Electronically delivered

October 30, 2019

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

RE: CCN: 245573
Cycle Start Date: September 12, 2019

Dear Administrator:

On September 30, 2019, we informed you that we may impose enforcement remedies.

On October 9, 2019, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby 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:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 12, 2019. (42 CFR 488.417 (b))

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 12, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 12, 2019.

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 a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

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 $10,483; 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 December 12, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Clara City Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 12, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient

practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

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 March 12, 2020 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you

have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

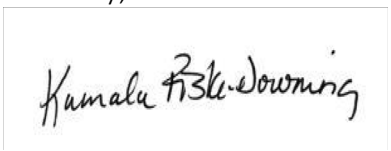
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING _____ B. WING _____	C 10/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY CARE CENTER	**1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222**

(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 From 10/7/19 through 10/9/19, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5573013C, with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess resident falls to ensure appropriate interventions were implemented to reduce the risk of accident hazards for 2 of 3 residents (R1 and R2) reviewed for falls. This caused actual	F 689	Resident 1□'s care plan reflects the post fall intervention of 2 person assist with bed mobility and use of the bed pan put in place after the incident on 9/29/19. Resident 2'□s care plan has been updated to reflect the intervention of	11/15/19

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

Electronically Signed | 11/01/2019

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F 689	Continued From page 1 harm when R1 fell out of bed and received bruising and a laceration to his face requiring sutures, and severe ongoing shoulder and hip pain. Findings include: R1's significant change 2/20/19, and 8/12/19, Minimum Data Assessment (MDS) identified R1 had diagnoses of repeated falls, weakness, heart failure, chronic obstructive pulmonary (lung) disease, and osteoporosis and had intact cognition. R1 required 2 person physical assist with toileting, and was dependent on staff for transfers. R1 also required extensive assistance of 2 staff for bed mobility. R1's 2/20/19, Care Area Assessment (CAA) identified he was extensive assistance of 2 staff for transferring and toileting and bed mobility. R1's current undated care plan identified he used a bedpan for toileting needs, but did not identify how many staff assistance was needed to assist him with transferring on and off the bedpan. Even though the 2/20/19 CAA identified he needed extensive assistance of 2 staff for toileting and bed mobility. R1's 9/28/19, Event Report identified R1 complained of pain after his fall. He received a laceration (cut) and a scrape from his fall. R1 was noted to have just finished using the bedpan. Nursing assistant (NA)-A had rolled R1 onto his left side after his bedpan use and was cleansing him. R1 moved his right leg over too far on the bed, causing him to slide out of bed, landing on his side. NA-A tried to grab him but could not stop his fall. R1 was found by LPN-A with blood on his	F 689	reminding him to lock brakes on 4WW before sitting down after the incident on 9/26/19. All residents have the potential to be affected by this deficient practice. Director of Nursing will review RAI Manual with MDS coordinator focusing on using the MDS assessments to create and update care plans to reflect ongoing resident needs. DON or designee will also review and revise post fall procedures and re-educate IDT team and Nurses to ensure fall interventions are added to the care plan and communicated to the staff providing care. DON will form a Falls Committee in conjunction with monthly QAPI meeting with direct care staff involvement to review monthly falls and discuss fall interventions to improve person centered focus. DON or designee will review all residents care plans who are at risk for falls to ensure that fall interventions since 1-1-19 are appropriately reflected on care plans and report findings to QAPI Committee for further review and action. DON or designee will review care plan of all residents who have fallen since previous audit to assure proper assessment and interventions have been added to the care plan and communicated to staff providing care weekly x4 weeks and monthly x 6 months after with results being shared with QAPI committee monthly for further review and action.	

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F 689	Continued From page 2	F 689		

face and head, left elbow, a scrape to his left knee and complained of shoulder and hip pain. Family and 911 were called. Management and R1's physician were then notified. Interventions listed were "Upon return, plan to change to 2 assist for bed mobility and bed pan use."

Review of R1's 9/28/19, Emergency Room (ER) Discharge Instructions identified he fell at the nursing home. As a result of that fall, R1 had a laceration to his right forehead and received a 2 layer closure [sutures and steri-strips] and a left elbow skin tear. The ER physician recommended a 4 person log roll when turning in bed.

