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	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarkfield Care Center	805 Fifth Street, Box 458 Clarkfield, MN 56223

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 39988 Based on interview and document review the facility failed notify the provider of a change in condition timely for 1 of 1 resident (R25) reviewed for hospitalization . Findings include: R25's 12/18/24, quarterly Minimum Data Set (MDS) assessment identified R25 with diagnoses of congestive heart failure, hypertension and was cognitively intact. The MDS indicated R25 required substantial assistance with activities of daily ling and did not utilize oxygen. R25's February 2025, medication administration record lacked indication R25 utilized oxygen. The facility Standing Orders dated 7/26/24, included orders for oxygen at 2 liters per minute per nasal canular for complaints of shortness of breath or chest pain and call provider or ER if oxygen's saturation do not improve to 90% or above. The standing orders did not include order for increasing the oxygen higher than 2 liters. Review of R25's progress notes (PN) identified the following information: 1) PN dated 2/13/25 at 12:53 p.m., R25 complained of fatigue as well as coldness in her lower extremities. Her vital signs were blood pressure (BP)109/64, pulse (P) 110, temperature (T) 97.3, respirations (R) 15, and oxygen saturation (O2) 93%. Nursing staff encouraged R25 to be evaluated in the emergency room as R25's BP [blood pressure] and HR [heart rate] have not been stable over the last 3-4 days. R25 had been offered to go to the emergency room s, however, R25 refused. 2) PN dated 2/14/25 at 11:06 a.m., nurse was called to R25's room as R25 was unable to stand with assistance of staff or a sit to stand mechanical device. R25 reported feeling dizzy and light-headed vital signs were identified as BP 30/unknown, P 30, R17, T 97.0 F and O2 was at 86%. The writer contacted the emergency department (ER) and was advised to send resident to ER. 3) PN dated 2/14/25, at 3:29 p.m., a nurse- to- nurse report from the emergency room indicated R25 had been diagnosed with a bladder infection and would be returning to the facility. 4) PN dated 2/14/25 at 5:46 p.m., indicated R25 had returned to the facility at 4:55 p.m. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5) PN dated 2/15/25 at 5:35 p.m. indicated the night nurse had been placed on oxygen during the night. During the day morning hours, R25's oxygen saturation (amount of oxygen in the blood) was noted to be 91%. R25 had been alert and orientated before breakfast, however, began to show increased confusing after lunch. At 4:20 p.m. R25's vital signs were BP 118/77, P 118, R 20, T 97.7, O2 79%. The writer identified they had increased R25's oxygen to 3 LPM/NC (liters per minute per nasal cannula) and oxygen saturation increased to 86%, then increased to 4 LPM/NC and oxygen saturation increase to 89%, then increased to 5 LPM/NC and oxygen saturation increased to 90-91%. Now this afternoon R25 has been noted to have increased shortness of breath, be lethargic, has had no appetite today. Writer informed R25 she was sending her to the ER and resident voiced understanding. The progress notes lacked identification of the night nurse's assessment and why or what circumstances lead to R25 being placed on facility standing orders. The progress notes further lacked the identified assessments of the vital signs being monitored throughout the day on 2/15/25 other than the one done at 4:20 p.m. Review of R25's blood pressure records identified on 2/14/25 at 8:10 a.m., R25's BP as 146/95, then on 2/15/25 at 7:08 a.m., BP as 178/149, and the last documented BP was on 2/15/25 at 7:12 a.m., of 113/72. There were no further documented blood pressure readings. During interview on 3/11/25 at 11:38 a.m., registered nurse (RN)-B indicated she had care for R25 on 2/15/25. licensed practical nurse (LPN)-A had placed R25 on oxygen around 5:00 a.m. RN-B stated she could not recall why R25, required oxygen, but R25 did not display any type of concerns during the morning shift. However, at 4:20 p.m. R25 began displaying respiratory distress and was transferred back to the hospital. Upon review of the record, RN-B confirmed the documentation lacked rational as to why R25 required oxygen at 5:00 a.m. and the physician was not notified. The record lacked further assessment of R25 during the day until R25 displayed signs of respiratory distress and was transferred back to the hospital. RN-B confirmed the provider had not been updated until R25 had been sent to the ER later that afternoon. During interview on 3/11/25 at 11:54 a.m., with RN-A identified when a resident was started on oxygen per the facility standing orders the nurse should be updating the provider as that would be a change in condition. During interview on 3/11/25 at 4:05 p.m., with LPN-A identified she had missed documenting her assessment and vitals she obtained on R25 the morning of 2/15/25. She revealed she had placed R25 on oxygen per the facilities standing orders around 5:00 a.m., just before the change of shift. R25 had complained of being short of breath and her oxygen saturations were 88-89% and LPN-A reported she had asked R25 if she had used oxygen while at the hospital and she had said yes and that it had helped so she started her on the oxygen. LPN-A confirmed she had not updated the provider however, had reported the information to the day charge nurse. During interview on 3/11/25 at 2:20 p.m., with the administrator/director of nursing confirmed that if a nurse-initiated oxygen per the facility standing orders the nurse should update the provider of the change in condition. She would expect the provider to be updated and for the nurse to document their assessment of the resident in the resident's medical record. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of undated, Notification of Changes policy identified times to promptly notify the resident's medical provider and representative of change in condition. The policy identified any time there was clinical complications or circumstances that required a need to alter the resident's treatment.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39988 Based on interview and document review, the facility failed to notify the designated State Mental Health Authority (SMHA) (Yellow Medicine County) for 1 of 1 resident (R11) with new onset mental illness. Findings include: R11's 12/11/24, annual Minimum Data Set (MDS) assessment indicated R11 had been admitted in October of 2022 and R11's cognition was intact. R11 had the diagnoses including atrial fibrillation, heart failure, hypertension, renal failure, diabetes, arthritis, dementia, depression, and psychotic disorder. R11 required substantial assistance with cares and received, antipsychotic, antidepressant, diuretic, and antiplatelet medications. R11's diagnosis list printed 3/10/25, identified new diagnoses which included unspecified mood affective disorder diagnosed on [DATE], unspecified psychosis not due to a substance or known physiological condition diagnosed on [DATE], and restlessness and agitation diagnosed on [DATE]. R11's care plan printed 3/10/25, indicated R11 was dependent on staff for meeting his emotional, intellectual, physical, and social needs related to unspecified psychosis, major depression, and dementia. R11 displayed behaviors of being sexually inappropriate, yelling, arguing with staff, swearing, refusing cares, hallucinations, delusion, wandering, and using abusive language that was initiated on 5/26/23. R11 had delirium or an acute confusional episode related to unspecified psychosis and received an antipsychotic medication that was initiated 12/15/23. R11's 10/25/22, Initial Pre-Admission Screening (PAS) results identified a diagnosis of depression and did not indicate the need for a Level II PASARR to be completed. The record lacked documentation which would indicate the local mental health authority had evaluated R11 for appropriate placement via a level II (Resident Review) following the new diagnoses of unspecified mood disorder, unspecified psychosis, restlessness and agitation. During interview on 3/11/25 at 2:54 p.m., with registered nurse (RN)-A confirmed R11 had received a PAS upon admission to the facility, which indicated he did not require a level II screening. However, confirmed while in residing at the facility, R11 had received new mental health diagnoses. The facility did not notify the local mental health authority to request a resident review to determine if R11 required additional mental health services. RN-A she was unaware residents who received a new diagnosis of a mental health disease were to be re-evaluated by the local mental health authority. During interview on 3/12/25 at 8:01 a.m., with the administrator/director of nursing who confirmed if a resident received a new mental health diagnosis the local authority should be contacted to complete a level II screening. She was unaware that RN-A was not aware she needed to contact the local mental health authority. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated, Resident Assessment-Coordination with PASARR Program Policy identified the facility would coordinate assessments to ensure individuals with a mental disorder or related condition received care and services in the most integrated setting appropriate to the resident needs. The social service or designee would be responsible for resident PASARR screening and referring to the appropriate authority. The facility would reach out to the appropriate authority for any resident that received a new mental health disorder or condition not previously identified on the initial PAS for a level II screening.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39988 Based on interview and document review the facility failed to assess, investigate, and document for 1 of 1 resident (R11) who had a newly identified burn. Findings include: R11's 12/11/24, annual Minimum Data Set (MDS) assessment identified R11 had been admitted in October of 2022 and R11's cognition was intact. R11 required substantial assistance with cares and had pain that he rated a 5 on scale of 1-10. R11 took a scheduled pain, antipsychotic, antidepressant, diuretic, and antiplatelet medication. R11 was on oxygen. R11 had the diagnoses of atrial fibrillation, heart failure, hypertension, renal failure, diabetes, arthritis, dementia, depression, and psychotic disorder. Review of R11's Skin Assessments identified: 1) 7/18/24, skin issue identified as other located on left gluteal fold. Area has 2 small open areas each measuring 0.5 cm x 0.5 cm a Mepilex dressing was applied. This was identified as the first observation. 2) 12/18/24, skin issue identified as burn located on upper right side of chest. The area measured 2 cm x 2.5 cm and scabbed. Note of assessment identified that on 12/18/24 residents obtained a burn to right upper chest, redness now surrounds the areas, resident was seen by provider on 12/19/24 and ordered Bacitracin. This was identified as the first observation. 