DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 27, 2026

Administrator
FIELD CREST CARE CENTER
318 SECOND STREET NORTHEAST
HAYFIELD, MN 55940

RE: CCN:245431

Cycle Start Date: February 19, 2026

Dear Administrator:

On February 19, 2026, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 19, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 19, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities

MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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February 27, 2026

Administrator
FIELD CREST CARE CENTER
318 SECOND STREET NORTHEAST
HAYFIELD, MN 55940

Re: State Nursing Home Licensing Orders
Event ID: 1E34F4-H1

Dear Administrator:

The above facility survey was completed on February 19, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is 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 order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245431	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST , HAYFIELD, Minnesota, 55940

(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
E0000	Initial Comments On 2/17/26 through 2/19/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		03/09/2026
F0000	INITIAL COMMENTS On 2/17/26 through 2/19/26, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. 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. 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.	F0000		03/09/2026
F0689 SS = D	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	F0689	Field Crest Care Center strives to maintain proper oxygen storage, maintenance, handling and use. No negative impact to resident R24 related to oxygen removal or handling of oxygen canister. Resident has order in place that it is appropriate to remove oxygen while in beauty shop. All other residents with oxygen orders were also reviewed and are appropriate to have oxygen removed when in beauty shop. On admission, all residents with oxygen orders are assessed by provider	04/01/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245431	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

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F0689 SS = D	Continued from page 1 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 ensure an oxygen tank was handled safely for 1 of 1 resident (R24) reviewed for safety hazards. Findings include: R24's face sheet printed on 2/18/26, included diagnosis of chronic obstructive pulmonary disease (COPD, a lung disease making it difficult to breathe). R24's admission Minimum Data Set (MDS) dated 11/10/25, indicated intact cognition, clear speech, could understand and be understood. R24 required supervision or partial assistance with activities of daily living. R24 used oxygen. R24's physician orders dated 2/4/26, indicated room air – 2 lpm (liters per minute) oxygen via NC (nasal cannula) with exercise/activity to maintain oxygen saturation greater than 88%. R24's care plan with revised date of 2/11/26, indicated the resident had COPD. Oxygen settings: Room air – 2 LPM O2 via NC with exercise/activity - attempt to titrate to room air to maintain oxygen saturations greater than 88%. During an observation on 2/18/26 at 8:00 a.m., an E-size oxygen tank was observed standing unsecured in the hallway outside of the beauty shop. There had been oxygen tubing draped on it. During an interview on 2/18/26 at 8:02 a.m., nursing assistant (NA)-A stated the tank belonged to a resident who was in the beauty salon getting her hair done. NA-A did not know if the tank standing unsecured posed a safety risk. NA-A did not recall specific training on oxygen tank safety. During an interview on 2/18/26 at 8:05 a.m., NA-B approached the tank and said she had asked a nurse about it who said it can't be left unsecured as it created a trip hazard and if knocked over, could explode. NA-B stated she had received oxygen safety	F0689	Continued from page 1 when reviewing orders, to determine if appropriate to have oxygen removed during beauty shop services. Facility policy was reviewed to ensure only properly trained staff handle oxygen canisters. Education will be provided to all staff on policy to ensure they are aware who is appropriate to handle oxygen. Staff that manage oxygen will be re-educated on proper handling and storage of oxygen. Beautician will be educated on proper staff that are able to handle oxygen within the facility and expectations for her to contact staff when needing assistance with a resident's oxygen canister prior to entering beauty shop. Beautician only in facility one day per week. Audits will be completed by clinical manager for 4 weeks, when the beautician is in the facility to ensure that oxygen is handled properly during these times. Compliance will be reviewed at upcoming quarterly Quality Assurance and Performance Improvement Committee meetings. Education and audits will be completed by 4/1/26.	

