DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 6, 2022

CMS Certification Number (CCN): 245551

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 29, 2022 the above facility is certified for:

36 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 36 skilled nursing facility beds36.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

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Electronically delivered
May 6, 2022

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

RE: CCN: 245551
Cycle Start Date: March 4, 2022

Dear Administrator:

On March 17, 2022, we notified you a remedy was imposed. On March 29, 2022 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 23, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 1, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 17, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 1, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 23, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

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

Electronically delivered
March 17, 2022

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

RE: CCN: 245551
Cycle Start Date: March 4, 2022

Dear Administrator:

On March 4, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 1, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 1, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 1, 2022.

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

This Department is also recommending that CMS impose:

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 1, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Clarkfield Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 1, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program

Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 4, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245551	A. BUILDING _____ B. WING _____	03/04/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/28/22 through 3/4/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED H5551022C (MN80149) and H5551023C (MN74085), with a deficiency cited at F689. The following complaints were found to be UNSUBSTANTIATED H5551025C (MN68038) and H5551026C (MN66464). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		3/23/22

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

Electronically Signed | 03/23/2022

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

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F 677	Continued From page 1 by: Based on observation, interview and record review the facility failed to provide nail care to 2 of 10 residents (R2 and R13) who required assistance with Activities of Daily Living (ADL). Findings include: R2's 18/22, significant change Minimum Data Set (MDS) identified R2 required total assist of 2 staff for transfers, locomotion, bed mobility and extensive assist with all other ADL's. R2's 12/29/21, care plan made no mention of personal hygiene, oral care or bathing. Observation on 2/28/22 at 5:01 p.m., of R2 identified R2's right hand had brownish-black dirt-like debris under her thumb nail and under her 4th digit finger nail. R2's finger nails were noted to have small amounts of old red nail polish on the edges of some of her finger nails. Observation on 3/2/22 at 7: 10 a.m., during morning cares identified nursing assistant (NA)-A washed R2's hands with soap and water but failed to clean or trim R2's nails underneath. Following cares, R2's right hand was noted to still have brownish-black dirt-like debris under her thumb nail and 4th digit finger nail. Observation and interview on 3/3/22 at 9:25 a.m., with NA-C who confirmed R2 right thumb nail and 4th digit finger nail had dark brown debris under both nails, NA-C revealed that R2 had a bath earlier this morning by NA-A and her finger nails should have been cleaned at that time. NA-C stated that the licensed nurse cuts R2's finger nails as she is diabetic. NA-C stated if staff notice	F 677	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. F677 SS =D ADL Care Provider to Dependent Residents It is the policy of The Clarkfield Care Center to provide services needed to for residents that are unable to carry out activities of daily living independently. Action taken for affected residents: R2 and R13 both have care plans that have been reviewed, updated and is current. Actions taken to identify other potential residents: All residents will be observed for the need of nail care on admission, quarterly, annually and with significant change as their ADL's are assessed. Measures put in place to ensure deficit practice will not recur: Education will be completed for nursing staff on expectations in regard to meeting resident's ADL needs and assistance by March 23rd 2022 Monitoring put in place to ensure deficit practice will not recur: Audits will be completed weekly for four weeks on residents to assure ADL needs are met including nail care. Results of the audits will be presented to QAPI (Quality Assurance/Performance Improvement)	

