DEPARTMENT OF HEALTH AND H	UMAN SERVICES		CENTERS FOR MED	ICARE & MEDICAID SERVICES
			AND TRANSMITTAL	ID: QQT1
PAI	RT I - TO BE COMPL	ETED BY THE STAT	ΓE SURVEY AGENCY	Facility ID: 00104
1. MEDICARE/MEDICAID PROVIDER NO.(L1) 245431		DRESS OF FACILITY ST CARE CENTER		 TYPE OF ACTION: <u>7</u> (L8) Initial 2. Recertification
 STATE VENDOR OR MEDICAID NO. (L2) 304240500 	(L4) 318 SECONE (L5) HAYFIELD ,) STREET NORTHEAS MN	ST (L6) 55940	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHII (L9)	P 7. PROVIDER/SUP	PPLIER CATEGORY 05 HHA 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 4/2/2016 (L 8. ACCREDITATION STATUS:	.34) 02 SNF/NF/Dual 10) 03 SNF/NF/Distinct	06 PRTF 10 NF 07 X-Ray 11 ICF/III	14 CORF D 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF	08 OPT/SP 12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY	IS CERTIFIED AS:		
From (a):	X A. In Complian	nce With	And/Or Approved Waivers Of T	The Following Requirements:
To (b):	Program Rec Compliance		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds 45 (L	18)1. Ac	ceptable POC	4. 7-Day RN (Rural SN	
12.Total Facility Beds4513.Total Certified Beds45	·	iance with Program	5. Life Safety Code	9. Beds/Room
	bi norm compi	and/or Applied Waivers:	* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDOWN			15. FACILITY MEETS	
18 SNF 18/19 SNF 19 45	SNF ICF	IID	1861 (e) (1) or 1861 (j) (1):	(L15)
	L39) (L42)	(L43)		
16. STATE SURVEY AGENCY REMARKS (IF A	PPLICABLE SHOW LTC CA	NCELLATION DATE):		
17. SURVEYOR SIGNATURE	Date :		18. STATE SURVEY AGENCY	APPROVAL Date:
Gary Nederhoff, Unit Supervisor	04	4/05/2016 (L19)	Kamala Fiske-Downing,	Enforcement Specialist 04/12/2016 (L20)
PART II - TO) BE COMPLETED B	Y HCFA REGIONAL	L OFFICE OR SINGLE ST	TATE AGENCY
19. DETERMINATION OF ELIGIBILITY		PLIANCE WITH CIVIL	21. 1. Statement of Finan	
1. Facility is Eligible to Participate	KIGH	TS ACT:	 3. Both of the Above 	l Interest Disclosure Stmt (HCFA-1513) :
2. Facility is not Eligible	L21)			
22. ORIGINAL DATE 23. LTC A	GREEMENT 24.	. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
	NNING DATE	ENDING DATE	VOLUNTARY 00	
02/01/1987			01-Merger, Closure	05-Fail to Meet Health/Safety
(L24) (L41)		(L25)	02-Dissatisfaction W/ Reimburse	
	RNATIVE SANCTIONS		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER
A. Sus	spension of Admissions:	(L44)	04-Ouler Reason for windrawar	07-Provider Status Change 00-Active
(L27) B. Res	scind Suspension Date:	(111)		
		(L45)		
28. TERMINATION DATE:	29. INTERMEDIARY/C	CARRIER NO.	30. REMARKS	
	03001			
(L28)		(L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMINATION	OF APPROVAL DATE		
(L32)		(L33)	DETERMINATION APPR	ROVAL



Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245431

April 12, 2016

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

Dear Ms. Gustason:

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

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

Effective March 29, 2016 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.