Interview on 10/7/19 at 11:10 a.m., with the director of nursing (DON) identified she was aware of R1's 9/28/19 fall from bed while using the bedpan. They placed a new interventions for 2 person to assist using the bed pan as part of a new intervention. The DON was unaware the MDS assessments from 1/19/19, had identified R1 needing a 2 person assist for toileting. That information had not been updated on R1's care plan to prevent R1's fall. Her expectation was the care plan should have been updated after the assessment identifying appropriate staff intervention to prevent future falls.

R1 was observed on 10/7/19 at 11:45 a.m., with multiple steri-strips across his right eyebrow with deep purple bruising that extended from the eyebrow to his cheek and nose. R1's bed had bilateral grab bars on his bed. The bed was located in the middle of the room, which allowed staff to stand on either side of the bed. There was approximately 3 to 4 feet between the right side of the bed and the far wall with the window. R1 stated he was using the bedpan the evening of

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F 689	Continued From page 3 9/28/19 when he fell. He rolled to his left (right side of bed) facing away from staff while they provided personal care after using the bedpan. He had only had 1 staff assistance with toileting at any time previous to the fall. R1 stated nurse aide (NA)-A tried to stop him from falling but was unsuccessful and fell "on my face". They called his family and then went to the emergency room. R1 received stitches but had no fractures. R1 complained of severe shoulder and hip pain since the incident. He would try and rub his neck and shoulder to ease the pain, but had no success. Staff have never used 2 person assist while transferring him in bed prior to the incident, but they had now. Interview on 10/7/19 at 12:05 p.m., with NA-A identified the events surrounding R1's fall. She was sitting at the nurses station desk when R1 placed his call light on. She placed R1 on the bed pan. Once he was finished, she removed the bedpan, and he rolled to his left side. R1 had thrown his right leg over firmly during the move, causing him to fall out of bed. NA-A identified R1 was a 1 person assist prior to the fall, as identified on the care plan. While providing any care for a resident, nurse-aide staff refer to the nurse aide care plan which identified R1 was only a 1 person assist for toileting. NA-A was hired 5 months ago and had always performed 1 staff assist with toileting. She brought the need for 2 staff assist for safety up to nursing a "few times" but his care plan never changed. NA-A felt it was unsafe to toilet R1 with just 1 staff but the facility has not updated the care plan to identify this. Interview on 10/7/19 at 12:12 p.m., with licensed practical nurse (LPN)-A regarding R1's fall identified LPN-A was called to his room by NA-A.	F 689		

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F 689	Continued From page 4	F 689		

R1 was located on the floor, on far right side of his bed. He was curled up, laying on his left side. R1 had blood under his head and face. LPN-A stated R1 complained of pain in his left shoulder and hip. She called RN-B to assist and they did vital signs and called emergency services (EMS) immediately. She did not want to move R1 for fear of unknown injury. R1 returned from the hospital at approximately 8:00 p.m. that same evening. LPN-A had work with R1 for over one year and knew R1 well and indicated R1's care plan directed staff only 1 assist with toileting. She was not responsible for ensuring assessments followed over to the care plan. RN-C was responsible to update the focus (nurse aide) sheets and care plans.

Interview on 10/7/19 at 12:44 p.m., with RN-B identified she was responsible for the day-to-day changes on the care plan, and not the MDS assessment changes. RN-B was aware of the 8/12/19 MDS identifying R1 was to have 2 assist with toileting, but "that was his look-back period," not what he maybe needed after. Ultimately it was RN-C's job to update the care plan after an MDS assessment.

Interview on 10/7/19 at 12:50 p.m. with RN-C identified she also felt the assessment data collected from the MDS was only valid during that look-back period. RN-C agreed the MDS was used to identify care a resident would need. RN-C felt staff could adjust the information how they determined assistance should be. RN-C was unaware R1 had required 2 assist for toileting since January, 2019. She had not performed any assessment to see if R1 had not required 2 staff. When asked why staff had not updated the care plans with current assessment data derived from

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F 689	Continued From page 5	F 689		

the MDS, she would not answer. She had agreed without use of the correct amount of staff, accidents could be likely to occur. R1's care plan had been updated since his 9/28/19 fall and 2 staff were required to assist with toileting to prevent any future similar occurrences.

Interview on 10/7/19 at 5:06 p.m., with family member (FM)-A identified he was called immediately after R1's accident. He went to the hospital with R1 whom received stitches but no fractures. FM-A was told R1 had fallen out of bed after they were providing cares using the bed pan. FM-A visits the facility often, even daily, and has only seen 1 staff assisting R1 to use the bed pan. FM-A was unaware R1 had been identified in January 2019 of needing 2 staff assist for use of R1's bedpan. FM-A states R1 had complained of pain since his incident and had a hard time moving around in his chair and performing tasks.

