                                                                                                         | 1)(2)<br>its.                                                                                                                                                                                                                                                                        | 7 000                      |                                                                                                          | 11/20/21               |
|                          | supervision and ass<br>accidents.<br>This REQUIREMEN<br>by:<br>Based on observat                                                                                                                                                                                                                                                                                                | resident receives adequate sistance devices to prevent  NT is not met as evidenced tion, interview, and document ailed to ensure care planned                                                                                                                                        |                            | Resident 1 passed away 11/14/21                                                                          |                        |

Electronically Signed

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

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

TITLE

(X6) DATE

|                          | OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULT<br>A. BUILDI |                                                                                                    | E CONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | COMF                                                          | E SURVEY<br>PLETED         |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|----------------------------|
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 245573                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | B. WING                |                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 10/2                                                          | C<br>26/2021               |
|                          | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                        | STREET ADDRESS, CITY, STATE, ZIP CODE  1012 NORTH DIVISION STREET PO BOX 797  CLARA CITY, MN 56222 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                               | <u></u>                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG    |                                                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | BE                                                            | (X5)<br>COMPLETION<br>DATE |
| F 689                    | fall risk prevention i when R1 was direct footwear and a gait residents reviewed practice led to R1 fall Findings include:  R1's Face Sheet date admitted to the faci following pertinent of accident (CVA), (str. R1's admission min assessment dated having a brief intervace of "15" (no imprequired extensive adaily living (ADL's) in personal hygiene. The required extensive at transferring and limproom.  R1's care plan last R1 was at high fall gait and balance, at Interventions include assistance of one, or proper non-slip foot there is a fall.  During an interview stated nursing assistance, sweater, and for bed on 10/7/21 walker and walk the he did not have a gift. | interventions were followed ted to walk without proper to belt was not placed for 1 of 3 for falls. This deficient alling and sustaining skin tear.  ated 10/6/21, indicated R1 was ality on 10/6/21, with the diagnosis:cerebral vascular roke).  nimum data set (MDS) 10/13/21, identified R1 as wiew for mental status (BIMS) apairment in cognition). R1 assistance with activities of including dressing and The MDS further indicated R1 assistance with bed mobility, nited assistance with walking in revised on 10/6/21, indicated risk as evidenced by unsteady | F 6                    | 89                                                                                                 | All residents at risk for falls have the potential to be affected by this deficipractice.  The DON or designee will review far prevention and management prograpolicy and procedure, update as neand review with appropriate staff.  The DON or designee, will in-service nursing staff on fall prevention and management program policy and procedure including fall risk interveand care plan implementation on 11/22/21.  DON or designee will audit all residerisk for falls for interventions being care plan and further audit that the interventions listed are being follow staff on varying shifts daily x 5, there weekly x 4, and monthly x4 and repfindings to the QAPI Committee for and further action. | cient all am eeded ce all ntions ents at on the red by n port |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ` ′                 | IPLE CONSTRUCTION  IG                                                                           | (X3) DATE SURVEY COMPLETED C |                            |  |
|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------|------------------------------|----------------------------|--|
|                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 245573                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | B. WING_            |                                                                                                 | 10                           | /26/2021                   |  |
|                                                                                                      | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>1012 NORTH DIVISION STREET PO<br>CLARA CITY, MN 56222    | DDE                          |                            |  |
| (X4) ID<br>PREFIX<br>TAG                                                                             | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                    | (X5)<br>COMPLETION<br>DATE |  |
| F 689                                                                                                | on the waste basker wastebasket made R1 further stated h walker and sustain right upper arm. R2 arm and pulled on feet. R1 pivoted an was on the bed, N2 minute later LPN-A happened. R1 state onto the wastebask wastebasket, his kin an injury on both an A progress note dalicensed practical ribeing informed by 10:35 p.m. that R1 assessed the skin 2 cm x 0.8 cm wide wound, completed strips and a 3 x 3" further documented the same location adocumentation four post fall assessme potential contributir interventions.  A progress note daindicated that direct documented R1's fa fall and sustained A progress note daindicated that direct documented R1's fa fall and sustained A progress note daindicated that direct documented R1's fa fall and sustained A progress note daindicated that direct documented R1's fa fall and sustained A progress note daindicated that direct documented R1's fa fall and sustained A progress note daindicated that direct documented R1's fa fall and sustained A progress note daindicated that direct documented R1's fa fall and sustained A progress note daindicated that direct documented R1's fa fall and sustained A progress note daindicated that direct documented R1's fa fall and sustained A progress note daindicated that direct documented R1's fa fall and sustained A progress note daindicated that direct documented R1's fa fall and sustained A progress note daindicated that direct documented R1's fa fall and sustained A progress note daindicated that direct documented R1's fa fall and sustained A progress note daindicated that direct documented R1's fa fall and sustained A progress note daindicated that direct documented R1's fa fall and sustained A progress note daindicated that direct documented R1's fa fall and sustained A progress note daindicated that direct documented R1's fa fall and sustained A progress note daindicated that direct documented R1's fa fall and sustained A progress note daindicated that direct documented R1's fall and sustained A progress note daindicated that direct documented | tated his left shoulder landed et and the sharp edge of the a skin tear on his upper arm. is right upper arm hit the ed another skin tear on the I stated NA-A grabbed his right the walker to get him to his d sat on the bed. Once R1 A-A quickly left the room. A came in and asked R1 what ed he reported to LPN-A he fell ket with his shoulder on the nees on the floor, and now has rms.  Ited 10/07/21, at 10:55 p.m. by hurse (LPN)-A documented nursing assistant (NA)-A at had a skin tear. LPN-A tear and documented finding a eskin tear. LPN-A cleansed the skin preparation, applied steri Mepilex bandage. LPN-A d R1 currently had a bruise in as the skin tear. There was no not in the medial record that a nt was completed to identifying factors and needed  Ited 10/8/21, at 2:37 p.m. tor of nursing (DON) amily was notified that he had d a skin tear.  Ited 10/08/21, 3:57 p.m. | F 68                | 39                                                                                              |                              |                            |  |
|                                                                                                      | notified by staff at 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ered nurse (RN)-A, was<br>6:00 a.m. that R1 reported<br>rening. R1 stated NA-A was                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                 |                              |                            |  |

| AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                    | (X3) DATE SURV      |                                                                                                   |         |                            |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------|---------|----------------------------|
|                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 245573                                                                                                                                                                                                                                                                                                                                                                             | B. WING             |                                                                                                   | ,       | C<br>10/26/2021            |
|                                                                                                           | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                    |                     | STREET ADDRESS, CITY, STATE, ZIP CODI<br>1012 NORTH DIVISION STREET PO BO<br>CLARA CITY, MN 56222 | Ē       |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                  | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)     | OULD BE | (X5)<br>COMPLETION<br>DATE |
| F 689                                                                                                     | shoes, sweater and walk to the bed. R1 unassisted to the bed and that fell after the fell and landed with wastebasket, and he he he are 10/07/21, skin the 10/07/21, skin the 10/07/21, skin the sking R1 what hap slipped on the edge edge of the recliner did his bottom touch. During an interview NA-A stated on 10/19. The went to hel stated he took R1's had socks on. NA-A feet from the recliner could walk to the bedirected R1 to we continue to get R1 recliner is approximand NA-A started wand that he did not stated R1 took a stecatch him. NA-A stallanded on the waster recliner and the bedright arm. NA-A stallanded on the immediately went to remember her naminformed her that R1 was the state R1 took a started R | dy for bed and NA-A took R1's I shirt off and directed R1 to stated he was walking ed and his socks were slippery king one step. R1 stated he his left arm/chest on the lis knees were on the floor.  Ited 10/11/21, at 12:14 p.m. a created an updated note for ear. LPN-A documented opened, and his reply was he e of the recliner and sat on the /garbage can, but at no point | F 6                 | 89                                                                                                |         |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ` ′                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | IPLE CONSTRUCTION IG |                                                                                                   | TE SURVEY<br>MPLETED<br>C |                            |
|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------------------------------------------------------------|---------------------------|----------------------------|
|                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 245573                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | B. WING _            |                                                                                                   | 10                        | )/26/2021                  |
|                                                                                                      | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                      | STREET ADDRESS, CITY, STATE, ZIP CO<br>1012 NORTH DIVISION STREET PO E<br>CLARA CITY, MN 56222    | DE                        |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                             | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | SHOULD BE                 | (X5)<br>COMPLETION<br>DATE |
| F 689                                                                                                | end of his shift and he did not follow the to use a gait belt ar were on R1 during  During an observat R1 was observed in into his room by un therapist (PT)-A. Possible the pivot to the rect obe unsteady and PT-A to stand and plowering to sit in the to lack of strength.  During an interview LPN-A stated NA-A approximately 11:00 area and could be of that R1 has a skin to NA-A state it happer R1 and that he sat to the bed. LPN-A shappened and there LPN-A stated she are indicated he did the garbage can. Lefall to the floor, she LPN-A further stated did not use a gait be only in his socks, we stated when she are sitting on the bed we underwear on, so se skin. LPN-A she did | curn to R1's room as it was the he left the facility. NA-A stated a care plan which directed him he densure proper footwear the transfer.  ion on 10/26/21, at 9:45 a.m. a wheelchair being wheeled known name physical T-A assisted R1 to stand and cliner. R1's gait was observed required the assistance of civot. R1 was observed while a recliner to abruptly land due a con 10/26/21, at 11:13 a.m. awas observed on 10/07/21, at 0 p.m. going to the charting overheard reporting to NA-B tear. LPN-A further overheard ened while he was transferring on top of the garbage can next at the went to assess R1's wound. The stated she asked NA-A what a went to assess R1's wound. The stated since R1 did not did not think it was a fall. The dR1 informed her that NA-A celt and directed him to walk which made him slip. LPN-A rived to R1's room, he was with only his tee shirt and he was able to assess his d not see the right upper arm ut it was found by another | F 68                 | 39                                                                                                |                           |                            |