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F 677	Continued From page 2 dirty nails when completing cares they should be cleaning them at that time. Interview on 3/3/22 at 11:00 a.m., with NA-A who revealed he gave R2 a bath earlier in the morning and confirmed R2's finger nails were noted to be dirty at that time. He stated he was unable to find a nail brush to clean them with but that was on his "to-do" list. Interview on 3/3/22 at 11:14 a.m., with registered nurse (RN)-B confirmed during her skin assessment of R2 after her bath that R2 did have dirty finger nails. RN-B stated she had planned on getting a nail clippers and cleaning R2's finger nails but had gotten "side tracked". RN-B stated she would make sure R2's finger nails were cleaned. RN-B's expectation was staff would clean resident's finger nails during cares if they notice they were dirty. If they are not able to trim nails because resident's were diabetic, they should get the nurse to do so. Review of grievance log identified on 2/14/22, family had concern with R2's "dirty finger nails" and had removed R2's finger nail polish on 2/9/22, so that R2's "dirty fingernails" would be easier to be seen. Interview on 3/3/22 at 3:42 p.m., with director of nursing (DON) identifed her expectation was staff would clean resident's fingernails if they observed them to be dirty. The DON further identified that she had a list of expectations for duties she has each staff sign when hired, which included providing resident nail care. R13's 1/17/22, admission MDS identified R13 had severe cognitive impairment, and required	F 677	committee to come to agreeance on when ceasing audits is appropriate.	

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F 677	Continued From page 3 extensive assistance of 2 persons for bed mobility, transfers, locomotion on/off unit, dressing, eating, toileting and personal hygiene. Observation on 3/01/22 at 2:03 p.m., of R13 identified she was lying on her back in bed, sleeping. The nails of her left hand were very long, approximately 1/4 to 1/2 inch, and had yellowish discoloration with brown dirt-like debris under the nails of her thumb and first 3 finger nails that were visible resting on the doll. Observation on 3/02/22 at 8:31 a.m., during morning cares provided by NA-A and NA-B, R13 had yellowish discoloration on the nails of her left hand with brown dirt-like debris visible underneath her nails. R13's thumbnail on her right hand was observed to be long and unkempt in appearance. The nails on R13's left hand remained with the dirt-like substance. Observation and interview on 3/03/22, at 11:32 a.m., with registered nurse (RN)- A of R13 identified R13's left hand continued to have a brown, dirt-like substance around the nail beds and under her nails. RN-A stated nail care included trimming and/or cleaning of nails and was to be done on bath days and with daily cares as needed. Observation and interview on 3/02/22 at 1:56 p.m., with the DON of R13's hands identified she agreed R13's nails had a brown, dirt-like substance beneath her nails on her left hand. Her expectation was resident hands were to be maintained clean and appropriately trimmed by staff if a resident was unable to do so themselves.	F 677		

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F 677	Continued From page 4 Review of the 1/3/22, Providing Nail Care Policy identified routine cleaning and inspection of nails was to be provided during ADL care on an ongoing basis.	F 677		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to perform root cause analyses and identify appropriate interventions to prevent the falls for 2 of 2 residents (R10 and R119). Both residents' falls resulted in actual harm when R10 suffered a neck fracture and R119 suffered pelvic fractures as a result. Findings include: R10 Review of the 1/12/22 at 1:25 p.m., facility incident report identified nursing staff walked past R10's room and heard him hollering for help. R10 was found lying face down on the floor in front of wheelchair with his legs under the wheelchair with his body partially covering the top of the wheelchair foot pedals. R10's call light was attached to the front of his shirt. Staff log-rolled R10 onto his back, noting he had blood on left index finger with small skin tear. A bruise was	F 689	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility□s allegation of compliance. F689 SS =G Free of Accidents Hazards/Supervision/Devices It is the policy of the Clarkfield Care Center to assess a resident's risk for falls and prevent further occurrences by assessing residents at least quarterly and with falls and developing interventions to prevent recurrence using root cause analysis. Action taken for affected residents: R 10	3/23/22