Interview on 10/9/19 at 3:30 p.m., with physician (MD-A identified he was made aware of R1's fall immediately after the incident. He was told R1 had fallen from the bed after being turned for cares after toileting. MD-A was unaware R1 was identified to be a 2 person assist since January 2019. MD-A agreed the care plan should have been updated to reflect staff assistance to prevent the fall of R1. MD-A wrote orders that day for R1 to have physical therapy related to his shoulder and hip pain in an attempt to offer relief.

R2's quarterly 9/16/19, MDS identified he had diagnoses of previous left leg fracture, dementia, COPD, low blood oxygen, and stroke. R2 had moderate cognitive impairment and required supervision for locomotion on and off the unit.

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F 689	Continued From page 6 R2's annual 1/19/19, Care Area Assessments (CAA) identified he had fallen at his residence prior to admission and had a history of repeated falls. R2 had poor safety judgement with self-transfer and his room was close to the nurses station for monitoring. R2's 9/26/19, Event Report identified he used a 4 wheeled walker with a seat on it. R2 entered the room for care conference, went to sit on his walker but the brake was not engaged. The walker moved and he fell to the floor on his left side. Interventions identified at that time were to remind R2 to apply his brakes before he sits on the walker seat. R2's Focus Sheet Change Form dated 9/26/19, used immediately after the fall for items needing to be transferred to the care plan, identified he needed reminding to lock his walker brakes. The line indicating nursing staff had updated the care plan was blank. R2's undated current care plan identified he was at high risk for falls with one fall since his admission to the facility. There was no intervention related to R2's 9/26/19, fall identified on the care plan. The intervention that was to be placed after R2's 9/26/19 fall was reminding him to lock his breaks on his walker. Interview on 10/07/19 at 1:45 p.m., with the DON identified she was unaware R1 and R2's care plans had not been updated to reflect appropriate care plan revision, reflecting accurate needs of his MDS or Fall Report. She agreed staff need to ensure accurate information was placed on the care plan to prevent falls.	F 689		

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F 689	Continued From page 7 Review of the 7/7/15, Resident MDS and Care Planning Policy and Procedure identified care plans were to be revised as needed or with an assessment. CAA triggers were the basis for the care plan. All care plans were to be updated quarterly and as needed. Review of the 6/27/19, Fall Prevention Program Policy and Procedure identified the expected outcome after a fall was to be fall prevention strategies and interventions were to be implemented promptly after a fall to prevent further falls. The fall risk assessment, nursing diagnoses and interventions were to be based on use of the Fall Risk Assessment, the fall itself, CAA's and other clinically relevant information.	F 689		

Electronically Delivered

October 30, 2019

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

Re: State Nursing Home Licensing Orders - Complaint Number H5573013C

Dear Administrator:

A complaint investigation was completed on . At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following investigator's 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.

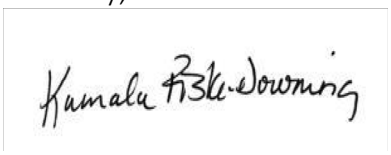
When all licensing orders are corrected, the form should be signed and returned electronically to:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00061	A. BUILDING: _____ B. WING _____	10/09/2019

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CLARA CITY CARE CENTER	1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/7/19 through 10/9/19, an abbreviated survey was conducted to investigate complaint H5573013C. Your facility was NOT in compliance. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been	2 000		

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2 000	Continued From page 1 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 found 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, which are in violation of the state statute after the statement, "This Rule is not met as evidence 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. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in	2 830		11/15/19

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2 830	Continued From page 2 the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess resident falls to ensure appropriate interventions were implemented to reduce the risk of accident hazards for 2 of 3 residents (R1 and R2) reviewed for falls. This caused actual harm when R1 fell out of bed and received bruising and a laceration to his face requiring sutures, and severe ongoing shoulder and hip pain. Findings include: R1's significant change 2/20/19, and 8/12/19, Minimum Data Assessment (MDS) identified R1 had diagnoses of repeated falls, weakness, heart failure, chronic obstructive pulmonary (lung) disease, and osteoporosis and had intact cognition. R1 required 2 person physical assist with toileting, and was dependent on staff for transfers. R1 also required extensive assistance of 2 staff for bed mobility. R1's 2/20/19, Care Area Assessment (CAA) identified he was extensive assistance of 2 staff for transferring and toileting and bed mobility.	2 830	Corrected	

