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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: DSET

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 July 1, 2013 (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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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):
Post Certification Revisit to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective June 24th, 2013, the facility is certified for 63 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Robin Lewis, HFE NEII 12/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/20/2013 (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
07/09/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5431 December 20, 2013

Ms. Cheryl Gustason, Administrator
Field Crest Care Center
318 Second Street Northeast
Hayfield, Minneosta 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 24, 2013, the above facility is certified for:

63 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 63 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

July 5, 2013

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

RE: Project Number S5431023

Dear Ms. Gustason:

On May 20, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 16, 2013. 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 July 1, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 26, 2013 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 May 16, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 24, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 16, 2013, effective June 24, 2013 and therefore remedies outlined in our letter to you dated May 20, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5431r13.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245431	A. Building B. Wing	7/1/2013

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 **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **06/24/2013**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **06/24/2013**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **06/24/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **06/24/2013**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/GPN	07/05/2013	30238	07/01/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/16/2013			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

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 01 - MAIN BUILDING 01 B. Wing	6/26/2013

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 Reg. # NFPA 101 LSC K0052	06/21/2013	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By MM/PS	Date: 07/05/2013	Signature of Surveyor: 25822	Date: 06/26/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 5/13/2013		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: DSET

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 **05/16/2013** (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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HPR SWS 06/05/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 06/29/2013 (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

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

At the time of the May 15, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. In addition, at the time of the May 15, 2013 standard survey an investigation of H5431018 was completed and found to be unsubstantiated. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 3767

May 20, 2013

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

RE: Project Number S5431023, H5431018

Dear Ms. Gustason:

On May 16, 2013, 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. In addition, at the time of the May 16, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5431018 that was found to be unsubstantiated.

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>Plan of Correction</u> - 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
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506

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 25, 2013, 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 25, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 August 16, 2013 (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 November 16, 2013 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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:

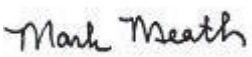
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File 5431s13.rtf

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 _____	05/16/2013

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

MAY 29 2013
MN Dept of Health
Rochester

(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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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 standard recertification survey was conducted and a complaint investigation had also been completed at the time of the standard survey. An investigation of complaint H5431018 had not been substantiated during this survey.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to reposition a resident according to the care plan for 1 of 1 resident (R1) reviewed with a current pressure ulcer. Findings include: R1 was not provided repositioning according to the care plan on 5/14/13, from 12:21 p.m. to 3:09 p.m. (2 hours and 48 minutes) and on 5/15/13, from 6:52 a.m.	F 282 6/5/13 sph	See Attachment # 1	6/24/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheryl A. Easton — TITLE: Administrator — (X6) DATE: 5/30/2013

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 COMPLIANCE

Field Crest Care Center has been providing nursing home services to the community for past 43 years. Its policies and procedures have been developed in accordance with the law and the community standard of practice.

Field Crest Care Center objects to and disagrees with both the findings of noncompliance and the level of deficiencies cited. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that this State of Deficiency was correctly cited, and is also not to be construed as an admission against interest against Facility, its Administrator or any employees, agent or other individuals who draft or may be discussed in the Credible Allegation of Compliance. In addition, preparation and submission of the Credible Allegation of Compliance does not constitute an admission or agreement of any kind by this Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegation by the survey agency.

Accordingly, we are submitting the Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegation of noncompliance or admissions by the Facility.

Attachment 1

Regulation 483.20(k)(3)(ii) Tag F282
Services by Qualified Personnel per Care Plan

Field Crest Care Center assures that services are provided that meet professional standards of quality and are delivered by appropriately qualified persons (e.g., licensed, certified) in accordance with each resident's written plan of care. The interdisciplinary care planning team 1) uses an assessment process to develop an individualized care plan for each resident that supports the highest practicable level of function and well-being 2) implements procedures and practices as outlined in the plan 3) reviews the plan at least quarterly and with significant changes in condition and 4) makes modifications as necessary.

The policies for assessing skin risk and developing a skin-related plan of care to maintain skin integrity as well as the procedures for communicating the resident's needs to the direct care staff were reviewed and found appropriate.

During the mandatory meeting June 12, 2013, the nursing staff will be reminded/instructed that the plans of care must be followed and that job performance expectations include being aware of and following the resident's plan of care, especially cares that are directed toward maintaining skin integrity and treating skin break down.