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F0689 SS = D	Continued from page 2 training. NA-B stated the beautician had removed the tank from the cart and put it in the hallway. During an interview on 2/18/26 at 8:06 a.m., NA-C brought an oxygen tank hand cart and placed the tank into the cart. NA-C stated an unsecured oxygen tank was a safety risk because the tank could fall over and explode. During an interview on 2/18/26 at 8:14 a.m., beautician (B)-B, stated she did not remove the oxygen tank from R24's wheelchair and place it in the hallway. B-B stated she was aware oxygen could not be used in the salon, but it would not be up to her to remove a tank from a resident. During an interview on 2/18/26, at 10:15 a.m., NA-A stated she had removed the oxygen tank from R24's wheelchair after escorting R24 to the beauty salon, and had placed the tank in the hallway, unsecured. NA-A stated she was now aware oxygen tanks needed to be placed in a cart and not left standing unsecured. During an interview on 2/18/26 at 12:30 p.m., the co-executive director (CED)-A who was also director of social services, stated she had been made aware of the unsecured oxygen tank by staff and would have expected staff to adhere to safe practices per policy. CED-A provided a policy titled Oxygen Storage, Maintenance, Handling and Use dated 1/27/18, which NA-A had signed off on, on 11/6/18 as part of oxygen safety training. The policy indicated oxygen cylinders would be stored in racks with chains, sturdy portable carts, or approved stands. Oxygen cylinders would never be left free-standing. Facility Oxygen Storage, Maintenance, Handling and Use policy dated 1/16/26, indicated oxygen cylinders would be stored in racks with chains, sturdy portable carts, or approved stands. Oxygen cylinders would never be left free-standing.	F0689		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/19/2026**

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20000	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 2/17/26 through 2/19/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		03/09/2026

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule 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 surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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.	20000		
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid	21426	Acknowledged and corrected	04/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/19/2026**

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21426	Continued from page 2 employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure baseline tuberculosis (TB) testing had been completed for 3 of 5 residents (R10, R16, R31) per Center for Disease Control and Prevention (CDC) recommendations and facility policy. This had the potential to affect all 32 residents residing in the facility. Findings include: R10’s face sheet printed 2/18/26, indicated R10 was admitted on 7/25/25. R10’s Baseline TB screening Tool and Tuberculin skin testing (TST) dated 7/24/25, indicated on 7/25/25 at 2:45 p.m., R10 was administered TST test, and on 7/28/25, at 4:00 p.m., indicated 0 millimeters (mm) result and read as negative. R10 TST – second step was administered on 8/4/25 at 3:16 p.m., and on 8/7/25 at 6:00 p.m., R10's tuberculin skin test was read 0 mm and indicated negative. The results of R10’s first and second step TST skin test were read after 72 hours. R16’s face sheet printed 2/18/26, indicated R16 was admitted on 1/13/26. R16’s Baseline TB screening Tool and Tuberculin skin testing (TST) dated 1/13/26, indicated on 1/1/13/26 at 3:20 p.m., R16 was administered TST test, and undated and untimed, result indicated 0 mm result and read as negative. The results of R16’s TST first step result did not have a date or time read. R31’s face sheet printed 2/18/26, indicated R31 was admitted on 12/4/25. R31’s Baseline TB screening Tool and Tuberculin skin testing (TST) dated 12/4/25, indicated on 12/4/25 at 5:00 p.m., R31 was administered TST test, and on 12/14/25 at 5:50 p.m., indicated 0 mm result and read as negative. The results of R31’s first step TST skin test was read after 72 hours.	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/19/2026**

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FIELD CREST CARE CENTER	**318 SECOND STREET NORTHEAST , HAYFIELD, Minnesota, 55940**

