DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8OMN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00104

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245431**

2. STATE VENDOR OR MEDICAID NO. (L2) **304240500**

3. NAME AND ADDRESS OF FACILITY
(L3) **FIELD CREST CARE CENTER**
(L4) **318 SECOND STREET NORTHEAST**
(L5) **HAYFIELD, MN** (L6) **55940**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **1/23/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 03/28/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/28/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
____

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245431

March 28, 2017

Ms. Cheryl Gustason, Administrator
Field Crest Care Center
318 Second Street Northeast
Hayfield, MN 55940

Dear Ms. Gustason:

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

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

Effective January 13, 2017 the above facility is certified for or recommended for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 28, 2017

Ms. Cheryl Gustason, Administrator
Field Crest Care Center
318 Second Street Northeast
Hayfield, MN 55940

RE: Project Number S5431028

Dear Ms. Gustason:

On December 20, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 8, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On January 23, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 10, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 8, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 13, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 8, 2016, effective January 13, 2017 and therefore remedies outlined in our letter to you dated December 20, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245431 Y1	A. Building B. Wing Y2	1/23/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 55940

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0176	Correction	ID Prefix F0278	Correction	ID Prefix F0315	Correction
Reg. # 483.10(c)(7)	Completed	Reg. # 483.20(g)-(j)	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	01/13/2017	LSC	01/13/2017	LSC	01/13/2017
ID Prefix F0332	Correction	ID Prefix F0356	Correction	ID Prefix F0431	Correction
Reg. # 483.45(f)(1)	Completed	Reg. # 483.35(g)(1)-(4)	Completed	Reg. # 483.45(b)(2)(3)(g)(h)	Completed
LSC	01/13/2017	LSC	01/13/2017	LSC	01/13/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 3/27/2017	SIGNATURE OF SURVEYOR 10160	DATE 1/23/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/8/2016	☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245431	A. Building 01 - MAIN BUILDING 01 B. Wing	1/10/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 55940

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 12/06/2016	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 12/30/2016	ID Prefix Reg. # NFPA 101 LSC K0751	Correction Completed 12/30/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 03/27/2017	SIGNATURE OF SURVEYOR 37008	DATE 01/10/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/6/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8OMN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00104

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245431**

2. STATE VENDOR OR MEDICAID NO. (L2) **304240500**

3. NAME AND ADDRESS OF FACILITY
(L3) **FIELD CREST CARE CENTER**
(L4) **318 SECOND STREET NORTHEAST**
(L5) **HAYFIELD, MN** (L6) **55940**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/08/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 12/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/30/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 20, 2016

Ms. Cheryl Gustason, Administrator
Field Crest Care Center
318 Second Street Northeast
Hayfield, MN 55940

RE: Project Number S5431028

Dear Ms. Gustason:

On December 8, 2016, a standard 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 17, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions

are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 March 8, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 8, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	**318 SECOND STREET NORTHEAST HAYFIELD, MN 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
F 000	INITIAL COMMENTS 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a self-administration of medication assessment was completed for 1 of 1 resident (R30) observed to have self-administer a nebulizer treatment. Findings include: R30's Admission Record, dated 10/19/16, indicated R30 was diagnosed with Pneumonia, cerebral infraction (stroke), hypertension and atrial fibrillation. R30's quarterly Minimum Data Set (MDS) dated 10/17/16, indicated R30 was severely impaired	F 176	Field Crest Care Center respects the residents' right to self-administer drugs after the interdisciplinary team has determined that this practice is safe. The policy for self-administration of medications was reviewed and found appropriate. Residents who prefer to take medications independently will be allowed to do so after 1) an assessment has been done showing the resident is capable of safely self-administering medications and 2) the physician has written an order for self-administration.	1/13/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/23/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 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
F 176	Continued From page 1 and required extensive assistance with bed mobility, transfers, dressing and toileting, personal hygiene, walking in her room and in the corridor, and was independent with eating. R30's Physician's Order Sheet, dated on 12/8/16, indicated an order for DuoNeb; (ipatroropium-Albuterol) 1 vial dose nebulizer QID (four times a day) and Q4H (every four hours) for SOB (shortness of breath), May self-administer neb after nursing to start, stop, document and store (this was not included on the medication orders prior to 12/8/16). On 12/6/16, at 4:02 p.m. Licensed Practical Nurse (LPN)-A was observed to set up nebulizer for R30. After setting up and stating the nebulizer treatment LPN-A left R30 alone in her room seated in her recliner. On asking LPN-A when she returned minutes later, LPN-A stated she was going to get another nebulizer for another resident then come back. LPN-A was asked if R30 has a self-administration order. LPN-A stated she was unaware of whether she has one or not. Document review found no assessment for R30 to self-administer medication. On 12/06/16, at 4:28 p.m. LPN-A stated that it was her normal routine for R30, to set up, leave and come back in ten minutes when giving the nebulizer treatment. On 12/7/16 1:41 p.m. Director of Nursing (DON) interviewed and verified that there was no order for self-administration of medication when LPN-A administered nebulizer to R30. After inquiring about the self administration assessment the DON gave the surveyor a newly completed document at 4:02 p.m. the DON provided a	F 176	The care plan will reflect who will be responsible for storage, documentation, and the location of drug administration. The appropriateness of a resident self-administrating drugs will be reviewed at least quarterly and more often as necessary. During the January 5, 2016 mandatory meeting, the nurses and trained medication aides will be reinstructed on 1) the residents' right to self-administer medications 2) the regulatory requirement for a physician's order and interdisciplinary assessment of capability before a resident is permitted to self-administer medications and 3) that the care plan must reflect who will be responsible for storage, documentation, and the location of drug administration. The records of all residents who self-administer medication will be audited to assure appropriate assessments, care planning and physician orders. Resident number 30 - The resident has been assessed and found capable of being left alone during nebulizer treatments. The physician has written an order for self-administration of the nebulizer treatments after set-up by the nursing staff. The staff will continue to be responsible for setting up the nebulizer treatments, storage of the nebulizer medication/ equipment, and documentation of the medication administration. The care plan was reviewed and revised. The resident's ability to safely self-administer nebulizers	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 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
F 176	Continued From page 2 document entitled Medication/Nebulizer Self Admin. Safety Screen effective date 12/7/16 at 9:18 a.m. and Physician's Telephone Orders signed by attending physician 12/7/16.	F 176	will be reviewed during the interdisciplinary care conference and with changes in condition. The Director of Nurses/designee will monitor compliance with self-administration of medication requirements through observation and record review. The records of all residents with orders for nebulizer treatments will be reviewed to ensure that those who are capable of self-administering the medication have the appropriate assessments, physician orders, and care plans. For the next three months, resident who are admitted with nebulizer treatments and those with new orders for nebulizer treatments will be monitored to ensure that there are related assessments, orders and care plans consistent with regulatory guidelines and facility policy. Compliance will be monitored at the January quarterly Quality Assurance and Improvement Committee meeting.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that	F 278		1/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 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