The care plan for resident number 1 was reviewed and found to be appropriate. The repositioning schedule will remain the same and use of the Roho cushion will continue.

Compliance with repositioning intervals will be monitored by the charge nurses through observation of staff cares. Resident care observations will be assigned by the Clinical Manger at least weekly for the next two months and then randomly thereafter. The times the resident was repositioned will be tracked using the *Resident Repositioning* auditing forms. If noncompliance with the plan of care is noted, additional auditing and staff training will be done. Compliance will be reviewed at the July 2013 Quality Assessment and Assurance Meetings and ongoing.

Completion date: June 24, 2013

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 _____ MAY 29 2013 MN Dept of Health	05/16/2013

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 282	Continued From page 1 to 10:39 a.m. (3 hours and 47 minutes). R1 had diagnoses that included but not limited to stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon, and muscle. Also end stage multiple sclerosis. During review of R1 ' s care plan dated 6/19/12, identified R1 had an alteration in skin integrity evidenced by a stage IV pressure ulcer to coccyx. The care plan directed staff to reposition resident every two to two and half hours and to protect bony prominence with pillow or positioning device, pad, protect fragile skin. During interview on 5/15/13, at 12:02 p.m., the director of nursing reviewed R1 ' s care plan and tissue tolerance and verified R1 was to be repositioned every two to two and a half hours and would expect staff to follow the care plan. During review of Care Planning policy dated 4/12, the policy indicated a care plan was a personalized plan of daily care based on the nature of the illness and are to be utilized by all personnel involved in the care of the resident.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	See Attachment #2	6/24/13

Attachment 2

Regulation 483.25(c) Tag F314
Prevention of Pressure Sores

Based on the comprehensive assessment, Field Crest Care Center ensures that residents who enter the facility without pressure sores do not develop pressure sores unless the resident's clinical condition demonstrates that they were unavoidable. Residents receive necessary treatment and services to promote healing, prevent infection, and prevent new pressure areas from developing.

The skin related policies and procedures were reviewed and found appropriate. At the time of admission all residents' skin condition and skin risk factors are assessed. Weekly skin assessments continue for the first four weeks of stay. Skin condition/risk is reassessed quarterly and with any significant changes in condition as part of the comprehensive assessment process. The direct care staff routinely inform the charge nurse of any skin problems noted during cares. Observation of skin on all areas of the body is part of the bathing protocol.

Care plans are developed to address and minimize risks of skin breakdown. The plans of care focus on services that maintain skin integrity, prevent pressure sores, and provide treatment as prescribed.

During the mandatory meeting June 12, 2013, the nursing staff will be instructed on the necessity of knowing, implementing, and enforcing the residents' repositioning schedule and other care plan interventions to manage skin risks. The certified nursing assistants were instructed that their job performance expectation includes being aware of and following the resident's plan of care for maintaining skin integrity including repositioning at prescribed intervals and use of pressure reduction devices with a focus on appropriate use of Roho cushions.

The care plan for resident number 1 was reviewed and found to be appropriate. The repositioning schedule will remain the same and use of the Roho cushion will continue.

Compliance with repositioning intervals and use of pressure reduction devices will be monitored by the charge nurse through observation of staff cares. Resident care observations will be assigned by the Clinical Manger at least weekly for the next two months and then randomly thereafter. The times the resident was repositioned will be tracked using the *Resident Repositioning* auditing forms. If noncompliance with the plan of care is noted, additional auditing and staff training will be done. Compliance will be reviewed at the July 2013 Quality Assessment and Assurance Committee Meetings and ongoing.

Completion date: June 24, 2013

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F 314	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide necessary treatment and services to promote healing and prevent new pressure ulcers from developing for 1 of 1 resident (R1) reviewed with a stage IV pressure ulcer. Findings include: R1 was not provided repositioning according to the assessed needs on 5/14/13, from 12:21 p.m. to 3:09 p.m. (a total of 2 hours and 48 minutes) and on 5/15/13, from 6:52 a.m. to 10:39 a.m. (a total of 3 hours and 47 minutes). R1 had diagnoses that included but not limited to stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon, and muscle. Slough or eschar may be present on some parts of wound bed. Often includes undermining and tunneling) and end stage multiple sclerosis. The quarterly Minimum Data Set (MDS), (resident assessment and care screening tool) dated 3/29/13, indicated R1 required assistance with bed mobility, transfers and toileting needs. The MDS also revealed R1 had short and long term memory deficit, sometimes understands others and had a stage IV pressure ulcer. The Braden skin risk assessment dated 3/21/13 indicated R1 was at high risk for skin breakdown. R1's tissue tolerance dated 12/19/12, directed staff to reposition resident for both sitting and lying every two to two and half hours. R1 was to have a ROHO cushion in chair and alternating pressure	F 314		