|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                           |                                                                                                                                                                                                                              |                     | FIPLE CONSTRUCTION  NG                                                                             |        | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------|--------|-------------------------------|--|
|                          |                                                                                                                                                                | 245573                                                                                                                                                                                                                       | B. WING             |                                                                                                    |        | C<br><b>10/26/2021</b>        |  |
|                          | PROVIDER OR SUPPLIER                                                                                                                                           |                                                                                                                                                                                                                              |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1012 NORTH DIVISION STREET PO BOX<br>CLARA CITY, MN 56222 |        |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                                                                                                                               | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                                                                                                 | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)   | JLD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 689                    | During an interview DON stated a fall is DON stated the fall considered a fall an immediately.  The facility Fall Pre Program policy, las directed that any un | on 10/26/21, at 12:33 p.m. an unplanned rapid descent. to the wastebasket is ad should have been reported  vention and Management t modified on 01/12/21, nintentional change in position and in the event of a fall, notify | F 6                 | 89                                                                                                 |        |                               |  |



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 17, 2021

Administrator Clara City Care Center 1012 North Division Street PO Box 797 Clara City, MN 56222

Re: State Nursing Home Licensing Orders

Event ID: FYO311

#### Dear Administrator:

The above facility was surveyed on October 25, 2021 through October 26, 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 <u>only a suggestion</u> 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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. 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:

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, Minnesota 56001

Email: <u>elizabeth.silkey@state.mn.us</u>Office: (507) 344-2742 Mobile: (651) 368-3593