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. Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 5, 2016

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

RE: Project Number S5431027

Dear Ms. Gustason:

On March 2, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 18, 2016. 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 April 2, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 28, 2016 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 February 18, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 29, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 18, 2016, effective March 29, 2016 and therefore remedies outlined in our letter to you dated March 2, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kumalu 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building		DATE OF RE	VISIT
	B. Wing	Y2	4/2/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
FIELD CREST CARE CENTER		318 SECOND STREET NORTHEAST		
		HAYFIELD, MN 55940		

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

ITE Y4		DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
		10				10	14			10
ID Prefix	F0176	Correction	ID Prefix	F0279		Correction	ID Prefix	F0280		Correction
Reg. #	483.10(n)	Completed	Reg. #	483.20	(d), 483.20(k)(1)	Completed	Reg. #	483.20(d)(3), 483 (2)	.10(k)	Completed
LSC		03/29/2016	LSC			03/29/2016	LSC			03/29/2016
ID Prefix	F0282	Correction	ID Prefix	F0314		Correction	ID Prefix	F0329		Correction
Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	483.25	(c)	Completed	Reg. #	483.25(I)		Completed
LSC		03/29/2016	LSC			03/29/2016	LSC			03/29/2016
ID Prefix	F0356	Correction	ID Prefix	F0428		Correction	ID Prefix	F0441		Correction
Reg. #	483.30(e)	Completed	Reg. #	483.60	(c)	Completed	Reg. #	483.65		Completed
LSC		03/29/2016	LSC			03/29/2016	LSC			03/29/2016
ID Prefix	F0465	Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.70(h)	Completed	Reg. #			Completed	Reg. #			Completed
LSC		03/29/2016	LSC			-	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
REVIEWI STATE A		REVIEWED BY (INITIALS)	DATE		SIGNATURE OF				DATE	20/2040
REVIEWI CMS RO		GPN/kfd REVIEWED BY (INITIALS)	4/5/2016 DATE		TITLE	10160			04/0 DATE)2/2016
FOLLOW 2/18/201		Y COMPLETED ON			RANY UNCORRECTED DEFICIENCI				I YE	s 🔲 no

POST-CERTIFICATION REVISIT REPORT

IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVIS 3/28/2016	SIT Y3
NAME OF FACILITY FIELD CREST CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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).

DATE
Y5
Correction Completed 03/07/2016
Correction Completed
Correction Completed
Correction Completed
Correction Completed
2016 3
20

DEPARTMENT OF HEALTH AND	HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDICAID SERVICES
Μ	IEDIC	ARE/MEDICAII) CERTIFIC	CATION A	AND TRANSMITTAL	ID: QQT1
PA	ART I -	TO BE COMPL	ETED BY 1	THE STAT	TE SURVEY AGENCY	Facility ID: 00104
1. MEDICARE/MEDICAID PROVIDER NO.(L1) 245431		3. NAME AND AD (L3) FIELD CRE				 4. TYPE OF ACTION: <u>2</u>(L8) 1. Initial 2. Recertification
 STATE VENDOR OR MEDICAID NO. (L2) 304240500 		(L4) 318 SECONI (L5) HAYFIELD ,		ORTHEAS	GT (L6) 55940	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSH (L9)	ΗP	7. PROVIDER/SU 01 Hospital	PPLIER CATEC 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 02/18/2016 8. ACCREDITATION STATUS: 0	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 0 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		A. In Complian	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):		Program Re Compliance			2. Technical Personnel	6. Scope of Services Limit
		1. Ac	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	F) 8. Patient Room Size
	(L18)	V D. Natin Com	uliana mith Dua		5. Life Safety Code	9. Beds/Room
13.Total Certified Beds 45	(L17)	X B. Not in Com Requirements	and/or Applied V	-	* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKDOWN		•			15. FACILITY MEETS	
	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
45						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARKS (IF	APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Kyla Einertson, HFE NE II		0.	3/14/2016	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 03/28/2016 (L20)
PART II - T	O BE	COMPLETED B	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIBILITY			PLIANCE WITH	H CIVIL		ncial Solvency (HCFA-2572)
1. Facility is Eligible to Participate		KIGH	ITS ACT:		 Ownersmp/Control Both of the Above 	ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE 23. LTC	AGREE	MENT 24	. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEG 02/01/1987	GINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure 0	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24) (L4	1)		(L25)		02-Dissatisfaction W/ Reimburse	
25. LTC EXTENSION DATE: 27. ALT	ERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER
A. S	Suspension	n of Admissions:	(L44)		04-Other Reason for withdrawar	07-Provider Status Change 00-Active
(L27) B. R	escind S	uspension Date:	(L44)			00-2 Kilve
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
(L28)				(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	. DATE		
(L32)				(L33)	DETERMINATION APPE	ROVAL