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F 689	Continued From page 5 noted on R10's right side of his forehead. Vital signs (blood pressure, heart rate etc.) were taken and found to be within normal limits. Neurological checks (determines potential brain abnormalities) were initiated and showed his pupils had normal assessment finding as well. Staff asked R10 what happened. R10 replied "I don't know...I was reaching for something....help me off the floor.". R10's 12/26/21, Significant Change Minimum Data Set (MDS), identified he had severe cognitive impairment, exhibited no behaviors, and required extensive assistance from 1 or 2 staff for most all Activities of Daily Living (ADL). R10 had diagnoses of coronary artery disease, high blood pressure, arthritis, seizure disorder, depression, and long-term use of blood thinners. R10's Care Area Assessment (CAA) triggers identified R10 had cognitive loss with dementia. Staff were to anticipate and meet his needs. R10 triggered for falls due to balance issues and was assessed as at risk for falls. R10 required staff support for transfers and safety needs. R10's medications included aspirin (NSAID) for heart health and daily Coumadin use, both which thin the blood and increase the risk for bleeding. R10's current, undated care plan identified he was at high risk for falls and was on 30-minute safety checks. His call light was to be kept within reach and his bed was to be in lowest position with floor mat while in bed. His wheelchair was to have Dycem cushion (a non-slip material) on top of his wheelchair seat, to decrease his risk of sliding off. His personal possessions were to be placed within reach upon having been seated in his chair or lying in his bed to reduce his risk of self-transferring or over-reaching. Nursing staff to place R10 back into his recliner after each meal.	F 689	was reassessed for fall risk and care plan updated. R119 has expired. Actions taken to identify other potential residents: Education provided to staff to staff that any fall requires an RCA immediately, the RCA will then be evaluated at IDT the next business day. Any resident who falls will be reviewed by the Interdisciplinary Team (IDT) the next business day to assist in determining the if root cause was conducted properly and assure appropriate interventions have been implemented the and care plan updated to prevent recurrence. Education provided to staff to staff that any fall requires an RCA immediately, the RCA will then be evaluated at IDT the next business day. Measures put in place to ensure deficit practice will not recur: Policy and procedure for fall risk and procedure for resident falls was reviewed and updated. Education will be completed for licensed nurses and IDT on Incident charting and root cause analysis after an occurrence. Monitoring put in place to ensure deficit practice will not recur: Audits will be completed weekly on residents with falls for root cause analysis of falls as well as intervention effectiveness and IDT review for four weeks. Results will be reported to QAPI for need of ongoing monitoring. Completion Date: March 23rd 2022	

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	245551	A. BUILDING _____ B. WING _____	03/04/2022

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F 689	Continued From page 6 There was no mention of how staff would ensure 30-minute checks were completed or that the 30-minute intervals of supervision was sufficient to prevent falls in between checks. Review of R10's progress notes and electronic medical record identified there was no system to ensure 30 min checks were being performed or how 30-minute intervals were identified to be adequate for supervision. There was also no evidence a root cause analysis had been performed to identify if 30 minute checks were appropriate for supervision to prevent falls. Observation on 2/28/22 at 2:00 p.m., of R10 identified he was in his bed with the bed in low position, a mat on the floor beside the bed, and a soft cervical collar in place. Further observations of R10 between 2:15 p.m. and 5:30 p.m., identified he continued to be sleeping in his bed. At 5:45 p.m. an unidentified staff member was seated at R10's bedside encouraging him to eat supper, which he refused. Observation and document review on 3/1/22 at 10:00 a.m., of R10 identified he was seated in his recliner in room sleeping. At times will moan or make a vocalization and then appears to return to sleeping. R10 was no longer wearing cervical collar. Review of the physicians orders identified it had been discontinued. Observation on 3/01/22 at 2:00 p.m., of R10 identified he was lying in bed sleeping with his bed in low position and a fall mat on the floor. At 3:00 p.m. continued to be lying in bed sleeping with bed in low position and mat on floor. Observation on 3/2/22 at 7:00 a.m. through 10:00	F 689		

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F 689	Continued From page 7	F 689		

a.m., identified R10 was lying in bed sleeping with his bed in low position and mat on the floor. At 10:00 a.m. R10 was observed dressed and well groomed, seated in his recliner watching TV. No staff were providing direct supervision at any time, other than when attempting to cue R10 to eat.

