



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 25, 2024

Licensee
Field Crest Assisted Living
305 4th Street Northeast
Hayfield, MN 55940

RE: Project Number(s) SL20885015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 2, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.

- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Renee L Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20885	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2024
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NAME OF PROVIDER OR SUPPLIER FIELD CREST ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 305 4TH STREET NE HAYFIELD, MN 55940
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL20885015-0</p> <p>On July 1, 2024, through, July 2, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 34 residents; 16 receiving services under the provider's Assisted Living Facility license.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.</p>	
0 800 SS=F	<p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of</p>	0 800		

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

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0 800	<p>Continued From page 1</p> <p>good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 2, 2024, at 8:45 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A and director of maintenance (DM)-F. During the tour, survey staff observed the following: 1. The door closer arm was disconnected on the fire rated door for the laundry room. The arm was reinstalled during the facility tour, but the door did not positively latch upon closing. 2. Door closer arms were disconnected on the fire rated doors for all three resident storage rooms and the mechanical room across from resident apartment 111. These fire doors did not self-close and positively latch. Fire rated doors must be maintained as designed to protect the opening in which they were installed and to protect adjacent spaces.</p>	0 800		

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0 800	Continued From page 2 3. The inspection tag for the backflow prevention device was dated 2000 in the boiler room. Backflow devices must be tested upon installation and at least annually thereafter by a certified backflow assembly tester. During the facility tour interview on July 2, 2024, at 10:15 a.m., LALD-A and DM-F verified these fire door assemblies were not properly maintained. DM-F verified annual inspections had not been recorded on the backflow prevention device tag. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

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0 810	<p>Continued From page 3</p> <p>proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.</p> <p>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to meet the required evacuation drill frequency. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 2, 2024, the licensed assisted living director (LALD)-A and director of maintenance (DM)-F provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility.</p> <p>DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by a review of completed fire drill reports. Three fire drills were conducted in 2024. These</p>	0 810		

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0 810	Continued From page 4 drills were completed in March, April, and June, all during first shift. No fire drill records for 2023 were provided. During an interview on July 2, 2024, at 10:15 a.m., LALD-A and DM-F verified the evacuation drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 970		

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0 970	<p>Continued From page 5</p> <p>On , July 1, 2024, the surveyor reviewed the licensee's blank contract which included the following waivers of liability on page 12: "You acknowledge familiarity with the Apartment, the premises and services of [the licensee] and are willing to, and do, assue all risks associated with occupancy. You acknowledge that we are not an insurer of your safety. [The licensee] and our affiliates, employees and agents are not liable to you or to any other person for any loss or inconvenience of any kind, including personal injuries sustained by you or any other person, or any loss or damage to property of any kind, which is not the direct result of intentional or negligent acts in violation of applicable standards of care. We are not responsible for the actions of, or for any damages, injury or harm caused by third parties, such as other residents, family members, guests, intruders, or trespassers, who are not under out control. You agree to release, indemnify, defend and hold [licensee], their affiliates, employees, and agents harmless from any and all liability connected with your occupancy of the Apartment, except as limited herein. You further agree to indemnify, defend and hold us harmless from any and all liability caused by or related to your acts or the act of your agents, family members or guests."</p> <p>On July 2, 2024, at 3:30 p.m., registered nurse (RN)-B and administrator-A confirmed the contract required residents to waive the licensee's liability for health, safety, or personal property. RN-B confirmed the same contract was used for all residents living in the facility.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one</p>	0 970		

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0 970	Continued From page 6 (21) days	0 970		
01620 SS=D	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.</p> <p>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.</p> <p>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing client monitoring and reassessment, not to exceed 14 calendar days from the initial assessment for one of three residents (R1).</p>	01620		