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21426	Continued from page 3 On 2/18/26 at 3:28 p.m., the co-executive director (CED)-A who was also director of social services, indicated in an email R31's first TST was read seven days late, confirmed R10's TST was read late, and R16's result did not indicate a date and time, and indicated the facility would expect TST results to be read within 48-72 hours of administration and include a date and time read. Facility Tuberculosis {TB) Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by MDH* Updated 4/2025, indicated: TB patient screening (boarding care and nursing homes only) Baseline TB screening includes: (1) two-step TST or single TB blood test, (2) TB symptom screen, and (3) assessment of the patient's risk factors for TB exposure and progression. Additional information is available at Prevention and Control of TB in Health Care and Other Congregate Settings http://www.health.state.mn.us/divs/idepc/diseases/tb/rules/index.html). Facility Tuberculosis Screening: Residents Policy dated 10/14/25, indicated: Residents of long-term care facilities have been identified as a high-risk group for re-activation of latent TB infection, acquisition of TB infection and potential spread of TB within a facility. This facility has a comprehensive TB screening program that is administered by the Infection Control Nurse and/or Director of Nursing. tuberculin Skin Test (TST): 1. For all new admissions, a tuberculin skin test will be done within 72 hours after admission if there is no documented TST result from within three months before admission. 2. The 2 step Tuberculin Skin Test (TST) method will be performed using five units (0.1 ml) of purified protein derivative tuberculin given intracutaneously (see procedure). 3. Residents with a documented history of a previous positive TST will not be retested. 4. Routine repeat TST of residents is not recommended except under the following circumstances: a. Resident is a known contact of an active TB case b. Repeat testing of employees suggests possible transmission in the facility from an undetected case	21426		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21426	Continued from page 4 c. If testing is needed to evaluate the resident for suspected active TB disease. 5. TST results will be documented in the resident's medical record. a. Skin results will be documented in millimeters of induration rather than stating the result is "positive" or "negative". b. The tuberculin manufacturer and lot number will be recorded. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current TB policies and procedures to ensure all residents are screened and tested for TB disease on admission. The DON or designee could develop a monitoring system by auditing residents' charts to ensure ongoing compliance. The DON or designee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21665	Physical Environment CFR(s): MN Rule 4658.1400 A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Findings include: R24's face sheet printed on 2/18/26, included diagnosis of chronic obstructive pulmonary disease (COPD, a lung disease making it difficult to breathe). R24's admission Minimum Data Set (MDS) dated 11/10/25, indicated intact cognition, clear speech, could understand and be understood. R24 required supervision or partial assistance with activities of daily living. R24 used oxygen. R24's physician orders dated 2/4/26, indicated room air – 2 lpm (liters per minute) oxygen via NC (nasal cannula) with exercise/activity to maintain oxygen saturation greater than 88%. R24's care plan with revised date of 2/11/26, indicated the resident had COPD. Oxygen settings: Room air – 2	21665	Acknowledged and corrected	04/01/2026

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21665	Continued from page 5 LPM O2 via NC with exercise/activity - attempt to titrate to room air to maintain oxygen saturations greater than 88%. During an observation on 2/18/26 at 8:00 a.m., an E-size oxygen tank was observed standing unsecured in the hallway outside of the beauty shop. There had been oxygen tubing draped on it. During an interview on 2/18/26 at 8:02 a.m., nursing assistant (NA)-A stated the tank belonged to a resident who was in the beauty salon getting her hair done. NA-A did not know if the tank standing unsecured posed a safety risk. NA-A did not recall specific training on oxygen tank safety. During an interview on 2/18/26 at 8:05 a.m., NA-B approached the tank and said she had asked a nurse about it who said it can't be left unsecured as it created a trip hazard and if knocked over, could explode. NA-B stated she had received oxygen safety training. NA-B stated the beautician had removed the tank from the cart and put it in the hallway. During an interview on 2/18/26 at 8:06 a.m., NA-C brought an oxygen tank hand cart and placed the tank into the cart. NA-C stated an unsecured oxygen tank was a safety risk because the tank could fall over and explode. During an interview on 2/18/26 at 8:14 a.m., beautician (B)-B, stated she did not remove the oxygen tank from R24's wheelchair and place it in the hallway. B-B stated she was aware oxygen could not be used in the salon, but it would not be up to her to remove a tank from a resident. During an interview on 2/18/26, at 10:15 a.m., NA-A stated she had removed the oxygen tank from R24's wheelchair after escorting R24 to the beauty salon, and had placed the tank in the hallway, unsecured. NA-A stated she was now aware oxygen tanks needed to be placed in a cart and not left standing unsecured. During an interview on 2/18/26 at 12:30 p.m., the co-executive director (CED)-A who was also director of social services, stated she had been made aware of the unsecured oxygen tank by staff and would have expected staff to adhere to safe practices per policy. CED-A provided a policy titled Oxygen Storage, Maintenance, Handling and Use dated 1/27/18, which NA-A had signed off on, on 11/6/18 as part of oxygen safety training. The policy indicated oxygen cylinders would be stored in racks with chains, sturdy portable carts, or	21665		

