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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: COXB

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 **06/08/2015** (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:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

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

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 06/15/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/15/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
06/11/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245431

June 15, 2015

Ms. Cheryl Gustason, Administrator
Field Crest Care Center
318 Second Street Northeast
Hayfield, Minnesota 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 June 1, 2015 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 11, 2015

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

RE: Project Number S5431026

Dear Ms. Gustason:

On May 4, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 24, 2015 that included an investigation of complaint number . This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 8, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 29, 2015 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 April 24, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 1, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 24, 2015, effective June 1, 2015 and therefore remedies outlined in our letter to you dated May 4, 2015, 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, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245431	A. Building B. Wing	6/8/2015

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0164 Reg. # 483.10(e), 483.75(l)(4) LSC	06/01/2015	ID Prefix F0329 Reg. # 483.25(l) LSC	06/01/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	GPN/kfd	06/11/2015	10160	06/08/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/24/2015

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245431	A. Building B. Wing 01 - MAIN BUILDING 01	5/29/2015

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0017	Correction Completed 04/24/2015	ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 05/11/2015	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 05/11/2015
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 PS/kfd	Date: 06/11/2015	Signature of Surveyor: 25822	Date: 05/29/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 4/22/2015		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: COXB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00104

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(L1) **245431**
2.STATE VENDOR OR MEDICAID NO.
(L2) **304240500**

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(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 **04/24/2015** (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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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 :
Gail Sorensen, HFE NE II 05/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/10/2015 (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)

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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

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 4, 2015

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

RE: Project Number 5431026

Dear Ms. Gustason:

On April 24, 2015, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - 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
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 June 3, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 3, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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 July 24, 2015 (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 October 24, 2015 (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 electronic 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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 _____	04/24/2015

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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		6/1/15

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

Electronically Signed | 05/13/2015

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.

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	245431	A. BUILDING _____ B. WING _____	04/24/2015

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

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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide personal privacy during cares in a resident's room for 1 of 3 residents (R52) observed during cares. Findings include: R52 was observed on 4/22/15 from 1:04 p.m. to 1:30 p.m. while hospice provided wound care. Nursing assistant (NA)-A assisted Heartland Hospice registered nurse (RN)-Z to pivot transfer R52 to bed. No privacy was provided to shield R52 from direct vision through the hall door. After assisting R52 to lie in bed NA-A opened the hallway door to leave and stated she would ask about the privacy curtain. RN-Z undressed R52's lower extremity and left the room to obtain supplies. RN-Z opened the door to leave the room while RN-B stood in front of the bed to provide some form of privacy using the roommate ' s privacy curtain. At 1:30 p.m. RN-Z redressed R52 and positioned her on her back on the bed, opened the door and left. At 2:39 p.m. on 4/22/15 NA-B and NA-C entered the room to provide personal incontinence care for R52. Again R52's was not provided privacy when the hall door was opened. At 2:43 p.m. NA-B opened the hallway door and left the room	F 164	483.10(e) 483.75(l)(4) Tag F164 Field Crest Care Center staff respects the resident□s right to confidentiality of his or her clinical records and personal privacy including accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings with family and resident groups. The facility has policies and procedures appropriately addressing the residents□ right to privacy and confidentiality. During the May 6, 2015 mandatory meeting, all staff were reminded of the state and federal regulations and facility policies addressing residents□ privacy rights. The nurses and nursing assistants were instructed/informed regarding being sensitive to care delivery practices that could compromise resident dignity. Procedures to assure respect for the residents□ right to privacy during personal cares were reinforced (e.g., closing doors, pulling divider curtains, covering residents when in view from common areas, knocking before entering, providing personal cares/treatments out of view of	