F 278	Continued From page 3 the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to accurately code a quarterly Minimum Data Set (MDS) for 1 of 3 residents (R1) reviewed for activities of daily living (ADLs). Findings Include: R1's Minimum Data Set (MDS) quarterly assessment dated 11/6/16, identified R1 required extensive assistance of two staff members for toileting. R1's Minimum Data Set (MDS) quarterly assessment dated 8/6/16, identified R1 was totally total dependent on staff for toileting.	F 278	Field Crest Care Center staff routinely complete assessments that accurately reflect the residents' status. Assessments are completed according to CMS guidelines as outlined in the User's Manual for the Resident Assessment Instrument. A registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals and signs to certify that the assessment is completed. Each individual who completes a portion of the assessment signs to certify the accuracy of that portion of the assessment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 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
F 278	Continued From page 4 R1 was observed during cares on 12/06/2016, at 3:28 p.m., two staff members checked R1 for incontinence of bowel movement and repositioned her in the bed. R1 was observed to be totally dependent on staff for toileting and repositioning. On 12/06/2016, at 3:15 p.m. nursing assistant (NA)-A stated R1 required total assistance for toileting. On 12/07/2016, at 10:59 a.m. registered nurse (RN)-A stated R1 was checked and changed for toileting. RN-A stated R1 should have been coded as total assistance for toileting on the quarterly MDS dated 11/6/16.	F 278	The policies and procedures for completing the minimum data set (MDS), including data gathering, were reviewed and found appropriate. The staff completing the MDS assessment 1) are qualified to assess relevant care areas 2) are knowledgeable about the resident's status and needs 3) have been trained to accurately document the resident's medical, functional and psychosocial needs and 4) know the importance of identifying the residents' strengths and providing services to maintain or improve their medical status, functional abilities, and psychosocial status. The policies and procedures for completing the minimum data set (MDS), including data gathering, were reviewed and found appropriate. The MDS software populates data from the certified nursing assistants (CNAs) electronic entries verifying the residents' functional status. The MDS coding includes the residents' capability to complete the activities of daily living (ADLs) and the amount of staff support needed to complete the tasks. The MDS Coordinator has received formal training on completion of the Resident Assessment Instrument with a focus on MDS coding. To be aware of changes in the ADL coding documented by the CNAs, the MDS Coordinator will now compare the current data with the previous MDS coding. Any coding changes will be investigated to ensure that the changes accurately reflect	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 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
F 278	Continued From page 5	F 278	the resident's current functional status for the ADLs coded in MDS Section G – bed mobility, transferring, walking in room and corridor, locomotion on and off the unit, eating, toilet use, and personal hygiene. The certified nursing assistants receive routine counseling/education regarding the criteria for coding the amount of staff assistance needed in performing ADL tasks (supervision, limited assistance, extensive assistance, totally dependent). Through small group and one-on-one counseling, the nursing assistants will be reeducated on the coding of resident self-performance of ADLs with a focus on toileting. The electronic ADL charting program includes guidance for the CNAs on appropriate coding of functional status on the MDS. The significance of the MDS and accurate coding of ADLs is included as part of the new employee orientation. The MDS Coordinator will routinely check the current coding with previous MDS entries. Any changes in the residents' ADL status will be investigated to ensure the coding changes accurately represent a change in function. Resident number 1 has a neurogenic bladder and bowel and does not use the toilet or commode. The resident does not participate in managing her indwelling catheter. Her bowels move after routine insertion of a suppository, and although she can assist with positioning herself in bed on the incontinent pad, she does not participate in the hygiene required after	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 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
F 278	Continued From page 6	F 278	the bowel movement. The nursing assistants have been reminded to code the resident's toileting (totally dependent) and bed mobility (needs extensive assist) status separately for MDS purposes. The MDS coding for toileting will be corrected on subsequent MDS assessments. The care plan has been reviewed and found to accurately reflect the resident's ADL care needs. To monitor compliance, the Director of Nurses/designee will audit the accuracy of MDS coding for bed mobility and toileting for all annual and quarterly assessments completed for three weeks. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the January quarterly Quality Assurance and Improvement Committee meeting.	