3) 12/25/24, skin issue identified as burn located on upper right side of chest. The area measured 2 cm x 2.3 cm scabbed area, improving. 4) 1/2/25, skin issue identified as burn located on upper right side of chest. The area measured 2 cm x 2.3 cm scabbed area, improving. 5) 1/22/25, skin issue identified as burn located on upper right side of chest. The area measured 0.2 cm x 0.2 cm irregular shaped scab, improving. There were no more skin assessments located in R11's medical record. Review of R11's progress notes between 12/12/24 through 3/10/25 had no mention of R11 having a burn on his right upper chest. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/10/25 at 5:58 p.m., with administrator/director of nursing identified that a nursing assistant had reported to RN-A that there was a area of concern on R11's chest. RN-A had thought that the nurse who was originally told had made a progress note but I guess they did not. She reported that RN-A had investigated how R11 got the burn and that they had discussed it at their interdisciplinary team meeting (IDT). She confirmed that there was no incident report completed for the injury and there should have been. She further confirmed the last skin assessment completed for R11 was done on 1/22/25 and she was unsure why there had been no further skin assessments completed as that one identified the area was still open. Interview on 3/10/25 at 6:47 p.m., with registered nurse (RN)-A identified a nursing assistant that no longer worked at the facility had reported the burn to the nurse that was on duty which she could not recall who that was. She revealed the nurse should have documented the assessment of the burn and made an incident report. She revealed she should have followed up and made sure there had been documentation of the burn and an incident report completed but she had not done that. She further identified she should have documented further on R11's skin assessment that the burn had healed confirming she just stopped the skin assessments. R11's provider did order Bacitracin for the burn but identified that also had not been documented in R11's progress notes. Review of 12/19/24, physician order identified provider ordered Bacitracin twice a day to right chest. The order lacked reason for Bacitracin order and an end date. Review of R11's undated, care plan identified the facility had not made revisions follow R11's burn incident to include interventions to prevent further incidents. Interview on 3/10/25 at 7:09 p.m., with R11 who revealed he got a burn on his shoulder area. He reported it was from one of those hand warmers that you stick in your gloves. He revealed he got the hand warmer from another resident and had used it to try to loosen the muscle in his shoulder area. He reported that the nurse did come and look at the burn and told him he could not use that hand warmer. He reported the nurse looked at it about 2 weeks ago, but it has been healed now for a while. Interview on 3/11/25 at 2:20 p.m., with administrator/director of nursing identified she would expect if an injury such as a burn was identified the nurse would assess the burn, investigate how it occurred, document the findings and notify the provider and family. Review of the undated, When to Notify for All Licensed Nurses, protocol identified that the nurse should notify the administrator/director of nursing, the assistant director of nursing immediately when an incident with a serious injury occurred such as burns, major lacerations, head injury, hematoma etc.prior to filing a State Agency report as there was only 2 hours to report timely. Review of 2/15/24, Accidents and Incidents Investigating and Recording policy identified regardless of incident or accident, including injuries of an unknown source, staff must report to the department supervisor and fill out an accident or incident report form on the shift the accident or incident occurred. The nurse should assess the resident and notify the provider of the incident or accident. The policy identified the details that were required to be documented under risk management that included that the resident's care plan needed to be updated with immediate interventions.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336 Based on observation, interview, and document review, the facility failed to follow physician orders for 1 of 2 residents (R7) reviewed for oxygen therapy. Findings include: R7's significant change Minimum Data Set (MDS) dated [DATE], identified R7 was cognitively intact and had diagnoses of chronic respiratory failure and pneumonia. R7 used oxygen therapy. R6's undated care plan identified the goal was to have no signs or symptoms of poor oxygen absorption. Interventions were for staff to administer medication as ordered, monitor effectiveness and side effects, elevate head of bed to prevent shortness of breath when lying flat, maintain a clear airway and instruct R7 to clear her own secretions with effective coughing, to use humidified oxygen of 1 to 2 liters (L) as needed, and to keep oxygen (O2) greater than 90%. R7's Order Summary Report printed 3/10/25, identified R7 was to receive oxygen via nasal cannula (flexible tube that enters your nose to deliver oxygen) continuously at 2 LPM (liters per minute) starting 12/16/24. During observation on 3/10/25 at 11:04 a.m., R7 sat in her recliner with nasal cannula in her nose and the tubing was connected to the oxygen concentrator. The oxygen flow meter was set at 2.5 liters. During observation and interview on 3/10/25 at 12:04 p.m., licensed