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01620	<p>Continued From page 7</p> <p>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1 was admitted March 20, 2023, and had diagnoses including chronic obstructive pulmonary disease (COPD).</p> <p>R1's record included documentation of an initial comprehensive nursing assessment completed March 20, 2024, but lacked a 14 day assessment completed no more than 14 calendar days after initiation of services.</p> <p>On July 2, 2024, at 3:30 p.m., registered nurse (RN)-B stated she was unable to locate the 14 day assessment for R1. RN-B stated she completed assessments for the licensee's clients upon admission, within 14 days of admission, and every 90 days, or as needed. She was unsure why the 14 day assessment was not included in R1's resident record.</p> <p>The Resident Pre-Admission Assessment & Monitoring Process-Nursing policy, dated February 6, 2024, indicated the licensee will complete a resident reassessment no more than 14 calendar days after the initiation of services, and, if needed, finalize the service agreement.</p> <p>No further information was provided.</p>	01620		

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01620	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	<p>144G.70 Subd. 4 (f) Service plan, implementation and revisions to</p> <p>(f) The service plan must include:</p> <p>(1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;</p> <p>(2) the identification of staff or categories of staff who will provide the services;</p> <p>(3) the schedule and methods of monitoring assessments of the resident;</p> <p>(4) the schedule and methods of monitoring staff providing services; and</p> <p>(5) a contingency plan that includes:</p> <p>(i) the action to be taken if the scheduled service cannot be provided;</p> <p>(ii) information and a method to contact the facility;</p> <p>(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and</p> <p>(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident service plan</p>	01650		

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01650	<p>Continued From page 9</p> <p>included the required content for three of three residents (R1, R2, R3).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:</p> <p>R1's Service Plan dated March 13, 2024, indicated R1 received services including assistance with medication management and activities of daily living (ADLs).</p> <p>R2's Service Plan dated February 19, 2024, indicated R2 received services including assistance with medication management, and ADLs.</p> <p>R3's Service Plan dated February 19, 2024, indicated R3 received services including medication set-up by the registered nurse.</p> <p>R1, R2, and R3's service plans lacked the following required information: -the schedule and methods of monitoring staff providing services.</p> <p>On July 2, 2024, at 3:30 p.m., registered nurse (RN)-B stated they were unaware of the requirement to include the schedule and methods of monitoring staff providing services in the service plan for all of the licensee's residents.</p> <p>The licensee's Contents of Service Plans policy,</p>	01650		

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01650	Continued From page 10 dated August 11, 2021, indicated the service plan would include the schedule and methods of monitoring staff providing services to licensee residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were stored according to manufacturer's instructions for one of one medication refrigerator. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 2, 2024, at 8:00 a.m., the licensee's	01880		

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01880	<p>Continued From page 11</p> <p>medication refrigerator's daily temperature log was requested. Registered nurse (RN)-B stated they did not monitor or keep a log of the temperature of the medication refrigerator.</p> <p>In the presence of RN-B, the surveyor observed the contents of the medication refrigerator that included six unopened Humulin insulin pens.</p> <p>The manufacturer's instructions for Humulin pens indicated to store unopened Humulin pen in a refrigerator at 36°F to 46°F.</p> <p>The licensee's Storage of Medications policy, dated August 11, 2021, indicated the RN will develop an individualized medication management plan for the client that will address the storage of the client's medications according to manufacturer's recommendations.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01880		

Type: Full
Date: 07/01/24
Time: 10:21:52
Report: 8074241120

Food and Beverage Establishment Inspection Report

Page 1

Location:

Field Crest Assisted Living
305 4th Street Ne
Hayfield, MN55940
Dodge County, 20

Establishment Info:

ID #: 0039378
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074773266
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 50ppm at Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: milk
Violation Issued: No

Process/Item: Hot Holding
Temperature: 172 Degrees Fahrenheit - Location: chicken
Violation Issued: No

Process/Item: Hot Holding
Temperature: 167 Degrees Fahrenheit - Location: potatoes
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

All food comes from licensed nursing home kitchen.

Type: Full
Date: 07/01/24
Time: 10:21:52
Report: 8074241120
Field Crest Assisted Living

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8074241120 of 07/01/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____/____/____

Signed: _____

Establishment Representative

Signed:  _____

Andrea Kieffer

Rochester District Office