Interview on 3/03/22 at 10:07 a.m., with licensed practical nurse (LPN)-A identified R10 was in his wheelchair the day of the incident. LPN-A heard a noise, investigated it, and found R10 lying face down on the floor with his lower legs on the wheelchair foot pedals. R10 had a hematoma on the right side of his forehead, and a skin tear on his finger. The MD was contacted as R10 was receiving coumadin which put him at high risk for bleeding complications. R10 was ordered to be transferred to the ED for evaluation. The facility was notified R10's fall resulted in a cervical fracture. He would return with a cervical collar in place. LPN-A identified R10 reported he was reaching for something and fell. It was suspected he had hit the corner of the table and that caused the head and neck injury. LPN-A identified no new interventions had been identified or a root cause analysis completed she was aware of to identify the need for increased supervision.

Interview on 3/04/22 at 9:43 a.m., with LPN-B and nursing assistant (NA)-C identified R10 was supposed to be transferred into his recliner after meals or persuaded to attend an activity. R10 happened to be left seated in his wheelchair at the time of the fall. R10 was known to attempt self-transfer at times. When this would occur, it was usually when he was left alone seated in his wheelchair.

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F 689	Continued From page 8 Interview on 3/04/22 at 9:54 a.m., with NA-A identified R10 was supposed to be transferred into his recliner or bed after meals. NA-A reported he did not think R10 was supposed to be unattended if he was in his wheelchair. NA-A reported R10 was impulsive, but when he was in his recliner he was usually comfortable and normally would not attempt to self-transfer. If he was in his wheelchair, he was likely to attempt to self-transfer, usually into his recliner. Interview on 3/04/22 at 10:40 a.m. with registered nurse (RN)-B identified following a fall on 11/11/21, when R10 had fallen from his wheelchair when left unattended, his care plan had been updated to include staff were to ensure he was transferred from his wheelchair to his recliner after meals. This "usually" stopped self-transfer attempts in the absence of direct supervision. RN-B stated the care plan had not been followed on 1/12/22 when R10 fell from his wheelchair while in his room unattended. She further identified she expected staff to follow the care plan. She was not aware of any reason why staff had deviated from the care plan and left R10 was in his wheelchair unattended. She confirmed the noon meal was served at 11:15 a.m. and the fall occurred at 1:25 p.m.. R10 should have been transferred into his recliner after that meal and not left unsupervised in his wheelchair. Interview on 3/4/22 at 3:31 p.m. with the MD identified he was aware R10 had a history of attempting to self-transfer and resulting falls, but he was not aware the facility had not followed the care plan on 1/12/22, when R10 had fallen in his room. The MD voiced his expectation for the facility to follow R10's plan of care for supervision to keep him as safe as was possible. He further	F 689		

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F 689	Continued From page 9 identified that when in his recliner R10 did not usually attempt to self-transfer according to nursing staff. R119 Review of the 6/21/21 at 9:15 a.m., report to the SA identified R119 was found lying on the floor in her room by RN-C as they were passing by her room. R119 was assessed and found to be bleeding from an abrasion on her temporal area in addition to a quarter sized bump at the site. Vital signs and neurological assessments were initiated according to facility protocol. R119 was assisted into her wheelchair and positioned by the east nursing station to allow for frequent monitoring by staff. Later, at approximately 12:00 p.m., while being assisted to the toilet by staff, R119 voiced complaints of hip and buttock pain. R119's MD was updated, and orders were received for evaluation in either the ED or the local clinic. R119 was transported to the ED via ambulance. At 4:15 p.m., RN-B contacted the ED for an update and was informed R119 had suffered a pelvic fracture and was being admitted to acute care. R119's 3/24/21, MDS identified she had severe cognitive impairment, required extensive assistance with all ADLs, except eating, and had a history of multiple falls. R119's diagnoses included Alzheimer's disease, major depressive disorder, Type 2 diabetes, dementia, osteoporosis. R119's current, undated care plan identified she was at high risk for falls with a known history of falling due to her impaired cognition. Staff were to apply anti-rollback breaks on her wheelchair, ensure her brakes were unlocked when R119	F 689		