practical nurse (LPN)-B stated R7 was to receive 2 liters of oxygen. LPN-B observed R7's oxygen flow meter, and voiced it was set at 2.5 LPM. LPN-B decreased the flow rate to 2 LPM. She identified staff nurses were to check and identify appropriate oxygen settings on each shift and to follow physician orders for oxygen use. During interview on 3/12/25 at 5:33 p.m., director of nursing stated they expected staff nurses to follow oxygen orders as directed by the primary physician. Review of current, undated Oxygen Administration policy identified staff nurses were responsible for resident's safety with oxygen use. In addition, staff nurses were to administer oxygen therapy under the direction of physician orders. Lastly, staff nurses were to verify and check oxygen equipment to ensure oxygen concentrator equipment and safety checks were completed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39988 Based on interview and document review, the facility failed to coordinate with the provider and pharmacy to ensure a prescribed medication was available and administered for 1 of 1 residents (R10) reviewed who did not receive ordered medication. Findings include: R10's 2/26/25, quarterly Minimum Data Set (MDS) assessment identified R10's cognition was intact. R10 had no behaviors and required assistance with cares. R10 was frequently incontinent of urine. R10 was on a scheduled pain medication and rated her pain a 4 on scale of 1-10. She had no skin concerns and took a daily antidepressant, blood thinner, and diuretic (water pill). R10 was on oxygen therapy and planned to remain in the facility. Interview on 3/10/25 at 12:34 p.m., with R10 identified she had a yeast infection that was not resolved yet. She reported she was to be getting Monistat but had not received that for the last 2 weeks as staff told her they had to get a new order. In the meantime, she reported she itched, and it hurt when she voided. Review of progress notes identified: 2/19/25, communication with provider, R10 continues to complain of burning and itching in vaginal area. Question if she would benefit from Monistat cream. 2/20/25, received order for Monistat care instant itch relief external cream 1%, apply to vaginal area topically two times a day for vaginal itching and change to as needed when clear. 2/21/25, Monistat 1% cream no prescription. 2/28/25, Monistat 1% cream no prescription. 3/1/25, Monistat 1% cream no prescription. 3/2/25, Monistat 1% cream no prescription. 3/3/25, Monistat 1% cream no prescription. 3/4/25, Monistat 1% cream no prescription. 3/5/25, Monistat 1% cream no prescription. 3/6/25, Monistat 1% cream no prescription. 3/7/25, Monistat 1% cream no prescription. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/8/25, Monistat 1% cream unavailable, pharmacy was awaiting new prescription from provider and will send when received. 3/9/25, Monistat 1% cream no prescription. 3/10/25, Monistat 1% cream no prescription. 3/11/25, provider communication that R10 had complained of itching in her vaginal area and had pain when voiding. Provider ordered Monistat for 10 days. 3/11/25, resident seen by provider during routine rounds. Resident continues to complain of burning and itching. Resident reported that the Monistat did not help but then asked the provider for Monistat. R10 reported that she had never complained of burning and itching since she had been a resident there. The provider discontinued the order for Monistat and ordered Estradiol gel nightly for 2 weeks. Review of R10's February 2025, Administration Record identified Monistat Care Instant Itch Relief external cream 1%, apply to vaginal area typically two times a day for vaginal itching and change to as needed when clear. Charted administered 2/21/25, through 2/27/25, then charted as other 'see progress note' on 2/28/25. R10's March 2025, Administration Record identified Monistat Care Instant Itch Relief external cream 1% was charted as 'other see progress note' 3/1/25 through 3/11/25. During interview on 3/11/25 at 2:13 p.m., trained medication assistant (TMA)-A identified that the facility had the Monistat for R10 but then ran out and they could not get any more. She reported they were to fax the pharmacy a week before a resident runs out of a medication, and if they did not get that medication in from the pharmacy, they were to notify the charge nurse who then contacted the pharmacy. During interview on 3/11/25 at 2:20 p.m., administrator/director of nursing identified that licensed practical nurse (LPN)-B had been dealing with the pharmacy related to getting R10's Monistat. The pharmacy had sent a very small tube, and it ran out right away. The pharmacy kept saying they needed a new prescription. During interview on 3/11/25 at 2:41 p.m., LPN-B reported R10 had an order for Monistat, and according to the pharmacy, they only had an order for as needed (PRN) and the pharmacy was waiting on a new prescription from the clinic before they sent out another tube of Monistat. She revealed she did not know if anyone from the facility had reached out to R10's provider for a new prescription. She identified if the facility did not have a medication supply, they were to reach out to pharmacy first and then the pharmacy usually reached out to the clinic. If the facility still did not receive the ordered medication the facility was to reach out to the provider. A policy related to what staff were to do if a medication supply was not available was requested however, the administrator/director of nursing reported the facility did not have one.