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21665	Continued from page 6 approved stands. Oxygen cylinders would never be left free-standing. Facility Oxygen Storage, Maintenance, Handling and Use policy dated 1/16/26, indicated oxygen cylinders would be stored in racks with chains, sturdy portable carts, or approved stands. Oxygen cylinders would never be left free-standing. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies and procedures if necessary, and reeducate staff on oxygen tank safety. The administrator or designee could conduct audits to ensure compliance and report the results to the Quality Assurance Performance Improvement (QAPI) committee to ensure appropriate oversight and/or need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/20/2026. At the time of this survey, FIELD CREST 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. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K0000		03/09/2026

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 reverse for further 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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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. FIELD CREST CARE CENTER is a 1-story building with partial basement. The original building was constructed in 1969 and was determined to be of Type II (111) construction, with a partial basement. In 1972, an addition was constructed and was determined to be of Type II (111) construction, with a full basement. In 1995, an addition was constructed and was determined to be of Type II (111) construction, with no basement. The facility is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 35 beds and had a census of 32 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0291 SS = C	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1	K0291	A new form was implemented with space to enter date and signature after completion of annual and monthly Emergency Lighting testing to ensure required documentation is complete. Education was provided to Maintenance Director on required documentation and new form completion. Facility maintenance schedule is discussed monthly at Safety Meeting. Documentation will be audited at the	03/05/2026

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K0291 SS = C	Continued from page 2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, test, and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code, sections 19.2.9.1, 7.9, 7.9.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/20/2026 between 10:00 AM and 1:00 PM, it was revealed by review of available documentation that no documentation was presented for review did not have associated date(s) as to when the testing occurred and did not have signature(s) of staff completing the testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0291	Continued from page 2 March and April Safety Meetings to ensure completed correctly. Maintenance Director is responsible for monitoring compliance. New documentation form completed and filled out properly on 3/5/26.	
K0345 SS = F	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 STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 19.3.4.2, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.3.1, Table 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K0345	1. A form for the semi-annual visual inspection of fire system was obtained from the MDH Fire/Life Safety Code website to be completed moving forward. Annual inspection was completed by Custom Alarm on 2/12/26. 2. Semi-annual inspection has been scheduled to be completed by Maintenance Director on August 8, 2026. Education was provided to Maintenance Director on required completion of semi-annual inspection. 3. Facility maintenance schedule is discussed monthly at Safety Meetings and this was added to schedule to ensure completion. 4. Maintenance Director is responsible for monitoring compliance. 5. New documentation has been obtained and education has been completed. Semi-annual testing will be completed moving forward.	03/05/2026

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K0345 SS = F	Continued from page 3 On 02/20/2026 between 10:00 AM and 1:00 PM, it was revealed by review of available documentation that no documentation was presented to confirm that semi-annual visual inspection of the fire alarm system is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0345		
K0353 SS = D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.4, 5.2, 5.2.1.1.1, 5.2.1.1.2(6). This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K0353	1. Paint splatter on sprinkler head in Wing 1 Tub Room was removed by Maintenance director on 3/5/26. 2. Education was provided to Maintenance Director on ensuring sprinkler heads are free of paint, dust and debris with inspections. 3. Quarterly building inspections are completed by Safety Committee. Will discuss and review inspection forms and upcoming Safety Meeting on 3/26/26 to ensure committee members are observing sprinkler heads during quarterly inspections. 4. Maintenance Director is responsible for monitoring compliance. 5. Sprinkler heads cleaned on 3/5/26.	03/05/2026