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F 164	Continued From page 2 to obtain supplies. R52 was lying on the bed with the incontinence brief in full view of anyone walking past the doorway. At 2:44 p.m. NA-B re-entered the room and again did not provided complete privacy for R52. The quarterly minimum data set (MDS) dated 1/30/15 indicated R52 had a BIMS (brief interview of mental status) of 4 or severe cognitive impairment and indicated R52 required extensive assistance from staff for toileting needs and personal grooming. At 11:10 a.m. on 4/23/15 the director of nursing stated the facility did not have a policy related to personal privacy and added the privacy curtain should have been pulled to give R52 full privacy.	F 164	others). The residents right to privacy, confidentiality, and dignified treatment is included in the orientation training for new employees and is addressed during the annual mandatory inservice training. Investigation found that due to cleaning and room changes, the privacy curtain had been removed from the room where resident number 52 resides. The curtain has been replaced. The housekeeping staff have been informed that privacy curtains removed for laundering must be replaced immediately. The housekeeping carts will be stocked with a replacement curtain. The Director of Environmental Services/designee will monitor for compliance by checking curtain placement in rooms being cleaned in preparation for admission of a new resident. The supervisory nursing staff have been instructed be observant of resident privacy and to counsel with the direct care staff if privacy rights are compromised. If resident privacy concerns are ongoing, the licensed nurses will report the findings to the administrative staff. The Director of Nursing has discussed the residents right to privacy with the hospice agency providing services to resident number 52. The hospice agency staff was requested to inform the facility of missing privacy curtains or other equipment/supplies needed to ensure maximum privacy/comfort during care delivery.	
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		6/1/15

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F 329 SS=D	Continued From page 3 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview the physician failed to justify the ongoing use of an antidepressant without an attempt of a gradual dose taper twice in the first year of receiving Celexa and antidepressant medication for 2 of 5 residents (R41, R5) reviewed for unnecessary medications. Findings include: R41 was admitted to the facility on 7/29/14	F 329	483.25(l) Tag F329 Unnecessary Drugs Field Crest Care Center staff ensure that each resident□s drug regime is free from unnecessary drugs. The resident□s drug regime is reviewed by the staff, physician and consultant pharmacist to assure that medications are not used in excessive	

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F 329	Continued From page 4 according to the facility's Admission Record that included the diagnoses of dementia without behavioral disturbance, depressive disorder, and restless leg syndrome. R41's Minimum Data Set (MDS) dated 2/5/15 indicated severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of six and did not have behaviors. The MDS also indicated R41 had the ability to express ideas and wants and usually understood others. The Patient Health Questionnaire (PHQ-9) score was zero; depression symptoms were not present. R41's care plan last revised on 11/10/14 read, "The resident uses antidepressant medication r/t [related to] depression ..." The care plan instructed staff to administer antidepressant medications as ordered by the physician and monitor and document side effects and effectiveness every shift. The care plan identified mood monitoring for tearfulness, loneliness, and loss of interest. R41's physician admission orders dated 7/29/14 included Celexa 10 milligrams (mg) every day. The facilities April's medication administration record (MAR) included physician's orders for Celexa 10 mg daily. Physician recertification exam visit dated 10/22/14 identified R41's PHQ-9 score on 8/14/14 was zero and there were no behavior or mood concerns. The physical exam indicated mood and affect were appropriate. The physician note also identified depression as a diagnoses and read, "prior his wife reported his mood was a little irritable. He has been on Celexa for years. With stability of disease despite h/o [history of] recurrence, overall level of debility, and no side effects, no GDR [gradual dose reduction] ..." R41's Psychoactive Medication registered nurse (RN) Review dated 11/1/14 read, "Resident	F 329	doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued. The goal is to simplify medication regimens, identify the lowest effective dose of medications (especially psychotropic medications), and to discontinue the use of psychotropic medications whenever possible. Medications are reviewed by the consultant pharmacist monthly and by the attending physician/nurse practitioner during routine 30/60 day visits and more often as indicated. Based on the resident□s comprehensive assessment, Field Crest Care Center staff routinely identify target behaviors that justify the use of psychotropic medications. At the time of the quarterly care conference and more often if needed, residents receiving psychotropic medications are reassessed by licensed nurses and the social worker. The medication type/dose, behavior/mood symptoms, and other related information are reviewed to assure that the record continues to reflect adequate indications for use and that the dose tapering attempts are in compliance with regulatory guidelines. The interdisciplinary team also meets weekly to review significant resident condition/changes. Residents receiving psychotropic medications are reviewed with special attention given to residents who have had changes in	