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 315		1/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	**318 SECOND STREET NORTHEAST HAYFIELD, MN 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
F 315	Continued From page 7 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess need for indwelling catheter to manage urinary incontinence and provide a detailed medical justification for the continued use of the indwelling catheter for 1 of 1 resident (R34) reviewed for urinary catheter use. Findings include: R34's has diagnosis of Retention of Urine-Unspecified with onset date of 5/13/16, Dementia Without Behavioral Disturbance according to the face sheet. Admission Minimum Data Set (MDS) dated	F 315	Based on the resident's comprehensive assessment, Field Crest Care Center ensures that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. The facility ensures that each resident who is incontinent of urine is identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible. A resident who enters the facility without an indwelling catheter is not catheterized	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 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
F 315	Continued From page 8 5/20/16 included indwelling catheter and no toileting program. Quarter MDS dated 11/20/16 also included indwelling catheter and not toileting program. During an interview with Registered Nurse (RN)-B on 12/7/16 12:46 p.m. stated that R34 was admitted from Assisted Living with the indwelling Foley catheter (device used to manage urine from the bladder). During review of progress notes dated 10/10/16, 8/10/16, 7/11/16,and 6/8/16 indicates that the resident had an indwelling catheter related to urinary retention. Urology document dated 11/25/16 indicates placement of indwelling Foley catheter after failed attempts at self-catheterizations and medication regimen while living alone in a Senior Care Center. R34's most current urology notes dated 11/25/14. On asking for more current urology visit none was provided. During an interview on 12/8/16 10:54 a.m. Director of Nursing stated that the Certified Nurse Practitioner (CNP) was here and stated the catheter is used for a neurogenic bladder and will not replace. Surveyor asked for the documentation justification for the CNP stating that the catheter was being used for that. No documentation was provided. Facility policy entitled Indwelling Urinary Catheters Protocol dated 11/2/11 reads appropriate indications for continuing use of an indwelling urinary catheter beyond 14 days may include the following: urinary retention cannot be treated or corrected medically or surgically	F 315	unless the resident's clinical condition demonstrates that catheterization is necessary. When a resident is admitted with an indwelling catheter, attempts are made to discontinue use of the catheter whenever possible. The policies and procedures for assessing urinary/bowel function, incontinence, and catheter use were reviewed and found appropriate. Bowel and bladder function is considered an important part of the resident's comprehensive assessment and is recognized as having a significant impact on the residents' quality of life. During the January 5, 2016 mandatory meeting, the licensed staff will be instructed on 1) the importance of ensuring there is a detailed medical justification for use of an indwelling catheter and 2) the need to request that the physician document a diagnosis justifying catheter use with referral to a urologist if indicated. Resident number 34 – The resident's indwelling catheter was removed December 8, 2016. The resident states she does not feel an urge to void and is intermittently catheterized when routinely ordered bladder scans indicate a post void residual in excess of 200 cc of urine. The care plan has been updated to reflect discontinuation of the indwelling catheter and the need for monitoring the resident's bladder function and urine output.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 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
F 315	Continued From page 9 characterized by documented post void residual, inability to manage the retention/ incontinence with intermittent catheterization.	F 315	Compliance will be monitored by the Director of Nursing/designee through record review of all residents with indwelling catheters to ensure that there is a detail medical justification for catheter use. For the next 90 days, the records of newly admitted residents with indwelling catheters will be audited to ensure that there is adequate documentation justifying use of the catheter. Compliance will be monitored at the January quarterly Quality Assurance and Improvement Committee meeting.	