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K0353 SS = D	Continued from page 4 On 02/20/2026 between 11:40 AM, it was revealed by observation that the sprinkler head located in WING 1 – Tub Room exhibited paint splatter on sprinkler head(s). An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353		
K0355 SS = F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation, observation and staff interview, the facility failed to properly inspect, and maintain fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.1.1, 7.2.1.2, 7.2.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 02/20/2026 between 11:50 AM, it was revealed by observation that the fire extinguisher located in the Elevator Equipment Room was last inspected on 07/2025. On 02/20/2026 between 11:55 AM, it was revealed by observation that the fire extinguisher located in Beauty Salon was missing monthly inspection dates. On 02/20/2026 between 10:00 AM and 1:00 PM, it was revealed by a review of available documentation that no fire extinguisher inspection documentation log-sheet was available for review – to assist in confirming that all facility fire extinguishers are being inspected monthly. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0355	1. An audit was completed by Environmental Services locating placement of all fire extinguishers in the facility and a log sheet 2. A fire inspection log sheet was created to use during monthly inspections that will include locations of all fire extinguishers to ensure they are inspected. Education provided to Maintenance Director and designated staff that complete monthly inspections. Viking will be in facility on 3/12/26 and staff will meet with them to ensure facility record of fire extinguishers matches their record. 3. Monthly log documenting completion and tag documentation will be audited by Maintenance Director in March and will be reviewed at upcoming Safety Meeting 3/26/26. 4. Maintenance Director is responsible for monitoring compliance. 5. Monthly fire inspection log sheet will be completed on each month going forward. Completion of form 3/6/26.	03/06/2026
K0712 SS = F	Fire Drills	K0712	1. March fire drill was completed on 3/5/26 and	03/06/2026

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K0712 SS = F	Continued from page 5 CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1, 4.7. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 02/20/2026 between 10:00 AM and 1:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that a fire drill was conducted for 1st shift – Q1 (2025). On 02/20/2026 between 10:00 AM and 1:00 PM, it was revealed by review of available documentation that documentation presented for review exhibited that 2nd and 3rd shifts had patterning of date(s) and timestamp(s) as to when drills were conducted. On 02/20/2026 between 10:00 AM and 1:00 PM, it was revealed by review of available documentation that documentation presented for review identified that 3rd shift – Q2 did not have a timestamp to confirm when that drill was conducted. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K0712	Continued from page 5 documentation and activation sheet from Custom Alarm was obtained. Fire drill schedule for 2026 was reviewed and updated to ensure no patterning occurs moving forward. 2. Education was provided to Maintenance Director on required documentation for fire drills. 3. Fire drill schedule will be reviewed at monthly Safety Meetings on an ongoing basis to ensure completion, documentation received, and that no patterning occurs during drills. 4. Maintenance Director is responsible for monitoring compliance. 5. Education, appropriate completion and documentation of a drill and updated schedule were completed on 3/6/26. Monitoring will be completed on an ongoing basis through Safety Committee.	
K0761 SS = F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and	K0761	1. Weather stripping was placed on door 24 on 3/6/26 and Maintenance Director ensured that door self-closed and sealed after application. 2. Education will be provided to Maintenance Director and all staff on appropriate closure of fire doors and process if not closing properly. This will be reviewed at upcoming monthly Safety Meeting 3/26/26.	04/01/2026