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F 689	Continued From page 10 was in her wheelchair, provide 15-minute safety checks, and assist R119 to lay down when restless after ambulating and toileting. Staff were also to assist her with standing or stretching her legs and toileting every 2 hours while awake, assist with ambulating in the halls, and assist her to the bathroom when she was exhibiting signs of being restless. Staff were to ensure her call light was within reach. Staff were to supervise R119 when she was out of her room and ensure she always wore shoes or gripper socks. R19 was known to have poor safety awareness related to her cognitive impairment. R119 had a history of self-transferring. If staff found her attempting to self-transfer or ambulate on her own with rolling walker, staff were to intervene and walk with her. Staff were to "catch" her whenever she was seen up and walking without staff assistance. Staff were to fall the facility fall protocol. Additional interventions identified staff were to keep her room door open at all times when R119 was not supervised, place a floor mat next to her bed on floor when R119 was in bed. Management was to ensure staff followed care plan safety interventions with direct care staff to ensure care plan was followed. Staff were to toilet R119 when she was seen crawling out of bed onto her floor mat. Staff working with resident were to have been re-educated on "better techniques" to use while R119 was restless or anxious. R119's care plan goals were to help minimize risk for injury with falls. There was no mention a root cause analysis was performed to ensure R119 was appropriately supervised or that 15-minute checks would be enough when R119 was exhibiting potential unsafe behavior to prevent falls. Interview on 3/03/22 at 9:53 a.m., with RN-B	F 689		

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F 689	Continued From page 11	F 689		

identified R119's family had previously been considering Hospice services due to her decline in cognition but had been informed she was reportedly not eligible due to not having weight loss. RN-B reported R119 had dementia and would frequently attempt to self-transfer. There was discussion with family about safety concerns and a possible transfer to another facility who had a specific dementia unit, but family declined. They were aware of the potential for harm as a result of frequent falls. When R119 was in her room, the door was left open except during cares. RN-B identified when R119 was in her room staff were not able to observe her unless they happened to be passing by or had entered her room. RN-B identified the facility was not able to provide 1:1 supervision due to staffing issues. R119 was well known to suddenly attempt to self-transfer without warning. RN-B identified following her fall with pelvic fracture, she was admitted to Hospice. R119 was not a surgical candidate to fix her fracture.

Interview on 3/03/22 at 1:13 p.m. with LPN-A identified R119 was a high fall risk. Her family was aware she continued to have falls and remained involved in her plan of care. R119 required the assist of 1 staff with a gait belt and use of her walker. LPN-A reported the care plan did identify R119 would often attempt to self-transfer and walk unattended. Staff were to monitor her when this would occur and assist her for safety. LPN-A identified there was not specific criteria in place to monitor R119's location or provisions in place when she was unsupervised and attempted to stand and ambulate. LPN-A identified staff were supposed to be aware when R119 was becoming agitated. At the time of her fall with fracture, R119 was observed 5 minutes

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prior to the fall and left alone again, unsupervised. She did not recall if R119 had been agitated prior to the fall. LPN-A reported 1:1 monitoring had been discontinued after being in place from 10/21/20 through 3/14/21 after previous falls. LPN-A confirmed R119 did not have 1:1 monitoring in place at the time of the fall. She was in her room without staff supervision.

Interview on 3/03/22 at 3:59 p.m., with RN-C, regarding R119's fall, identified he recalled R119 was in her recliner in her room at the time, unsupervised, just before her fall and recalled he did not think she had been exhibiting agitation at that time. He found R119 after her fall, when he was passing down the hall approximately 5 minutes after he had last seen her in her room. He found her lying on the floor in front of her recliner. R119 had some bleeding and a lump on her temporal area but had denied pain. She was not able to state what had happened. Following his nursing assessment, he had contacted ED on-call provider to update them on the fall and been instructed to monitor R119 for additional issues for changes in range of motion or pain. R119 was assisted from the floor to her wheelchair by 2 staff and positioned by the East nursing station to allow staff monitoring. Later, when staff attempted to toilet R119, she was not able to stand. RN-C updated the MD and orders were received to send her to the ED for evaluation.