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered March 2, 2016

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

RE: Project Number S5431027

Dear Ms. Gustason:

On February 18, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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 <u>Email: gary.nederhoff@state.mn.us</u> 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 March 29, 2016, 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 March 29, 2016 the following remedy will be imposed:

• Per instance civil money penalty. (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 May 18, 2016 (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 August 18, 2016 (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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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:

Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections State Fire Marshal Division Email: <u>tom.linhoff@state.mn.us</u> Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

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

		AND HUMAN SERVICES		FOF	MAPPROVED
CENTEF	RS FOR MEDICARE	& MEDICAID SERVICES	1	OMB N	<u>O. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ATE SURVEY OMPLETED
		245431	B. WING _	0	2/18/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
FIELD CF	REST CARE CENTER			318 SECOND STREET NORTHEAST HAYFIELD, MN 55940	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC 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 COMMENT	S	F 00	00	
	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve f compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.			
F 176 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with NT SELF-ADMINISTER D SAFE	F 17	76	3/29/16
	the interdisciplinary	nt may self-administer drugs if team, as defined by as determined that this			
	by: Based on observat review, the facility fa assessment to dete capable of safely se for 1 of 1 resident (have medications in Findings include: R40's Admission Re indicated that the re cognitive impairment	rmine whether a resident was elf-administering medications R40) who was observed to		 483.10(n) Tag F176 Self-administration of Drugs Field Crest Care Center respects the residents right to self-administer drugs after the interdisciplinary team has determined that this practice is safe. The policy for self-administration of medications was reviewed and found appropriate. Residents who prefer to tak medications independently will be allower to do so after 1) an assessment has been appropriated to do so after 1. 	e d
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

Electronically Signed

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.

03/11/2016

PRINTED: 03/14/2016

ALEMENT						
ND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · · ·	E SURVEY PLETED
		245431	B. WING		02/	18/2016
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP	CODE	
FIELD CF	REST CARE CENTER	1		318 SECOND STREET NORTHEAS HAYFIELD, MN 55940	Т	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
F 176	Continued From pa	ige 1	F 1	76		
	During an observati R40 was sitting quie television from his r perched on a bedsi machine and equip used to administer mist inhaled into the canister were observed sitting atop the mac medication was pour small amount of flui equipment, R40 sta medication after the for him. He stated t nursing staff had lei canister apart, turner was observed a mis bottom portion of the connected by tubing reapplied the canist back to its original p equipment there wa along with a tube of a prescription label inhaler was labeled explained that he ke inhaler at his bedsic the inhaler, one puf that he used the hyd itchy skin.	ion on 2/16/16 at 2:56 p.m., etly in his room watching recliner. Next to his recliner, de table was a nebulizer ment (a drug delivery device medication in the form of a e lungs). The mask and rved to be connected and was chine. The canister (where the ured) was observed to have a id in it. When asked about the ated that he had taken the e nursing staff would set it up hat he would take it after the ft the room. R40 then took the ed the machine on and there st that escaped from the ne canister which was still g to the machine. R40 then ter with the mask and put it position. Next to the nebulizer as observed to be an inhaler f hydrocortisone ointment with on both medications. The with the name Dulera. R40 ept the hydrocortisone and the de. R40 stated that he used if in the morning. R40 stated drocortisone ointment for his		 done showing the resident safely self-administering m 2) the physician has writter self-administration. The care plan will reflect w responsible for storage, do and the location of drug ad The appropriateness of sel of drugs will be reviewed at during the resident s care and more often as necessa During the March 23, 2015 meetings, the nurses and t medication aides will be reithe residents right to self medications 2) the regulator for a physician s order and interdisciplinary assessment before a resident is permitting self-administer medications the care plan must reflect w responsible for storage, do and the location of drug ad The records of all residents self-administer medication and the location of drug ad The records of all residents self-administer medication to assure appropriate asset planning and physician ord Resident number 40 - The cognitively intact, retired definition of the self self self self self self self sel	edications and a an order for ho will be cumentation, ministration. f-administration t least quarterly conference ary. mandatory rained instructed on 1) administer ory requirement d nt of capability ed to s and 3) that who will be cumentation, ministration. s who will be audited ssments, care ers.	
	dated February 201	dministration record (MAR), 6, indicated that the resident d and was taking Duoneb		admitted to the facility Dec On December 3, 2015 the practitioner determined the capable of safely self-admi	nurse resident was	