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were administered without errors for 2 of 5 residents (R22 & R9) observed for medication administration. This resulted in a medication error rate of 13 percent. Findings include: R22 was observed to receive medications during administration on 12/7/16 at 7:18 a.m. when Licensed Practical Nurse (LPN)-B administered Fosamax 70 milligrams (mg) (less then 8 ounces of water used) used for osteoporosis to R22. LPN-B gave R22 a cup of water to drink with	F 332	Field Crest Care Center has policies and procedures requiring that the preparation and administration of drugs and biologicals are in accordance with 1) physicians' orders 2) manufacturers' specifications and 3) accepted professional standards and principles. The goal is to have a medication error rate of less than 5% and be free of all significant medication errors. The medication administration policies and procedures were reviewed and found appropriate. During the January 5, 2016, mandatory meeting, the licensed nurses	1/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 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
F 332	Continued From page 10 medication and encouraged her to sit up in her chair for a half hour. R22's current Physician's Orders read Fosamax 70 mg by mouth one-time per week (Wednesdays); take 30 minutes before first food of the day and other medications with eight ounces of water. Interview with LPN-B following administration of medication to R22 confirmed she gave four ounces of water and not the ordered 8 ounces. On 12/7/16 at 7:57 a.m. LPN-B had been observed to administered R22 Omeprazole 40 mg, gastroesophageal reflux disease (GERD), calcium carbonate 500 mg one and one-half tabs (total of 750 mg) even though the physicians order states "500 mg three times per day", After the medications were taken by R22's breakfast tray was delivered at which time LPN-B explained to R22 that she could not eat for another 15 minutes. Even though the doctors order for Omeprazole 40 mg was to wait 3 minutes prior to eating. At 8:18 a.m. R22 was observed fifteen minutes after receiving Omeprazole to eat her meal. R22's current Physician Orders read omeprazole 40 mg by mouth every day-give 30 minutes prior to breakfast, calcium carbonate 500 mg by mouth three times a day. On 12/7/16 at 8:04 a.m. LPN-B confirmed the Medication Administration Record (MAR) reads give 30 minutes before meals for omeprazole. Also the directions on the calcium carbonate was incorrect compared to the physicians most current orders. R9 had been observed to receive medications during a medication pass on 12/7/16 at 8:10 a.m.	F 332	and trained medication assistants will be instructed on the importance of 1) following physician orders for administering medications with a specified amount of liquid 2) following orders for administering medications before/after/with meals 3) comparing the medication container label with the medication administration record (MAR) and 4) applying the adhesive sticker to the medication container alerting the staff to refer to the MAR when there are changes in orders. The consultant pharmacist has agreed to meet with the staff in the near future to reinforce standards of practice on the above issues. To monitor compliance, during the next three weeks the Assistant Director of Nurses/designee will randomly check the accuracy of medication label containers and observe medication administration for twenty residents including those who have orders for a specified amount of fluid to be given with the medication and those who have medications ordered before/after/with meals. Residents number 9 and 22 will be included in the observations. If inaccurate medication labels or medication errors are observed, additional auditing and staff training will be done. Medication errors will continue to be tracked according to facility procedure and evaluated for the need for corrective action. Compliance will be reviewed during the January quarterly Quality Assurance and Improvement Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	**318 SECOND STREET NORTHEAST HAYFIELD, MN 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
F 332	Continued From page 11 Trained Medication Aide (TMA)-A was observed during a morning medication administration to give, Mira lax 17 grams in water, Prilosec 40 mg, folic acid, cranberry capsule, (urinary tract infection prophylactic) Tylenol, Senna used for constipation. R9's medication were crushed, Prilosec capsule opened and poured in cup with applesauce, Mira lax in 8 oz juice. R9 observed to have eaten 75 percent of meal when medication was administered. R9's current Physicians Orders reads Mira lax 17 grams by mouth in 8 ounces of fluid daily for constipation, Prilosec 40 mg by mouth daily for gastrointestinal prophylaxis; give ½ hour before meal however this was given while the resident ate breakfast, folic acid 1 mg by mouth daily, cranberry pill 450 mg two times a day for recurrent Urinary tract infections(UTI), Tylenol 500 mg two tablets by mouth three times a day for pain, Senna-s 8.6-50 mg 2 tablets by mouth three times a day for constipation. 12/7/16 8:31 a.m. TMA-A confirmed MAR reads give Prilosec before breakfast TMA-A stated usually gives in room before breakfast. Interview with director of nursing (DON) on 12/7/16 at 1:03 p.m. DON's expectation to give Fosamax with 8 oz water as the order states and Prilosec give 30 minutes before meals as ordered. Facility policy, Medications Administration dated 3/2016 reads; To provide services that assure accurate acquiring, receiving, dispensing and administrating of all drugs.	F 332	meeting.	
F 356	483.35(g)(1)-(4) POSTED NURSE STAFFING	F 356		1/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 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
F 356 SS=C	Continued From page 12 INFORMATION	F 356		