Interview on 3/04/22 at 9:37 a.m., with LPN-B identified R119 had frequent falls due to attempts at self-transfer. R119 had dementia, would forget her limitations, and thought she was able to walk. Staff were to toilet R119 every 2 hours. Sometimes that helped deter her from attempting

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to self-transfer, other times not. LPN-B identified at times R119 needed 1:1 supervision for safety, because of her repeated attempt self-transfer. R119 would suddenly stand from a sitting position in her recliner or wheelchair and was known to be impulsive and not understand to wait for assistance. LPN-B reported she was not certain why 1:1 monitoring was stopped previously, but felt it was likely due to there not always having staff available to provide the 1:1 monitoring.

Interview on 3/04/22 at 9:54 a.m., with NA-A identified R119 had dementia and Alzheimer's and was "always restless". R119 would was repeatedly attempted to get out of bed or her chair and wander into other resident's rooms and had been known to attempt elopement. R119 was difficult to redirect and would become agitated easily. Neither location and/or activity provided impact her unsafe behaviors. NA-A reported, at one time R119 had 1:1 supervision due to her behaviors and falls, but he was not certain why it had been stopped. NA-A confirmed when R119 was in her room, staff were not able to visualize to enable appropriate supervision unless they happened to pass by or enter her room. NA-A was not working at the time of R119's fall and subsequent fracture, but stated he was familiar with R119 and her behaviors prior to that time.

Interview on 3/2/22 at 2:03 p.m., with the director of nursing (DON) identified R119 had experienced multiple falls, and the facility had attempted to put interventions in place to avoid any significant injury. The facility was not able to provide the necessary 1:1 supervision for a resident due to staffing constraints. There was no documentation to support a root cause analysis occurred prior to the decision to identity R119

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F 689	Continued From page 14 would be safe without the required increased supervision previously identified. There was also no root cause analysis performed on R10 to ensure 30 minute checks were appropriate supervision or if increased supervision was required. Review of the 3/31/21, Accidents and Incidents Investigating and Recording policy identified an investigation must be completed with a Root Cause Analysis documented. Information to be included was the date and time of the incident, nature of injury or illness, circumstances surrounding the incident, where the incident took place, the resident or injured person's account of the incident, physician contact and response, notifications to appropriate persons, actions taken following the incident, follow up and update to the care plan for immediate intervention.	F 689		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/02/2022. At the time of this survey, Clarkfield Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 03/27/2022

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Clarkfield Care Center is a 1-story building with a partial basement. The building was constructed at four different times. The original building was constructed in 1955 and was determined to be of Type II(111) construction. In 1958 an addition was constructed and was determined to be of Type II(111) construction. In 1970, an addition was constructed and determined to be of Type II(111) construction. The most recent addition was constructed in 2004 and determined to be of Type II(111) construction.	K 000		

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K 000	Continued From page 2 This facility was surveyed as one building under the 2012 Life Safety Code. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 36 beds and had a census of 18 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, observation, and staff interview, the facility failed to test and inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3 and 9.6.1.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.4.1.2. This deficient finding could have an isolated impact on the residents within the facility.	K 345	The facility called Summit to come back into the building on 3/3/22. 3/3/22 Summit was in the building and complete testing on Six old conventional heats in basements. Devises had addressable modules behind them Summit checked signals coming into panel and programmming building was fully sprinkled and protected in these spaces.	3/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245551	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/02/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 3 Findings include: On 03/02/2022, between 10:30 AM to 12:30 PM, it was revealed during documentation review and observation that the annual fire alarm inspection documentation stated that were no heat detectors within the facility. However, five old-style heat detectors and one new-style heat detector were observed during the inspection in the Boiler Room and Storage Rooms in the Basement. An interview with the Facility Maintenance Director verified this finding at the time of discovery.	K 345	During the Survey time of 3/2/22 facility will place these heats on routine prevetable maintenance to ensure they are checked annually with all other inspections Date in complinace 3/3/22.	