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F 314	Continued From page 3 mattress on the bed to reduce pressure to impaired skin. R1 ' s care plan dated 6/19/12 identified he had an alteration in skin integrity evidenced by a stage IV pressure ulcer to coccyx. The care plan directed staff to reposition resident every two to two and half hours and to protect bony prominences with pillow or positioning device, pad, protect fragile skin. During observation on 5/14/13, R1 was observed sitting in a reclining wheelchair located in the dining room from 12:21 p.m. to 3:09 p.m. At 3:09 nursing assistants (NA)-A and NA-D transferred R1 from wheelchair to bed using the ceiling track. ROHO cushion was observed to be flat at this time and not an effective pressure reducing device when not inflated while R1 was in the chair. Also at this time the area surrounding the pressure ulcer on R1 ' s coccyx was red. During interview on 5/14/13, at 3:27 p.m. registered nurse (RN)-A verified the ROHO cushion was not inflated. RN-A indicated the ROHO cushion was to be checked every day and signed off on the treatment sheet that it was properly inflated. During interview on 5/14/13, at 3:33 p.m. the occupational therapist assistant indicated nursing staff was responsible to maintain the ROHO cushion. During interview with NA-A on 5/14/13, at 3:14 p.m. indicated R1 was to be repositioned every two to two and a half hours. NA-A thought last time R1 was repositioned when got up for lunch	F 314		

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F 314	Continued From page 4 (lunch served at 11:30 a.m.). During continuous observation on 5/15/13, R1 was observed in reclining wheelchair from 6:52 a.m. to 10:39 a.m. when trained medication aide (TMA)-A and the staffing coordinator assisted R1 from wheelchair to bed. R1 had imprints in his skin from the ROHO cushion which was noted on both thighs. During interview on 5/14/13, at 4:04 p.m. the director of nursing (DON) expected staff to check the ROHO cushion every day to make sure it is inflated appropriately and verified it is on the treatment sheet for the licensed staff to check off as being inflated when used. During interview on 5/15/13, at 10:51 a.m. TMA-A indicated R1 should be repositioned every two hours. TMA-A verified R1 had not been repositioned since R1 got up this am. During interview on 5/14/13, at 11:59 a.m., activities assistant-A verified they had asked a nursing assistant if it was ok to take R1 to the bible study or if R1 needed to lie down. Activities assistant-A indicated she had tilted the chair so resident was repositioned before bible study. However, the resident was not lifted off the wheel chair pad to relieve pressure to the coccyx area. During interview on 5/15/13, at 12:02 p.m., DON indicated R1 needed to be off- loaded (totally lifted off the chair to remove any pressure to buttocks area which allows blood flow to the area). The DON confirmed tilting the wheelchair was not considered adequate repositioning (off-loading.) The DON reviewed care plan and	F 314		

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F 314	Continued From page 5 tissue tolerance information and verified R1 was to be repositioned every two to two and a half hours and would expect staff to follow the care plan intervention. During review of Pressure Sore Protocol dated 8/12, it says to assure residents with pressure sores are receiving necessary treatment and services to prompt healing, prevent infection and prevent new sores from developing. The policy directed staff for any resident at risk for developing a pressure ulcer should avoid uninterrupted sitting in any chair or wheelchair. Residents should be repositioned, shifting the pressure points (areas where bony parts under this skin on the body) under pressure per their repositioning schedule. For chair bound residents the uses of pressure reducing devices were to be used.	F 314		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a medication error rate of less than 5% out of 25 opportunities had been achieved. The facility had a medication error rate of 6.9 percent based on 2 of 7 residents (R32 and R13) were both observed to receive a medication in error during the medication pass. Findings include:	F 332	See Attachment #3	6/24/13

Attachment 3

Regulation 483.25(m) Tag F332
Medication Errors

The goal of Field Crest Care Center is to have a medication error rate of less than 5% and be free of all significant medication errors. The facility ensures 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 policies and procedures related to administration schedules for medications were reviewed and found appropriate. During the mandatory inservice June 12, 2013, the licensed nurses and trained medication aides will be reminded of the importance to administer medications according to manufacturers recommendations and physician instructions. The need to give Prilosec thirty minutes prior to meals will be reinforced. The trained medication aid administering Prilosec during/after meals was counseled on the correct administration time frames.