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F 329	Continued From page 5 continues taking Celexa 10 mg daily for diagnosis of depression. Target behaviors include, tearful, loneliness, loss of interest. No noted target behaviors exhibited ...." Physician recertification exam visit dated 12/24/14 identified diagnoses of depression and read, " prior his wife reported his mood was a little irritable. He has been on Celexa for years. With stability of disease despite h/o [history of] recurrence, overall level of debility, and no side effects, no GDR ..." The visit note lacked mention or assessment of mood monitoring and status. The visit note also indicated R41 had a history of multiple falls. R41's Psychoactive Medication RN Review dated 2/5/14 read, "Resident continue taking Celexa 10 mg daily for target behaviors of tearfulness, loneliness, and loss of interest. Resident has shown no episodes of target behaviors in the last quarter... Per last PCP [primary care provider] visit mood is stable on medication with overall debility and no side effects no GDR [gradual dose reduction] is recommended." Physician recertification exam visit dated 2/25/15 identified PHQ-9 score of zero and identified and no behavior or mood concerns with no sleep concerns and identified the diagnoses of depression and read, "Prior his wife reported his mood was a little irritable. He has been on Celexa for years. With stability of disease despite h/o [history of] recurrence, overall level of debility, and no side effects, no GDR..." The physical exam read, "...mood/affect appropriate-very spunky today." The visit note also indicated R41 had a history of multiple falls. According to the facility's fall incident reports from January 2015 through April 2015, R41 had falls without significant injury on 1/8/15, 1/19/15, 2/16/15, and 3/23/15.	F 329	behavior symptoms, psychotropic medication/dosage changes, residents being considered for gradual dose reductions, and residents who are scheduled for a physician/nurse practitioner visit in the next seven days. The social worker/designee will document the findings of the team and the physician/nurse practitioner will be informed of pertinent findings/concerns. The Director of Nurses met with the Medical Director May 8, 2015 to discuss psychotropic medication reviews, dose reductions, and related documentation. The Medical Director will discuss with the nurse practitioner the need for more detailed medication assessments and documentation to reflect regulatory compliance. The Medical Director and the nurse practitioner will be provided with a copy of Federal Regulation 483.259(l) (Tag F329) addressing unnecessary drugs. The form used to communicate resident condition at the time of the physician/nurse practitioner certifications has been revised to include more detailed information on target behaviors and past psychotropic medication dose reductions as well as a reminder that federal regulations require documentation of the rationale including risks and benefits justifying the current dose or an explanation of why the severity and recurrence of the symptoms contraindicate a dosage taper. The licensed nurses have been updated on the changes.	

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F 329	Continued From page 6 The package insert of Celexa indicated drug may cause an increased risk of falls. During an interview on 4/23/15, at 9:01 a.m. RN-B verified R41 had been prescribed Celexa for depression and verified R41 had not exhibited any signs or symptoms of depression. RN-B stated, "We [facility] requested a dose reduction back in October [2014], they [physicians] didn't decrease the dose. We know he needs a dose reduction. We try to get them to do it." During an interview on 4/23/15, at 9:25 a.m. certified nurse practitioner (CNP)-A stated a dose taper had not been attempted with R41 because of advanced dementia and that the PHQ-9 had not given an entire picture. R5 was observed on 4/21/15 from 2:27 p.m. to 6:00 p.m. and again on 4/22/15 at 9:18 a.m. and 4/23/15 at 7:45 a.m. R5 was noted to be pleasant. Physician documentation of 1/19/15 listed diagnoses that included depression/anxiety/insomnia and cognitive impairment. The annual MDS dated 1/31/15 indicated memory impairment but no BIMS score, and indicated R5 displayed no hallucinations or delusions, but did occasionally display physical and verbal behaviors directed toward others without impact on others or risk of injury. R5 had an order dated 1/6/14 for Zoloft (antidepressant) 50 mg daily. It was learned that R5 had been on Zoloft since 2012. The care plan dated 2/10/15 indicated the Zoloft was given for symptoms of accusations against others and expression of "ready to die." The point of care behavior monitoring for 2/1/15 through 4/23/15 was reviewed. Documentation	F 329	Resident number 41 □ The resident□s medication regimen was reviewed by the nurse practitioner April 23, 2015. The resident□s Celexa dose was reduced from 10 mg every day to 10 mg every other day for 14 days and then discontinue the medication. The resident received the last dose of Celexa May 7, 2015. The RN reassessed the resident□s behavior symptoms May 11, 2015. No symptoms of depression were recently noted. The resident□s behavior/mood and response to the discontinuation of Celexa will be reviewed by the interdisciplinary team May 13, 2015. Any observed behavior/mood concerns will be communicated to the physician/nurse practitioner. The behavior/mood plan of care has been updated accordingly. Resident number 5 □ The resident will be visited by the nurse practitioner May 18, 2015. The resident□s medication regimen, behavior/mood, and the regulatory issues related to the use of Zoloft will be reviewed with the nurse practitioner. Discussion will include the possibility of a gradual dose reduction. The family will be informed of any medication order changes and the care plan will be revised as necessary. To monitor compliance, the social worker will track the required attempts of gradual dose reductions of psychotropic medications. The consultant pharmacist will continue to monitor compliance during the monthly medication reviews. Compliance will be reviewed at the	