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

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

(X6) DATE

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                                                                                                                                                                     | ` ′                                                                                                                                                                                                                                       | E CONSTRUCTION      | (X3) DATE<br>COMP                                                                   | SURVEY<br>LETED |                          |  |
|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------|-----------------|--------------------------|--|
|                                                                                                     |                                                                                                                                                                     |                                                                                                                                                                                                                                           | 71. 501251110.      |                                                                                     |                 | С                        |  |
|                                                                                                     |                                                                                                                                                                     | 00061                                                                                                                                                                                                                                     | B. WING             |                                                                                     |                 | 6/2021                   |  |
| NAME OF I                                                                                           | PROVIDER OR SUPPLIER                                                                                                                                                |                                                                                                                                                                                                                                           |                     | STATE, ZIP CODE                                                                     |                 |                          |  |
| CLARA (                                                                                             | CLARA CITY CARE CENTER 1012 NC CLARA                                                                                                                                |                                                                                                                                                                                                                                           |                     | N STREET PO BOX 797<br>222                                                          |                 |                          |  |
| (X4) ID<br>PREFIX<br>TAG                                                                            | (EACH DEFICIENCY                                                                                                                                                    | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE          | (X5)<br>COMPLETE<br>DATE |  |
| 2 000                                                                                               | Initial Comments                                                                                                                                                    |                                                                                                                                                                                                                                           | 2 000               |                                                                                     |                 |                          |  |
|                                                                                                     | ****ATTE                                                                                                                                                            | NTION*****                                                                                                                                                                                                                                |                     |                                                                                     |                 |                          |  |
|                                                                                                     | NH LICENSING                                                                                                                                                        | CORRECTION ORDER                                                                                                                                                                                                                          |                     |                                                                                     |                 |                          |  |
|                                                                                                     | 144A.10, this corre-<br>pursuant to a surve<br>found that the defic<br>herein are not corre-<br>not corrected shall<br>with a schedule of f<br>the Minnesota Depart | hether a violation has been                                                                                                                                                                                                               |                     |                                                                                     |                 |                          |  |
|                                                                                                     | requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess                           | e rule provided at the tagule number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was |                     |                                                                                     |                 |                          |  |
|                                                                                                     | that may result fron<br>orders provided tha<br>the Department wit                                                                                                   | hearing on any assessments<br>n non-compliance with these<br>it a written request is made to<br>hin 15 days of receipt of a<br>ent for non-compliance.                                                                                    |                     |                                                                                     |                 |                          |  |
|                                                                                                     | was conducted at y<br>the Minnesota Depa<br>facility was found N<br>State Licensure. Pla<br>plan of correction y                                                    | rs: 0/26/21, a complaint survey our facility by a surveyor from artment of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders e when they will be completed.                  |                     |                                                                                     |                 |                          |  |

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

**Electronically Signed** 11/18/21

TITLE

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ` ′                         | E CONSTRUCTION                                                                                   |           | SURVEY<br>PLETED         |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------------------------------|-----------|--------------------------|
|                                                                              |                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |                                                                                                  |           | С                        |
|                                                                              |                                                                                                                                                                               | 00061                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | B. WING                     |                                                                                                  | 10/2      | 26/2021                  |
| NAME OF                                                                      | PROVIDER OR SUPPLIER                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             | STATE, ZIP CODE                                                                                  |           |                          |
| CLARA (                                                                      | CITY CARE CENTER                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | RTH DIVISION<br>ITY, MN 562 | N STREET PO BOX 797<br>22                                                                        |           |                          |
| (X4) ID<br>PREFIX<br>TAG                                                     | (EACH DEFICIENC)                                                                                                                                                              | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORI<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| 2 000                                                                        | Continued From pa                                                                                                                                                             | age 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2 000                       |                                                                                                  |           |                          |
|                                                                              | SUBSTANTIATED:<br>a licensing order is                                                                                                                                        | plaint was found to be H5573017C (MN77478) with sued at 4658.0520 Subp 1.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                             |                                                                                                  |           |                          |
|                                                                              | the State Licensing<br>Federal software. T<br>assigned to Minnes                                                                                                              | Correction Orders using Figure 1 Treath 13 decembers Figure 2 Treath 13 decembers Figure 2 Treath 13 december 13 d |                             |                                                                                                  |           |                          |
|                                                                              | appears in the far-l<br>Tag." The state sta<br>listed in the "Summ                                                                                                            | eft column entitled "ID Prefix<br>atute/rule out of compliance is<br>nary Statement of Deficiencies"                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                             |                                                                                                  |           |                          |
|                                                                              | the correction orde<br>the findings which a<br>statute after the sta<br>as evidence by." For                                                                                  | es the "To Comply" portion of r. This column also includes are in violation of the state atement, "This Rule is not met bllowing the surveyor's findings Method of Correction and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             |                                                                                                  |           |                          |
|                                                                              | You have agreed to receipt of State lice the Minnesota Dep Informational Bulle                                                                                                | p participate in the electronic<br>ensure orders consistent with<br>artment of Health<br>tin 14-01, available at<br>state.mn.us/facilities/regulatio                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                             |                                                                                                  |           |                          |
|                                                                              | attached Minnesota<br>being submitted to<br>no plan of correction<br>Statutes/Rules, ple<br>"CORRECTED" in<br>must then indicate<br>licensure process,<br>date, the date your | orders are delineated on the a Department of Health orders you electronically. Although on is necessary for State ase enter the word the box available for text. You in the electronic State under the heading completion orders will be corrected prior omitting to the Minnesota                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                             |                                                                                                  |           |                          |
|                                                                              | Department of Hea ePOC and therefor                                                                                                                                           | olth. The facility is enrolled in<br>the a signature is not required at<br>the rest page of state form.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                             |                                                                                                  |           |                          |