Facility ID: 00104

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TATEMENT	OF DEFICIENCIES	A MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	0. 0938-039 TE SURVEY MPLETED		
		245431	B. WING			100010		
	PROVIDER OR SUPPLIER	273731	D. 11110 _	STREET ADDRESS, CITY, STATE, 2		02/18/2016		
	REST CARE CENTER	3		318 SECOND STREET NORTHE HAYFIELD, MN 55940				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE		
F 176	muscles in the airw the lungs), 1 vial do for COPD (chronic disease). The MAF resident had an ord 200-5 mcg (microg type of propellant s puff inhaled twice of instructions for this mouth after each u the rinse water. When interviewed Registered Nurse (an inhaler, the neb hydrocortisone oint that R40 declined t hydrocortisone oint When interviewed Registered Nurse (have an assessme resident could safe without nursing sta this should have be self-administer me stated that otherwis have been locked u Review of the facili Self-Administration (June 2003), stated	vays and increase air flow to obse nebulizer four times a day obstructive pulmonary a also indicated that the der and was taking Dulera grams)/act (actuation) HFA (a spray used with an inhaler); 1 daily for COPD. Specific inhaler were to rinse the use making sure not to swallow on 2/17/16 at 2:43 p.m., (RN)-A stated that R40 did use ulizer medication as well as tment in his room. RN-A stated to have the inhaler and tment leave his room. on 2/17/16 at 3:01 p.m., (RN)-A stated that R40 did not in order to determine if the sty self-administer medications ff present. RN-A stated that een done in order for R40 to dications in his room. on 2/17/16 at 3:37 p.m., the (DON) stated that the nursing lone an assessment in order to the resident could safely dications in his room. She se, the medications should	F 17	 25, 2016. The resident v of safely self-administerit topical medications was home February 18, 2016 The Director of Nurses/or monitor compliance with self-administration of me requirements through ob record review. Complian monitored at the April qu Assurance and Improve meeting. 	ng inhaled and discharged to 5. designee will edication oservation and ice will be iarterly Quality			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 03/14/2016 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245431	B. WING	i		02/	18/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
FIELD C	REST CARE CENTER	1			18 SECOND STREET NORTHEAST HAYFIELD, MN 55940		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 176	176 Continued From page 3 could not self administer medications. It stated that the resident or the responsible party would sign the Self Administration of Medication form			176			
F 279 SS=D	that the resident or sign the Self Admin Review of the facilit Medication Storage the resident was to use of beside medi- medication was use how often it may be applicable, proper s the necessity of rep nursing staff. The re- repeat the instruction appropriate use of the completion of this in documented in the Periodic review of t resident was to be staff as deemed ne 483.20(d), 483.20(k COMPREHENSIVE A facility must use t to develop, review a comprehensive pla The facility must de plan for each reside objectives and time medical, nursing, a needs that are iden assessment. The care plan must to be furnished to a highest practicable	the responsible party would histration of Medication form. ty policy titled, Bedside e (February 2015), stated that be instructed in the proper factions, including what the ed for, how it was to be used, e used, proper cleaning where storage of the medication and borting each dose used to the esident should be able to ons or demonstrate the medication. The nstruction was to be resident's medical record. these instructions with the undertaken by the nursing ecessary. k)(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's	F	279			3/29/16