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F 329	Continued From page 7 was noted per shift on each day. In February 2015 R5 displayed yelling/screaming 9 times, threatening behavior once, kicking/hitting once and rejection of care one time. In March R5 displayed grabbing twice. No other behavior was noted. April 1, through April 23, 2015 the documentation indicated R5 display yelling/screaming twice, abusive language once, frequent crying twice and pushing/ kicking/hitting/scratching/spitting on three shifts. The behavior note of 4/2/15 indicated the resident continued to have confusion, anxiety, behaviors of yelling out, throwing items, and demeaning aggression to staff and resistive to cares. The behavior note of 4/4/15 noted anxiety, paranoia of staff, yells out, and disruptive at times. Neither note described the behaviors as to frequency, effectiveness of medication, or if nonpharmacological interventions were attempted and successful. The notes did not describe the behavior of " ready to die, or accusations against others. The physician documented of 1/19/15 read, "Continues on a stable regimen of Zoloft. With severity and recurrence of disease, no GDR [gradual dose reduction] unless side effects/problems." The physician did not provide a rationale including risk and benefits for no tapering of Zoloft or an explanation of what "severity and recurrence of disease " meant, if an attempt at a dose taper was last done and if it failed. RN-B was interviewed on 4/23/15 at 1:52 p.m. RN-B stated R5 began to receive Zoloft 25 mg daily on 9/24/12 and that the dose was increased to 50 mg on 1/6/14 and not indication if a dose	F 329	quarterly Quality Assurance and Performance Improvement meetings.	

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F 329	Continued From page 8 taper had been attempted for past 13 15 months. RN-B stated the Zoloft was given for symptoms of tearfulness, accusations, and withdrawn behaviors. RN-B stated that there was no other information related to an attempted gradual tapering of the medication to be found.	F 329		

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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. 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 2000 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:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/13/2015

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and 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. 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 33 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 017	Continued From page 2	K 017		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide the proper corridor separation from use areas as required by 2000 NFPA 101 sections 19.3.6.1. This deficient practice could affect 5 out of 33 residents. Findings include: On facility tour between 8:15 AM and 11:15 AM on 04/22/2015, it was observed that the basement - staff training room is now an area open to the corridor and is not covered by automatic smoke detection interconnect with the building fire alarm system.	K 017	K017 An approved self-closing door has been installed in the opening between the staff training room and the corridor. The Maintenance Director will be responsible for monitoring compliance.	4/24/15

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 _____	**04/22/2015**

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 017	Continued From page 3 This deficient practice was confirmed by the Facility Maintenance Director (LP) at the time of discovery.	K 017		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 10 out 33 residents. Findings include: On facility tour between 8:15 AM and 11:15 AM on 04/22/2015, observation revealed, that the the following was found: 1. Basement - Storage room # 3-58 (over 50 sq ft) will not shut and latch; 2. Basement - Storage room # 3-59 (over 50 sq	K 029	K029 A self-closing/latching hinge has been installed on the basement storage room (#3-58) door. Flooring has been removed in the threshold of the opening to basement storage room (#3-59) allowing the door to self-close and latch. The hinge to the first floor storage room (#3-43) door has been adjusted; the door now self-closes and latches. The Maintenance Director will be responsible for monitoring compliance.	5/11/15

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 _____	**04/22/2015**

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

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K 029	Continued From page 4 ft) will not shut and latch; 3. 1st floor - Storage room # 3-43 (over 50 sq ft) will not shut and latch These deficient practices were confirmed by the Facility Maintenance Director (LP) at the time of discovery.	K 029		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25. This deficient practice could affect all 33 residents Findings include: On facility tour between 8:15 AM and 11:15 AM on 04/22/2015, review of the annual inspection report from Olympic, dated 10/27/14, indicated that the annual inspection was not done with-in 12 month period. The 2013 annual inspection was completed on 9/27/2014. This deficient practice was confirmed by the Facility Maintenance Director (LP) at the time of	K 062	K062 The fire alarm system inspections have been included in a electronic system that automatically sends notification alerts to the Maintenance Director for required scheduled tasks. The Olympic Fire Protection Company who is contracted to perform the alarm testing will be notified as necessary of the need for annual inspection. The Maintenance Director will be responsible for monitoring compliance.	5/11/15

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 _____	**04/22/2015**

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

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K 062	Continued From page 5 discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 062		