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	04/08/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and document review, the facility failed to document the date when transmission-based precautions (TBP) were implemented for 2 of 3 residents (R2 and R27). Findings include: R2's comprehensive Minimum Data Set (MDS) assessment accepted on 3/18/26, identified his cognition was intact. R2 was dependent on staff for transfers and bathing, he required substantial/maximal assistance with dressing. Review of the facilities resident infection prevention surveillance logs identified R2 had a confirmed upper respiratory infection identified on 1/30/26. He was placed on droplet precautions on 1/31/26 through 2/6/26. He displayed symptoms of fever, new increased cough, shortness of breath, and had oxygen saturations of less than 94% on room air (normal 95% to 100%) which was a reduction of greater than 3% from his baseline. The treatment was oseltamivir (an antiviral medication used to treat infections) 75 milligrams (mg) two times daily for 5 days. The infection was resolved on 2/5/26. Review of R2's nursing progress notes identified on:1/30/26 at 11:39 p.m., licensed practical nurse (LPN)-A entered a nursing progress note identifying she had completed a respiratory assessment on R2. He had a non-productive cough, auditory wheezing, HIS temperature was 98.8 degrees Fahrenheit (F), and his oxygen saturations were at 90%. His heart rate was 114 beats per minute (BPM) (Normal 60-100 BPM), HIS blood pressure was 154/68 Millimeters of mercury (MM/HG), and his rate of respirations were 20 breaths per minute (BPM) (normal 16-20). R2 was tested for covid infection and the results were negative. Cough syrup was given. The progress note made no mention that R2 had been placed on TBP.1/31/26 at 7:02 a.m., registered nurse (RN)-A identified she had completed a respiratory assessment and noted R2 had increased congestion with A blood pressure of 124/79 MM/HG, a heart rate of 80 BPM, respirations 30 BPM, A non-productive cough, and decreased urine output. She informed R2 she would be calling the emergency department (ED) for guidance.1/31/26 at 7:06 a.m., RN-A identified she called 911 for an emergency transport to the hospital ED.1/31/26 at 12:43 p.m., RN-A identified she had received a call from the hospital with an update on R2. He had been diagnosed with influenza A and A urinary tract infection. They would be discharging R2 back to the facility with new orders. R27's quarterly Minimum Data Set (MDS) assessment accepted on 3/23/26, identified her cognition was intact and she was independent with activities of daily living (ADL)'s. Review of the facilities infection prevention surveillance identified R27 had a confirmed respiratory infection (pneumonia) that was identified on 1/12/26. The symptoms were new/increased cough, reduced oxygen saturations, and pleuritic chest pain. The treatment was cefdinir (antibiotic medication used to treat infections) 300 MG two times a day for 3 days. There was no information in the resident surveillance or medical record to identify when or if R27 had been placed on TBP to reduce the risk of transmission of infection to other residents and staff. Interview on 4/8/26 at 8:01 a.m., with the infection preventionist identified she agreed with the above information and would expect nursing to place residents on TBP upon identifying s/s of infection. In addition, the date that precautions were put into place should have been documented in the medical record. Interview on 4/8/26 at 11:24 a.m., with the administrator identified, she would expect all staff to follow the facilities infection prevention policies and procedures. Review of the facility provided 1/26/26, Infection Prevention and Control Program policy identified a resident with an infection or communicable disease shall be placed on (continued on next page)

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	transmission-based precautions as recommended by current CDC guidelines. Review of the facility provided 1/16/26, Infection Surveillance policy identified the RN's and LPN's are to participate in surveillance through assessment of resident and reporting changes in condition to the resident's physicians and management staff, per protocol for notifications of changes and in house reporting of communicable diseases and infections. Examples of notification triggers include signs and symptoms of infection, starting an antibiotic, microbiology test is ordered, a resident is placed on isolation precautions, whether empirically or by physician order, or microbiology test results show drug resistance.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and doc review the fac failed to ensure a Hospice care plan was provided for 1 of 1 resident R7Findings include: R7's 3/23/26, accepted Significant Change, Minimum Data Set (MDS) assessment identified R7, had severe cognitive impairment and was readmitted following acute care hospitalization with diagnoses including hypertension, dementia, malnutrition, anxiety disorder, depression, macular degeneration (legally blind). He required maximal assistance from staff for activities of daily living (ADLs), and a wheelchair was needed for mobility. R7's 2/26/26 at 3:22 p.m. progress notes identified he was admitted to hospice services with a terminal diagnosis of senile degeneration of the brain. Interview on 4/7/26 at 9:28 a.m. with trained medication aid (TMA)-A identified R7 was on Hospice services. He required he required total assistance with ADLs, except eating which required set up. TMA-A was not aware if there was a hospice schedule or care plan and thought there might have been some information at the nursing station. Interview on 4/7/26 at 9:44 a.m. with licensed practical nurse (LPN)- B identified R7 was still on hospice services, but the frequency of visits had decreased due to his improvement. The hospice nurse was supposed to have made a visit on Monday, but she had not come, and LPN-B was not aware of the reason, or when she planned to visit. There was not a schedule to identify visits, and the facility's care plan noted R7 was on hospice, but failed to identify services hospice was to provide, and services the facility was responsible for. LPN-B reported hospice staff were not able to document in the facility's electronic medical record. They gave staff a verbal update and later faxed a copy of their visit notes to the facility. Documents provided had been scanned into the electronic medical records system. Interview on 4/8/26 at 9:09 a.m. with the hospice registered nurse (RN)-B identified R7 had been improving and had not needed medication for pain or comfort. Hospice had decreased the frequency of their visits following discussion at their Interdisciplinary Team (IDT) meeting due to his improved status. A schedule and integrated care plan should have been developed and provided to the facility at the time of admission, but that had not occurred. She would immediately provide a copy of the hospice care plan to the facility. The agreement of what services and equipment hospice provided should have been in a binder at the nursing station, but nothing was able to be provided by facility staff. Interview on 4/8/26 at 1:00 p.m. with the director of nursing (DON) identified her expectation that hospice documentation was to include identifying responsibilities for services and equipment hospice was to provide in the care plan provided at the time of admission to hospice. A policy for hospice services was requested but not provided by the end of the survey.