The Director of Nurses/designee will monitor for compliance by observing medication administration time frames weekly for four weeks. If errors are observed, additional monitoring and staff training will be done. Compliance will be reviewed at the July 2013 Quality Assurance Committee.

Completion Date: June 24, 2013

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F 332	Continued From page 6 R32 received Prilosec (a medication used to reduce stomach acid) either during or after breakfast; however, the medications were scheduled on the medication administration (MAR) record to be given 30 minutes before breakfast. During medication administration pass on 5/15/13 at 9:02 a.m. registered nurse (RN)-C was observed to give R32 Prilosec 20 mg. R32 was sitting in the dining room and had just finished eating breakfast. Review of R32's current physician orders dated 3/28/13, revealed an order for Prilosec 20 mg to be given daily 30 minutes prior to breakfast. The medication was scheduled on the MAR to be given daily at 7:00 a.m. and also read, "Give 30 minutes before breakfast." R13 received Prilosec (a medication used to reduce stomach acid) either during or after breakfast; however, the medications were scheduled on the medication administration (MAR) record to be given 30 minutes before breakfast. During medication administration pass on 5/16/13 at 8:06 a.m., trained medication aid (TMA)-A was observed to administer Prilosec 20 mg to R13. R13 was sitting at the table in the dining room and had just finished eating a bowl of cereal. Review of the current physician's orders for R13 dated 5/14/13, revealed an order for Prilosec 20 mg to be given daily 30 minutes prior to breakfast. The medication was scheduled on the MAR to be given daily at 7:00 a.m. and also read,	F 332		

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F 332	Continued From page 7 "Give 30 minutes before breakfast." When interviewed on 5/16/13 at 9:00 a.m., TMA-A confirmed the physician's order was to administer the Prilosec 30 minutes before a meal and that she had not followed the order. TMA-A further confirmed that this was the usual practice to administer the Prilosec to R13 during her breakfast meal. During interview on 5/16/13 at 9:30 a.m., after informing the director of nursing (DON) of R32 and R13 receiving the Prilosec with meals the DON said if the physician order was to administer the Prilosec 30 minutes prior to the breakfast meal, then that is when it should be given. DON further stated the medication wouldn't be as effective if administered with or after meals. During interview on 5/16/13 at 9:40 a.m., in regards to R32 and R13 the pharmacist also confirmed that if the prescribing physician specified the Prilosec to be given 30 minutes prior to the meal, then he would expect the staff to follow the order as written.	F 332		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	See Attachment # 4	6/24/13

Attachment 4

Regulation 483.35(l) Tag F371
Sanitary Conditions

The goal of Field Crest Care Center is to store, prepare, distribute, and serve food under sanitary conditions. To reduce the risk of food borne illnesses, the dietary and nursing staff are trained on safe food handling practices.

The policies and procedures related to monitoring the dish washer water temperatures and equipment maintenance/cleaning were reviewed and revised. Acceptable dish machine water temperatures have been posted for staff reference. A brush has been purchased to assist in cleaning the area around the dish machine doors that are prone to mineral deposits. The fan cleaning check off log will be modified to differentiate between the fan in the dish machine area and the other kitchen fans.

The dietary manager is meeting with each dietary staff member to review the appropriate dish machine washing/rinsing water temperatures and the procedures for monitoring dish machine water temperatures. The staff will monitor the dish machine wash and rinse temperatures three times per day for one week. If temperatures are acceptable, routine daily monitoring of dish machine water temperatures will resume. The dietary staff will also be instructed on procedures for preventing mineral deposit build up inside the dish machine and the cleaning schedule for kitchen fans. The importance of following the cleaning schedule and signing/initialing when tasks have been completed will be addressed. The staff members will sign to verify that they have received and understand the information.

Compliance will be monitored by the dietary manager through at least weekly audits of the water temperature and cleaning logs, as well as visual inspection of the cleanliness of the dish machine and fans. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the July 2013 Quality Assurance Committee meeting.