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MILLI	IPLE CONSTRUCTION		0938-039 E SURVEY		
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED		
		245431	B. WING _		02/	02/18/2016		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	DE			
FIELD C	REST 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 COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE		
F 279	be required under § due to the resident's	ervices that would otherwise 483.25 but are not provided s exercise of rights under he right to refuse treatment	F 2	79				
	by: Based on interview facility failed to deve plan that included a from the use of an a 1 of 5 residents (R2 medications. Findings include: R26's physician ord an order for Loveno ml (milliliters), give daily for history of d and pulmonary emb administration recon medication was give orders.	IT is not met as evidenced and document review, the elop a comprehensive care list of possible side affects anticoagulation medication for (6) reviewed for unnecessary ers dated 12/28/15, identified x 120 mg (milligrams) per 0.8 120 mg subcutaneously (SQ) eep vein thrombosis (DVT) polism (PE). The medication rd, dated 2/16, showed the en daily per the physician		Tag F279 – Comprehensive Field Crest Care Center use of the comprehensive asses develop, review and revise t comprehensive plan of care individualized care plan 1) in measurable objectives and meet the resident's needs a the comprehensive assess describes the services that furnished to attain or mainta resident's highest practicabl mental, and psychosocial w 3) recognizes the residents' cares/services.	es the results ssment to the resident's . The ncludes timetables to .s identified in nent 2) are to be ain the le physical, ell-being and right to refuse			
	of the medication at PE. On 2/17/16, at 3:18 (DON) confirmed R the use of the medic and PE. The DON s	blan failed to identify the use and the diagnoses of DVT and p.m., the director of nursing 26's care plan failed to identify cation and diagnoses of DVT stated she would expect the be identified on R26's care		and the staff responsibilities development and revision o comprehensive plans of car reviewed and found appropri time of admission, a tempor is implemented. Within seve completion of the comprehe assessment, an interdiscipli is developed.	f the e were riate. At the rary care plan en days of ensive			

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	OF DEFICIENCIES	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3)	DATE	0938-039
ND PLAN C	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG _			PLETED
		245431	B. WING			02/ ⁻	18/2016
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
FIELD CI	REST CARE CENTER	2			18 SECOND STREET NORTHEAST AYFIELD, MN 55940		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIESID(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIXREGULATORY OR LSC IDENTIFYING INFORMATION)TAG			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETIC DATE	
F 279	This is a personaliz the nature of the ill long and short rang physicians orders f and other therapy; consultation servic be accomplished; I and interests of the	ensive Care Plan: Procedure: zed plan of daily care based on ness, treatment prescribed, ge goals which include: the or medication, treatments, diet the types of care and es needed; how they can best now the plan meets the needs e patient; what methods are nd the modification necessary	F 2	79	reminded of the facility policies for care plan implementation/reviews/updates 2 reminded that the residents' care plans must be current at all times and 3) instructed that care plans must address anticoagulant medications and related side effects, especially the risk of bleeding/bruising. The care plan for resident number 26 w reviewed by a registered nurse and has been revised to reflect the use of anticoagulant medications and possible side effects. Any adverse effects will be reported to the physician. The resident' care plan will continue to be reviewed quarterly and with significant changes i condition. As part of the quarterly care conference process, the interdisciplinary team revie the care plans for completeness, accuracy, and relevancy. For the next quarter, the MDS Coordinator will cond focused audits on the accuracy of the care plans of residents who are receivin anticoagulant medications. If noncompliance is noted, additional monitoring will be done. Compliance will be reviewed during the next quarterly Quality Assurance and Performance Improvement Committee meeting.) ras s s uct ng	
F 280 SS=D	483.20(d)(3), 483.1 PARTICIPATE PLA	0(k)(2) RIGHT TO NNING CARE-REVISE CP	F 2	80			3/29/16
	incompetent or oth	ne right, unless adjudged erwise found to be r the laws of the State, to					