Minnesota Department of Health

STATE FORM FY0311 If continuation sheet 2 of 8

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                     |                     |                                                                                                            |       | SURVEY<br>PLETED         |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------|-------|--------------------------|
|                                                                              |                                                                                                                                                                                                                                                            | 00061                                                                                                                                                                                                                                                                               | B. WING             |                                                                                                            | 1     | C<br>2 <b>6/2021</b>     |
|                                                                              | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                       | 1012 NOR                                                                                                                                                                                                                                                                            |                     | STATE, ZIP CODE N STREET PO BOX 797                                                                        |       |                          |
| (X4) ID<br>PREFIX<br>TAG                                                     | (EACH DEFICIENCY                                                                                                                                                                                                                                           | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETE<br>DATE |
| 2 830                                                                        | Proper Nursing Car<br>Subpart 1. Care in<br>receive nursing car<br>custodial care, and<br>individual needs an<br>the comprehensive<br>plan of care as des<br>4658.0405. A nursi<br>of bed as much as<br>written order from t                               | general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident | 2 830               |                                                                                                            |       | 11/23/21                 |
|                                                                              | by: Based on observati review the facility fa fall risk prevention i when R1 was direct footwear and a gait residents reviewed practice led to R1 fa Findings include: R1's Face Sheet da admitted to the faci following pertinent of accident (CVA), (str | ,                                                                                                                                                                                                                                                                                   |                     | Corrected                                                                                                  |       |                          |
|                                                                              | assessment dated<br>having a brief interv<br>score of "15" (no im                                                                                                                                                                                          | nimum data set (MDS) 10/13/21, identified R1 as view for mental status (BIMS) apairment in cognition). R1 assistance with activities of                                                                                                                                             |                     |                                                                                                            |       |                          |