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F 371	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain the dishwater temperatures at a minimum of 150 to 165 degrees Fahrenheit (F) during the wash and at a minimum 180 degrees during the final rinse to reach optimal sanitation of dishes and food contact items. Also to maintain equipment in a clean/sanitary manner to prevent food bourne illness. This had the potential to affect 36 of 36 residents, staff and visitors who ate food prepared in the kitchen. Findings include: During initial tour on 5/13/13, at 12:05 p.m. certified dietary manager (CDM) ran the dishwasher to verify temperatures for the wash and rinse cycle. The wash temperatures were 160 degrees F and the rinse cycle was 165 degrees F. The CDM indicated temperatures were to be documented daily and on review of the May log the CDM verified for the month of May the temperatures had not been checked for the dish washer. During tour on 5/16/13, at 7:15 a.m. the CDM again ran the dishwasher to verify wash cycle temperatures was at 160 degrees and the rinse cycle was at 170. CDM indicated the temperature should be at 180 degrees and ran the dishwasher again and then the temperature rose to 180 degrees. CDM indicated staff were informed to run the dishes through again if dishwasher not at appropriate temperatures. During interview on 5/16/13, at 7:24 a.m. dietary aide revealed they were not aware of what the	F 371		

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F 371	Continued From page 9 appropriate temperatures were to be for either the wash cycle or for the rinse cycle. During review of the undated policy entitled, Mechanical Dishwashing Procedure directed staff to fill dishwasher with water by releasing the hot water valve. Check temperature to insure wash water is 150-160 degrees Fahrenheit and rinse water is 180 degrees Fahrenheit and to record the temperature. During observation on initial tour on 5/13/13 and also on 5/16/13, noted brownish colored chunks and crumbles on the top front and back of the dishwasher along with the sides where the door opened and the clean dishes were removed from the dishwasher. During interview on 5/16/13, at 7:16 a.m. the CDM verified the chunks and crumbles on the top of the dishwasher and believed the chunks were hard water deposits. The CDM indicated ECOLAB provided routine preventative maintenance to the dishwasher on a monthly basis. The CDM also identified on the cleaning schedule the late dietary aide was responsible for cleaning off the dishwasher on a daily basis. According to the May 2013 Cleaning Schedule the dishwasher had been initialed off as cleaned everyday this past week. SOILED FANS: During observation on 5/16/13, at 7:16 a.m. noted a movable fan had dust and debris on the blades and grate. This fan was blowing on the clean dishes that had come from the dishwasher. One	F 371		

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F 371	Continued From page 10 of the crates which had clean dishes being dried by the fan had two pitchers and nine pitcher covers. There also was a cart present with clean coffee cups and water glasses, also a cart with large and small bowls, juice glasses along with two trays of dishes that were recently removed from the dishwasher which had the soiled fan blowing on them. There was another soiled fan which was facing the bread stand and even though it was not turned on it had been used in the past. During interview on 5/16/13, at 7:16 a.m. the CDM verified the fans had dust present and was circulating over the clean dishes. CDM indicated fans were to be cleaned on a monthly basis and had last been cleaned on 5/1/13.	F 371		

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

F5431021

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	05/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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	K 000	POC ok JP 6-3-13 RECEIVED MAY 31 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 6-25-13

EXIT: 5-16-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cheryl A. Thorton	Administrator	5/30/2013

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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 rogram participation.

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K 000	Continued From page 1 By email to: Barbara.Lundberg@state.mn.us and Marlan.Whitney@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 51 beds and had a census of 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to install the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.5.2, 19.3.6.1 and 9.6. The deficient practice could affect 15 out 38 residents. Findings include: On facility tour between 12:30 PM and 3:00 PM on 05/13/2013, observation revealed, that the 1st floor, ice machine room # 56 is open to corridor and does not have automatic smoke detection. This deficient practice was confirmed by the Facility Maintenance Director (KB) at the time of discovery.	K 052	K052 Field Crest Care Center contacted Custom Communication, Inc. May 13, 2013 to arrange for installation of a new smoke detector above the ice machine in the dining room. The installation date is planned for May 31, 2013. The Maintenance Director will monitor installation and compliance. Completion Date: June 21, 2013	

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K 052	Continued From page 3 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 052		