483.35
(g) Nurse Staffing Information
(1) Data requirements. The facility must post the following information on a daily basis:

(i) Facility name.

(ii) The current date.

(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

(A) Registered nurses.

(B) Licensed practical nurses or licensed vocational nurses (as defined under State law)

(C) Certified nurse aides.

(iv) Resident census.

(2) Posting requirements.

(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.

(ii) Data must be posted as follows:

(A) Clear and readable format.

(B) In a prominent place readily accessible to residents and visitors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	**318 SECOND STREET NORTHEAST HAYFIELD, MN 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
F 356	Continued From page 13 (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to post nursing hours as directed by the Centers for Medicare/Medicaid Services (CMS). This has the potential to affect the entire facility. Findings Include: On 12/5/16, at 12:32 p.m., the daily nursing hours posted for public display were dated 12/4/16 with a census of 34 (this was the day prior to this observation). On 12/5/16, at 12:37 a.m., during an interview with the staffing coordinator, she stated that Director of Finance completes daily staffing/resident census. On 12/5/16 at 12:43 p.m., during an interview with the Director of Finance she stated that she updates the census before she leaves for the day, the census is as of midnight and the staffing coordinator updates staffing hours. On weekends if census changes, staff can cross out and change on sheet. Director of Finance stated census at midnight on 12/5/16 was 34, now 35 since they had a new admission. Policy review revision date March 2016 reads; staffing coordinator is responsible for posting the staffing information and making changes in a	F 356	As required Field Crest Care Center posts the following information in a clear and readable format in a prominent location: 1. Facility name. 2. The current date. 3. The total number and the actual hours worked by the registered nurses, licensed practical nurses, and certified nursing assistants directly responsible for resident care per shift: 4. Resident census. The policy and procedures for preparing and posting the staffing/census information were reviewed and found appropriate. The night shift charge nurses has been reinstructed on the need to post the staffing information daily and in a timely manner. The Director of Finance will monitor compliance through random weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 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
F 356	Continued From page 14 timely manner.	F 356	checks of the timeliness of the staff information posting for 30 days. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed during the January quarterly Quality Assurance and Improvement Committee meeting.	
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be	F 431		1/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 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
F 431	Continued From page 15 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to administer medication immediately after being set-up for 1 of 1 resident (R49) who was insulin dependent. This had the potential to affect residents who are insulin dependent. Findings included: R49 had two syringes of pre-drawn up insulin located in the medication cart on 12/6/16 at 5:17 p.m. This was found while completing a medication pass with Licensed practical nurse (LPN)-A. LPN-A was asked about the practice of pre-filling syringes before giving them to the	F 431	Field Crest Care Center provides pharmaceutical services to meet the needs of each resident. The facility contracts with a licensed consultant pharmacist who collaborates with facility staff to coordinate pharmaceutical services and guide the development and implementation of related procedures to ensure the accurate acquiring, receiving, dispensing, storing and administering of all drugs and biologicals. The pharmacist has established a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and determines	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 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
F 431	Continued From page 16 resident. LPN-A verified that it was insulin pre-filled for R49. LPN-A was asked when she was going to complete the administration of the pre-filled insulin syringes. LPN-A stated, "After supper, this is my normal routine [to set up the two doses together] because supper time is busy." LPN-A confirmed that the one syringe was Humalog for R49 to be given after supper was eaten and the second syringe was Lantus insulin to be given to R49 at bedtime. Physician orders included Novolog insulin 16 units subcutaneous with supper and Lantus insulin 28 units subcutaneous in evening (P.M.). During an interview with Registered Nurse (RN)-B on 12/7/16 at 12:54 p.m. concerning pre-filling of insulin prior to giving, stated, "Not ok to preset medications up, not standard practice." During an interview with the Director of Nursing (DON) on 12/7/16 at 1:01 p.m., she said that the expectation is to administer medication right away after set up. During phone interview with the facility consulting pharmacist on 12/08/16 at 11:34 a.m. it was their expectation to not draw up insulin medication until just prior to giving to resident. Policy entitled Medication Administration revised 3/16 reads under Administration Requirements: are to distribute the medication to the resident in a timely manner.	