Minnesota Department of Health STATE FORM

Minnesota Department of Health

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STATEME | NT OF DEFICIENCIES<br>I OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | , ,            | E CONSTRUCTION                                               | (X3) DATE | SURVEY<br>LETED          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------|-----------|--------------------------|
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1012 NORTH DIVISION STREET PO BOX 797  CLARA CITY, MN 56222   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  1012 NORTH DIVISION STREET PO BOX 797  CLARA CITY, MN 56222  (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG CROSS-REFERENCED TO THE APPROPRIATE  DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 00061                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | B. WING        |                                                              |           |                          |
| CLARA CITY CARE CENTER  CLARA CITY, MN 56222  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | NAME OF | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | DRESS, CITY, S | STATE, ZIP CODE                                              |           | <u> </u>                 |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE  DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | CLARA   | CITY CARE CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                |                                                              |           |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | PRÉFIX  | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | PREFIX         | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO | LD BE     | (X5)<br>COMPLETE<br>DATE |
| daily living (ADL's) including dressing and personal hygiene. The MDS further indicated R1 required extensive assistance with bed mobility, transferring and limited assistance with walking in room.  R1's care plan last revised on 10/6/21, indicated R1 was at high fall risk as evidenced by unsteady gait and balance, and history of falls. Interventions included ambulate with the assistance of one, use a transfer belt, ensure proper non-slip footwear, and notify the doctor if there is a fall.  During an interview on 10/26/21, 9:29 a.m. R1 stated nursing assistant (NA)-A took off residents shoes, sweater, and shirt to help him get ready for bed on 10/721. NA-A instructed R1 to use his walker and walk the few feet to his bed. R1 stated he did not have a gait belt on and without having non-slip footwear on, he slipped and fell onto the wastebasket. R1 stated his left shoulder landed on the waste basket and the sharp edge of the wastebasket made a skin tear on his upper arm. R1 further stated his right upper arm. R1 stated NA-Q grabbed his right upper arm. R1 stated NA-Q grabbed his right upper arm and sustained another skin tear on the right upper arm. R1 stated hA-Q grabbed his right arm and pulled on the walker to get him to his feet. R1 pivoted and sat on the bed. Once R1 was on the bed, NA-A quickly left the room. A minute later LPN-A came in and asked R1 what happened. R1 stated he reported to LPN-A he fell onto the wastebasket, his knees on the floor, and now has an injury on both arms.  A progress note dated 10/07/21, at 10:55 p.m. by licensed practical nurse (LPN)-A documented being informed by nursing assistant (NA)-A a | 2 830   | daily living (ADL's) is personal hygiene. The required extensive a transferring and limit room.  R1's care plan last R1 was at high fall gait and balance, as Interventions included assistance of one, uproper non-slip foot there is a fall.  During an interview stated nursing assistance, sweater, and for bed on 10/7/21 walker and walk the he did not have a genon-slip footwear of wastebasket. R1 ston the waste basked wastebasket made R1 further stated him walker and sustainer right upper arm. R1 arm and pulled on the feet. R1 pivoted and was on the bed, NA minute later LPN-A happened. R1 state onto the wastebask wastebasket, his knan injury on both ar A progress note dat licensed practical nand since the same personal states. | including dressing and The MDS further indicated R1 assistance with bed mobility, ited assistance with walking in revised on 10/6/21, indicated risk as evidenced by unsteady and history of falls. The dambulate with the use a transfer belt, ensure twear, and notify the doctor if on 10/26/21, 9:29 a.m. R1 stant (NA)-A took off residents dishirt to help him get ready NA-A instructed R1 to use his efew feet to his bed. R1 stated ait belt on and without having and the sharp edge of the askin tear on his upper arm. Is right upper arm hit the ed another skin tear on the stated NA-A grabbed his right he walker to get him to his disat on the bed. Once R1 and asked R1 what and he reported to LPN-A he fell the with his shoulder on the nees on the floor, and now has ms. | 2 830          |                                                              |           |                          |