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2 830	Continued From page 3 R1's current undated care plan identified he used a bedpan for toileting needs, but did not identify how many staff assistance was needed to assist him with transferring on and off the bedpan. Even though the 2/20/19 CAA identified he needed extensive assistance of 2 staff for toileting and bed mobility. R1's 9/28/19, Event Report identified R1 complained of pain after his fall. He received a laceration (cut) and a scrape from his fall. R1 was noted to have just finished using the bedpan. Nursing assistant (NA)-A had rolled R1 onto his left side after his bedpan use and was cleansing him. R1 moved his right leg over too far on the bed, causing him to slide out of bed, landing on his side. NA-A tried to grab him but could not stop his fall. R1 was found by LPN-A with blood on his face and head, left elbow, a scrape to his left knee and complained of shoulder and hip pain. Family and 911 were called. Management and R1's physician were then notified. Interventions listed were "Upon return, plan to change to 2 assist for bed mobility and bed pan use." Review of R1's 9/28/19, Emergency Room (ER) Discharge Instructions identified he fell at the nursing home. As a result of that fall, R1 had a laceration to his right forehead and received a 2 layer closure [sutures and steri-strips] and a left elbow skin tear. The ER physician recommended a 4 person log roll when turning in bed. Interview on 10/7/19 at 11:10 a.m., with the director of nursing (DON) identified she was aware of R1's 9/28/19 fall from bed while using the bedpan. They placed a new interventions for 2 person to assist using the bed pan as part of a new intervention. The DON was unaware the MDS assessments from 1/19/19, had identified	2 830		

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2 830	Continued From page 4 R1 needing a 2 person assist for toileting. That information had not been updated on R1's care plan to prevent R1's fall. Her expectation was the care plan should have been updated after the assessment identifying appropriate staff intervention to prevent future falls. R1 was observed on 10/7/19 at 11:45 a.m., with multiple steri-strips across his right eyebrow with deep purple bruising that extended from the eyebrow to his cheek and nose. R1's bed had bilateral grab bars on his bed. The bed was located in the middle of the room, which allowed staff to stand on either side of the bed. There was approximately 3 to 4 feet between the right side of the bed and the far wall with the window. R1 stated he was using the bedpan the evening of 9/28/19 when he fell. He rolled to his left (right side of bed) facing away from staff while they provided personal care after using the bedpan. He had only had 1 staff assistance with toileting at any time previous to the fall. R1 stated nurse aide (NA)-A tried to stop him from falling but was unsuccessful and fell "on my face". They called his family and then went to the emergency room. R1 received stitches but had no fractures. R1 complained of severe shoulder and hip pain since the incident. He would try and rub his neck and shoulder to ease the pain, but had no success. Staff have never used 2 person assist while transferring him in bed prior to the incident, but they had now. Interview on 10/7/19 at 12:05 p.m., with NA-A identified the events surrounding R1's fall. She was sitting at the nurses station desk when R1 placed his call light on. She placed R1 on the bed pan. Once he was finished, she removed the bedpan, and he rolled to his left side. R1 had thrown his right leg over firmly during the move,	2 830		

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2 830	Continued From page 5 causing him to fall out of bed. NA-A identified R1 was a 1 person assist prior to the fall, as identified on the care plan. While providing any care for a resident, nurse-aide staff refer to the nurse aide care plan which identified R1 was only a 1 person assist for toileting. NA-A was hired 5 months ago and had always performed 1 staff assist with toileting. She brought the need for 2 staff assist for safety up to nursing a "few times" but his care plan never changed. NA-A felt it was unsafe to toilet R1 with just 1 staff but the facility has not updated the care plan to identify this. Interview on 10/7/19 at 12:12 p.m., with licensed practical nurse (LPN)-A regarding R1's fall identified LPN-A was called to his room by NA-A. R1 was located on the floor, on far right side of his bed. He was curled up, laying on his left side. R1 had blood under his head and face. LPN-A stated R1 complained of pain in his left shoulder and hip. She called RN-B to assist and they did vital signs and called emergency services (EMS) immediately. She did not want to move R1 for fear of unknown injury. R1 returned from the hospital at approximately 8:00 p.m. that same evening. LPN-A had work with R1 for over one year and knew R1 well and indicated R1's care plan directed staff only 1 assist with toileting. She was not responsible for ensuring assessments followed over to the care plan. RN-C was responsible to update the focus (nurse aide) sheets and care plans. Interview on 10/7/19 at 12:44 p.m., with RN-B identified she was responsible for the day-to-day changes on the care plan, and not the MDS assessment changes. RN-B was aware of the 8/12/19 MDS identifying R1 was to have 2 assist with toileting, but "that was his look-back period," not what he maybe needed after. Ultimately it was	2 830		