F 431	that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals are labeled in accordance with currently accepted professional principles, and include the appropriate instructions and expiration dates when applicable. In accordance with State and Federal laws, all drugs and biologicals are stored in locked compartments under proper temperature controls. The facility provides separately locked and permanently affixed compartments for storage of controlled drugs. The facility utilizes only persons authorized under state requirements to administer medications and have access to medication rooms/carts. Outdated and expired drugs and biologicals are routinely discarded according to accepted practice standards. During the January 5, 2016 mandatory meeting, the licensed nurses will be reinstructed on the facility policies and the standards of practice for administering insulin in a timely manner after the medication is drawn from a multi-dose vial. The consultant pharmacist plans to meet with the staff in the near future to address medication administration standards of practice including insulin administration. To monitor compliance, during the next three weeks, the Assistant Director of Nurses/designee will randomly observe the insulin set up procedure for the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	**318 SECOND STREET NORTHEAST HAYFIELD, MN 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
F 431	Continued From page 17	F 431	residents who receive insulin drawn from a multi dose vial. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be monitored at the January quarterly Quality Assurance and Improvement Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	**318 SECOND STREET NORTHEAST** **HAYFIELD, MN 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
K 000	INITIAL COMMENTS FIRE SAFETY 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division on Dec. 06,2016. At the time of this survey, Fieldcrest Care Center was found not in substantial 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/23/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	**318 SECOND STREET NORTHEAST** **HAYFIELD, MN 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
K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Fieldcrest Care Center is a 1-story building. 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. This facility is inspected as one building. 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 45 beds and had a census of 35 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 363	NFPA 101 Corridor - Doors	K 363		12/6/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	**318 SECOND STREET NORTHEAST** **HAYFIELD, MN 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
K 363 SS=E	Continued From page 2 Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 363	The doors to the flusher room in wing 1 and the hallway door to the link wing have been lubricated and adjusted such that the doors latch when closing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	**318 SECOND STREET NORTHEAST** **HAYFIELD, MN 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
K 363	Continued From page 3 hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. On facility tour between 09:00 AM and 01:00 PM on Dec. 6, 2016, based on observation and interview revealed or based on documentation review and interview that the findings include: It was observation that the door to Flusher room in Wing 1 and hallway door to the link wing does not latch when tested.	K 363	The Maintenance Director will be responsible for monitoring compliance with appropriate door closing. Secure door latching will be checked as part of the monthly fire drill procedures.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	**318 SECOND STREET NORTHEAST** **HAYFIELD, MN 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
K 363	Continued From page 4 This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartments. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 363		
K 372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. On facility tour between 09:00 AM and 01:00 PM	K 372	The openings in the smoke barriers in wing 1 will be sealed with intumescent fire barrier caulk. The smoke barriers will be inspected after construction which may penetrate the barrier with pipes or wiring. The Maintenance Director will monitor compliance by inspecting smoke barriers after construction which poses a risk of penetrating the barrier with pipes, wiring, etc.	12/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	**318 SECOND STREET NORTHEAST HAYFIELD, MN 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
K 372	Continued From page 5 on Dec. 6, 2016, based on observation and interview revealed or based on documentation review and interview that the findings include: It was observed that wing (1) has that penetrations around piping in the smoke barrier. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 372		
K 751 SS=D	NFPA 101 Draperies, Curtains, and Loosely Hanging Fabr Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 This STANDARD is not met as evidenced by: Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48	K 751	To comply with the safety code for flame spread rating, the curtains in the sun room will be sprayed with BanFire Poly Retardant which was ordered from the RDR Technology company December 15, 2016. According to tracking logs, the retardant spray has been shipped and it will be applied in a timely manner after it is received.	12/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELD CREST CARE CENTER	**318 SECOND STREET NORTHEAST** **HAYFIELD, MN 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
K 751	Continued From page 6 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 On facility tour between 09:00 AM and 01:00 PM on Dec. 6, 2016, based on observation and interview revealed or based on documentation review and interview that the findings include: It was observed that the curtain in the sun room do not have flame spread rating label on them. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 751	The Maintenance Director will monitor for compliance.	