Minnesota Department of Health

STATE FORM FYO311 If continuation sheet 4 of 8

Minnesota Department of Health

|                          | NT OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                           | E CONSTRUCTION                                                                                      | (X3) DATE<br>COMF | SURVEY<br>PLETED         |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-----------------------------------------------------------------------------------------------------|-------------------|--------------------------|
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | A. BOILDING.              | <del></del>                                                                                         |                   | C                        |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 00061                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | B. WING                   |                                                                                                     |                   | 26/2021                  |
| NAME OF                  | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | DRESS, CITY, S            | STATE, ZIP CODE                                                                                     |                   |                          |
| CLARA (                  | CITY CARE CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | TH DIVISION<br>TY, MN 562 | N STREET PO BOX 797<br>22                                                                           |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | IOULD BE          | (X5)<br>COMPLETE<br>DATE |
| 2 830                    | assessed the skin to 2 cm x 0.8 cm wide wound, completed strips and a 3 x 3" If further documented the same location adocumentation four post fall assessmen potential contributing interventions.  A progress note daindicated that direct documented R1's far a fall and sustained. A progress note dared documented registernotified by staff at 6 having a fall last evhelping him get reast shoes, sweater and walk to the bed. R1 unassisted to the beand that fell after that fell and landed with wastebasket, and he have a fall what has slipped on the edge edge of the recliner did his bottom touc. During an interview NA-A stated on 10/10. | tear and documented finding a skin tear. LPN-A cleansed the skin preparation, applied steri Mepilex bandage. LPN-A R1 currently had a bruise in as the skin tear. There was no not in the medial record that a not was completed to identifying factors and needed and tear.  Ited 10/8/21, at 2:37 p.m. tor of nursing (DON) amily was notified that he had a skin tear.  Ited 10/08/21, 3:57 p.m. tered nurse (RN)-A, was 6:00 a.m. that R1 reported ening. R1 stated NA-A was dy for bed and NA-A took R1's a shirt off and directed R1 to stated he was walking the ed and his socks were slippery king one step. R1 stated he his left arm/chest on the his left arm/chest on the his knees were on the floor.  Ited 10/11/21, at 12:14 p.m. A created an updated note for ear. LPN-A documented opened, and his reply was he ed of the recliner and sat on the regarbage can, but at no point the floor.  Ited 10/26/21, at 9:49 a.m. 10/26/21, at approximately 10:30 | 2 830                     |                                                                                                     |                   |                          |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | p R1 get ready for bed. NA-A shoes off and that he only                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                           |                                                                                                     |                   |                          |

Minnesota Department of Health

STATE FORM FY0311 If continuation sheet 5 of 8

Minnesota Department of Health

| AND DLAN OF CODDECTION IDENTIFICATION NUMBER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                              | (VO) DATE OUD (EV |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-------------------|
| AND PLAN OF CORRECTION INFINITION AND PLAN OF CORRECTION AND PLAN OF CORRECTION AND PROPRIEST AND PROPRI | CONSTRUCTION                                                 | (X3) DATE SURVEY  |
| A. BUILDING:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                              | COMPLETED         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
| 00061 B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                              | C                 |
| 00061 B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                              | 10/26/2021        |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | TATE, ZIP CODE                                               |                   |
| 1012 NORTH DIVISION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET PO BOX 797                                            |                   |
| CLARA CITY CARE CENTER  CLARA CITY, MN 5622                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                              |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | ( /               |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | CROSS-REFERENCED TO THE APPROP                               |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DEFICIENCY)                                                  |                   |
| 2 830 Continued From page 5 2 830                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                              |                   |
| 2 830 Continued From page 5 2 830                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                              |                   |
| had socks on. NA-A indicated it was only a few                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                              |                   |
| feet from the recliner to the bed and thought R1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                              |                   |
| could walk to the bed without falling. NA-A stated                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                              |                   |
| he directed R1 to walk to the bed so he could                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                              |                   |
| continue to get R1 undressed. NA-A stated the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                              |                   |
| recliner is approximately three feet from the bed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                              |                   |
| and NA-A started walking with only his socks on,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                              |                   |
| and that he did not place a gait belt on R1. NA-A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                              |                   |
| stated R1 took a step, slipped and he tried to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                              |                   |
| catch him. NA-A stated R1 fell to the left and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                              |                   |
| landed on the wastebasket that is between and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                              |                   |
| recliner and the bed, but he had a hold of R1's                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
| right arm. NA-A stated he is unsure if R1's knees                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                              |                   |
| were on the floor. NA-A then helped R1 to stand,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                              |                   |
| pivot and sit on the bed. NA-A stated he                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                              |                   |
| immediately went to the charge nurse (does not                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                              |                   |
| remember her name - identified as LPN-A) and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                              |                   |
| informed her that R1 fell and now has a skin tear.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                              |                   |
| LPN-A immediately went to VA's room. NA-A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                              |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
| were on R1 during the transfer.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
| to lack of strength.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                              |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
| During on interview on 40/00/04 -+ 44:40                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                              |                   |
| During an interview on 10/26/21, at 11:13 a.m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                              |                   |
| LPN-A stated NA-A was observed on 10/07/21, at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                              |                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                              |                   |
| landed on the wastebasket that is between and recliner and the bed, but he had a hold of R1's right arm. NA-A stated he is unsure if R1's knees were on the floor. NA-A then helped R1 to stand, pivot and sit on the bed. NA-A stated he immediately went to the charge nurse (does not remember her name - identified as LPN-A) and informed her that R1 fell and now has a skin tear.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                              |                   |