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K0761 SS = F	Continued from page 6 Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1, 5.2.15, NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section(s), 5.2, 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/20/2026 between 12:05 PM, it was revealed by observation that Fire Door assembly (# 24) did not self-close and seal that opening upon testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0761	Continued from page 6 3. Annual door inspections will continue on an ongoing basis. Safety Committee quarterly safety inspections will continue on an ongoing basis. Fire doors will continue to be monitored with monthly fire drills. 4. Maintenance Director is responsible for monitoring compliance. 5. Weather stripping was placed on door on 3/6/26. All staff education will be completed by 4/1/26	
K0914 SS = F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM	K0914	1. Annual door inspection was completed on 11/14/25 with several electrical outlets not passing inspection. Egan was contacted after inspection completed to assess and provide bid to facility. Bid was received on 1/30/26 and approved on 2/2/26 to proceed with work. Egan electrician in facility on 2/20/26 and completed repairs to electrical outlets on 3/4/26. 2. Facility will continue with annual electrical receptacle testing and proceed with repair of any receptacle that does not pass inspection. Records of will be maintained on if failure and plan for remedy until completed. 3. Schedule for safety inspections will continue to be discussed monthly at Safety Committee meetings. Repairs	03/04/2026

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K0914 SS = F	Continued from page 7 test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/20/2026 between 10:00 AM and 1:00 PM, it was revealed by a review of available documentation that findings / failures noted in the annual electrical outlet testing documentation, completed 11/14/2025, had not been addressed / corrected. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0914	Continued from page 7 will be documented in Safety Committee minutes. 4. Maintenance Director is responsible for monitoring compliance. 5. Repair of electrical receptacles was completed on 3/4/26.	
K0918 SS = F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual	K0918	1. Monthly generator load test was completed for March on 3/3/26 and documented by Director of Maintenance. 2. Education was provided to Maintenance Director on ensuring documentation of generator monthly load testing is maintained. 3. Completion of March documentation was reviewed by Co-Executive Director and will be audited at monthly Safety Meetings in March and April. Testing will continue to be scheduled and discussed at monthly Safety Meetings. 4. Maintenance Director is responsible for monitoring compliance. 5. Monthly testing and appropriate documentation for March was completed on 3/3/26.	03/03/2026

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K0918 SS = F	Continued from page 8 transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.3, 8.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/20/2026 between 10:00 AM and 1:00 PM, it was revealed by a review of available documentation that documentation presented for review identified that the most recent monthly load testing occurred in Dec. 2025. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0918		
K0921 SS = F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with	K0921	1. Inventory of PCREE in resident rooms was completed on 3/5/26. A policy was completed on 3/6/26 on facility PCREE program. Maintenance Director in process of obtaining manufacturer guidelines for PCREE currently in facility and will be inspecting each piece of equipment as determined and will record and maintain inspections in PCREE binder. 2. Education will be provided to Maintenance Director and facility staff on implementation of PCREE program to ensure that any care related electrical equipment is inspected and maintained per facility policy.	04/01/2026

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K0921 SS = F	Continued from page 9 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed initiate an electrical equipment – testing and maintenance program in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/20/2026 between 10:00 AM and 1:00 PM, it was revealed by a review of available documentation that no documentation was presented to confirm that a PCREE program was in place. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0921	Continued from page 9 3. Policy and program will be reviewed at upcoming Safety Meeting on 3/26/26. Maintenance Director and Safety Committee will continue to implement and update policy and program moving forward and discuss at monthly Safety meetings. 4. Maintenance Director is responsible for monitoring compliance. 5. PCREE will continue to be an ongoing program and will be implemented and maintained moving forward. Education of all staff will be completed by 4/1/26.	
K0923 SS = F Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and	K0923	1. Combustible material was removed from oxygen storage room immediately on date of inspection: 2/20/26. On that date, signage was placed to ensure no combustible material is in oxygen storage room. 2. Education will be provided to licensed staff, TMAs and nursing secretary to ensure no combustible material is in oxygen storage room. Policy reviewed and remains appropriate.	04/01/2026

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K0923 SS = F Bldg. 01	Continued from page 10 ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/20/2026 between 12:15 PM, it was revealed by observation that in the Med Gas (O2) Storage Room there was combustible storage positioned less-than 5	K0923	Continued from page 10 3. Nursing secretary will audit oxygen room weekly for four weeks to ensure compliance is maintained. 4. Maintenance Director and Director of Nursing are responsible for monitoring compliance. 5. Education and auditing will be completed by 4/1/26.	

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K0923 SS = F Bldg. 01	Continued from page 11 feet from the O2 storage vessels. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0923		