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2 830	Continued From page 6 RN-C's job to update the care plan after an MDS assessment. Interview on 10/7/19 at 12:50 p.m. with RN-C identified she also felt the assessment data collected from the MDS was only valid during that look-back period. RN-C agreed the MDS was used to identify care a resident would need. RN-C felt staff could adjust the information how they determined assistance should be. RN-C was unaware R1 had required 2 assist for toileting since January, 2019. She had not performed any assessment to see if R1 had not required 2 staff. When asked why staff had not updated the care plans with current assessment data derived from the MDS, she would not answer. She had agreed without use of the correct amount of staff, accidents could be likely to occur. R1's care plan had been updated since his 9/28/19 fall and 2 staff were required to assist with toileting to prevent any future similar occurrences. Interview on 10/7/19 at 5:06 p.m., with family member (FM)-A identified he was called immediately after R1's accident. He went to the hospital with R1 whom received stitches but no fractures. FM-A was told R1 had fallen out of bed after they were providing cares using the bed pan. FM-A visits the facility often, even daily, and has only seen 1 staff assisting R1 to use the bed pan. FM-A was unaware R1 had been identified in January 2019 of needing 2 staff assist for use of R1's bedpan. FM-A states R1 had complained of pain since his incident and had a hard time moving around in his chair and performing tasks. Interview on 10/9/19 at 3:30 p.m., with physician (MD-A identified he was made aware of R1's fall immediately after the incident. He was told R1 had fallen from the bed after being turned for	2 830		

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2 830	Continued From page 7 cares after toileting. MD-A was unaware R1 was identified to be a 2 person assist since January 2019. MD-A agreed the care plan should have been updated to reflect staff assistance to prevent the fall of R1. MD-A wrote orders that day for R1 to have physical therapy related to his shoulder and hip pain in an attempt to offer relief. R2's quarterly 9/16/19, MDS identified he had diagnoses of previous left leg fracture, dementia, COPD, low blood oxygen, and stroke. R2 had moderate cognitive impairment and required supervision for locomotion on and off the unit. R2's annual 1/19/19, Care Area Assessments (CAA) identified he had fallen at his residence prior to admission and had a history of repeated falls. R2 had poor safety judgement with self-transfer and his room was close to the nurses station for monitoring. R2's 9/26/19, Event Report identified he used a 4 wheeled walker with a seat on it. R2 entered the room for care conference, went to sit on his walker but the brake was not engaged. The walker moved and he fell to the floor on his left side. Interventions identified at that time were to remind R2 to apply his brakes before he sits on the walker seat. R2's Focus Sheet Change Form dated 9/26/19, used immediately after the fall for items needing to be transferred to the care plan, identified he needed reminding to lock his walker brakes. The line indicating nursing staff had updated the care plan was blank. R2's undated current care plan identified he was at high risk for falls with one fall since his admission to the facility. There was no	2 830		

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2 830	Continued From page 8 intervention related to R2's 9/26/19, fall identified on the care plan. The intervention that was to be placed after R2's 9/26/19 fall was reminding him to lock his breaks on his walker. Interview on 10/07/19 at 1:45 p.m., with the DON identified she was unaware R1 and R2's care plans had not been updated to reflect appropriate care plan revision, reflecting accurate needs of his MDS or Fall Report. She agreed staff need to ensure accurate information was placed on the care plan to prevent falls. Review of the 7/7/15, Resident MDS and Care Planning Policy and Procedure identified care plans were to be revised as needed or with an assessment. CAA triggers were the basis for the care plan. All care plans were to be updated quarterly and as needed. Review of the 6/27/19, Fall Prevention Program Policy and Procedure identified the expected outcome after a fall was to be fall prevention strategies and interventions were to be implemented promptly after a fall to prevent further falls. The fall risk assessment, nursing diagnoses and interventions were to be based on use of the Fall Risk Assessment, the fall itself, CAA's and other clinically relevant information. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the	2 830		

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2 830	Continued From page 9 facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		