Minnesota Department of Health

STATE FORM FY0311 If continuation sheet 6 of 8

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |                                                                                      |                           | (X3) DATE SURVEY<br>COMPLETED |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------------------------------------------------------------------------|---------------------------|-------------------------------|--|--|--|
|                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 00061                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | B. WING                                 |                                                                                      | I                         | C<br><b>26/2021</b>           |  |  |  |
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1012 NORTH DIVISION STREET PO BOX 797  CLARA CITY, MN 56222 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                         |                                                                                      |                           |                               |  |  |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC' | N SHOULD BE COMPLÉTE DATE |                               |  |  |  |
| 2 830                                                                                                                            | NA-A state it happe R1 and that he sat to the bed. LPN-A s happened and then LPN-A stated she a he indicated he did the garbage can. LI fall to the floor, she LPN-A further state did not use a gait b only in his socks, w stated when she ar sitting on the bed w underwear on, so s skin. LPN-A she did wound that night, b nurse the next day.  During an interview DON stated a fall is DON stated the fall considered a fall ar immediately.  The facility Fall Pre Program policy, las directed that any ur is considered a fall the charge nurse by SUGGESTED MET DON or designee, o | ened while he was transferring on top of the garbage can next stated she asked NA-A what went to assess R1's wound. Isked R1 what happened, and not fall but slipped and sat on PN-A stated since R1 did not did not think it was a fall. It d R1 informed her that NA-A elt and directed him to walk hich made him slip. LPN-A rived to R1's room, he was with only his tee shirt and he was able to assess his d not see the right upper arm ut it was found by another.  I on 10/26/21, at 12:33 p.m. an unplanned rapid descent. To the wastebasket is and should have been reported evention and Management the modified on 01/12/21, hintentional change in position and in the event of a fall, notify | 2 830                                   | DEFICIENC                                                                            | 1)                        |                               |  |  |  |
|                                                                                                                                  | interventions are in<br>help mitigate fall ris<br>review polices and<br>update as needed a<br>staff. The DON or con fall risk intervent                                                                                                                                                                                                                                                                                                                                                                                                                                                       | place and acted upon toto<br>k. The DON or designee could<br>procedures for fall prevention,<br>and review with appropriate<br>designee, could in-service staff                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                         |                                                                                      |                           |                               |  |  |  |

Minnesota Department of Health

STATE FORM FYO311 If continuation sheet 7 of 8

PRINTED: 11/22/2021

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING \_\_\_ 00061 10/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1012 NORTH DIVISION STREET PO BOX 797 **CLARA CITY CARE CENTER** CLARA CITY, MN 56222

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------|--------------------------|
| 2 830                    | Continued From page 7                                                                                                        | 2 830               |                                                                                                                 |                          |
|                          | TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                             |                     |                                                                                                                 |                          |
|                          |                                                                                                                              |                     |                                                                                                                 |                          |
|                          |                                                                                                                              |                     |                                                                                                                 |                          |
|                          |                                                                                                                              |                     |                                                                                                                 |                          |
|                          |                                                                                                                              |                     |                                                                                                                 |                          |
|                          |                                                                                                                              |                     |                                                                                                                 |                          |
|                          |                                                                                                                              |                     |                                                                                                                 |                          |
|                          |                                                                                                                              |                     |                                                                                                                 |                          |
|                          |                                                                                                                              |                     |                                                                                                                 |                          |
|                          |                                                                                                                              |                     |                                                                                                                 |                          |
|                          |                                                                                                                              |                     |                                                                                                                 |                          |
|                          |                                                                                                                              |                     |                                                                                                                 |                          |

Minnesota Department of Health