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			ON	FORM / //B NO.	03/14/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		E SURVEY PLETED
		245431	B. WING			02 /1	18/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
FIELD C	REST CARE CENTER			-	B18 SECOND STREET NORTHEAST HAYFIELD, MN 55940		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	participate in planni changes in care and A comprehensive c within 7 days after t comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative	ng care and treatment or	F 2	280			
	by: Based on interview failed to revise the of intervention for 1 of for accidents. In ad include identified ta of 5 residents (R26 medications. Finding include: R35's care plan, da the resident has ha balance and poor s interventions of allo partially shut when level when leaving not shut all of the w	NT is not met as evidenced y and record review, the facility care plan to include a fall 2 residents (R35) reviewed dition, the facility failed to rgeted mood symptoms for 1) reviewed for unnecessary ted revision 9/28/15, identified d multiple falls related to poor afety awareness with w resident to have door hallway is noisy, assess noise room, keep door cracked, do ray due to safety concerns, be at knee level, Dycem			Regulation 483.20 (d)(3) 483.10(k) Tag F280 Comprehensive Care Plans Field Crest Care Center staff develo comprehensive care plans within se days after the completion of the comprehensive assessment. Care p are prepared by an interdisciplinary which includes the attending physici registered nurse with responsibility f resident, and other appropriate staff Professional disciplines work togeth plan and provide necessary services enhance the residents' functional at and quality of life. The residents and families/legal representative are encouraged to participate in the car	op olans team, ian, a for the f. ner to s to oilities d their	

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		& MEDICAID SERVICES					0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION ()		SURVEY PLETED	
		245431	B. WING			02/1	8/2016	
NAME OF F	PROVIDER OR SUPPLIER	• •		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
FIELD CI	REST CARE CENTER	ł		-	18 SECOND STREET NORTHEAST IAYFIELD, MN 55940			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIOI DATE	
F 280	Continued From pa (non-slip pad) to wi	ige 7 neelchair to reduce/prevent	F 2	280	planning process and the quarterly c	are		
	sliding down in cha when resident is no mattress to bed, a wheelchair, offer to awake, first and se (PRN) to prevent th	ir, keep bathroom door shut ot in the bathroom, perimeter uto locking brakes on ileting every two hours while cond rounds and as needed ne need for self-transferring, attached to call cord, keep			conferences to the greatest extent possible. Care plans are routinely reviewed and revised by a team of qualified persons after each quarterly assessment and more often as necessary.			
	soft touch near edg	bed and wheelchair within hen resident in bed.			The care plan policies and procedure were reviewed and found appropriate During March 23, 2016 mandatory meetings, the nursing staff will be 1)	e.		
	Progress Notes, da identified R35 was body half way on be intervention implem	nvestigation Report and ted 2/4/16 and 2/5/16, found on knees with upper ed. Falls team reviewed and nented was resident is not to be when in wheelchair during e.			informed of the regulatory requirement that the residents' care plans be curr all times 2) reinstructed on the facility policies for care plan reviews and up and 3) reminded of the importance of identifying mood symptoms and risk falls/related safety interventions in th plan of care.	rent at y odates of of		
	of resident is not to wheelchair during a addition, the nursin dated 2/17/16, faile	ed to include the intervention be left in room alone when in an agitation episode. In g assistant resident kardex, d to include the intervention.			Resident number 35 – A registered r reassessed the resident's fall related of care including safety interventions February 22, 2016. The intervention the resident is not to be left alone in l	d plan s that his		
	identified a score o On 2/17/16, at 3:24 (DON) verified R35 the intervention of t room alone when in agitation episode a	ssment dated 12/15/15, f 10, a high risk for falls. p.m., the director of nursing 's care plan failed to include the resident is not to be left in the wheelchair during an nd she would expect the care The DON stated R35's care			room during periods of agitation has added to the care plan and to the nur assistant resident Kardex. The reside safety needs will continue to be reassessed as least quarterly and the care plan updated as necessary reflect current safety interventions.	rsing ent's e		
	plan would need to include the interver intervention to be o	be updated by the nurse to ntion in order for the n the nursing assistant kardex. all Risk, dated 1/28/10,			Resident number 26 - The resident w admitted to the facility September 3, He is currently receiving hospice sen due to end-stage disease related to a brain tumor. The resident has a diag	2014. vices a		

Facility ID: 00104

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245431 **B** WING 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **318 SECOND STREET NORTHEAST** FIELD CREST CARE CENTER HAYFIELD, MN 55940 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 280 Continued From page 8 F 280 indicated Procedure: 3. Residents at risk will be of depression currently being treated with identified on the care plan with specific Celexa. The resident's mood/depressive interventions to minimize the risk. 5. The symptoms will continue to be assessed residents care plan will be reviewed/revised to guarterly and with significant changes in indicate the resident is at risk for falls and specific condition. The care plan has been interventions in place. updated to include the resident's mood indicators of isolation, tearfulness and sadness. Behaviors/mood indicators that need to be reported to the nurses have R26's physician order dated 1/7/16, identified an order for Celexa 5 mg (milligrams) daily. R26's been added to the nursing assistant medication administration record dated 2/16, resident Kardex. The physician/hospice showed R26 received the medication daily as per agency will be notified of increased target physician orders. behaviors and depressed mood. R26's Psychotropic Med Review, dated 12/7/15, To monitor compliance the Nurse Manager/designee will audit the care indicated specific targeted behaviors were isolation, tearfulness and sadness. plans of residents who have fallen in the past 30 days to assure that all safety R26's care plan, dated revision 12/15/15, interventions are included and the social identified the resident uses antidepressant worker will audit the care plans of medication Celexa related to Depression. At risk residents receiving antidepressants to for depressed mood related to terminal diagnosis, assure the related target behaviors are reflected in the care plan and the nursing with interventions of administer antidepressant medication as ordered by physician, assistant Kardex. If care plan omissions monitor/document side effects and effectiveness. or inaccuracies are identified, additional assist the resident in developing a program of care plan audits and staff training will be activities that is meaningful and of interest done. The interdisciplinary team will (hunting, socializing with others), encourage and continue to review care plans for provide opportunities for exercise, physical completeness, accuracy, and relevancy activity, assist the resident, family, caregivers to during the residents' quarterly care identify strengths, positive coping skills and conferences, with significant changes in reinforce these, monitor for signs of depression, condition, and more often if necessary. isolation, lack of appetite and loss of interest. Compliance will be reviewed at the guarterly April Quality Assurance and Performance Improvement Committee R26's care plan failed to include the targeted behaviors of tearfulness and sadness and meeting. interventions to be implemented for the target behaviors. In addition, R26's nursing assistant kardex failed to include the targeted behaviors of

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 03/14/2016

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM	03/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245431	B. WING			02 / ⁻	18/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FIELD CI	REST CARE CENTER				18 SECOND STREET NORTHEAST AYFIELD, MN 55940		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280 F 282 SS=D	to be implemented On 2/17/16, at 3:18 care plan failed to in of sadness, tearfulr interventions monitic confirmed the R26's failed to include the isolation, tearfulness to be implemented. expect the targeted The DON stated the exception if the beh The facility policy C identified Comprehe This is a personaliz the nature of the illr long and short rang physicians orders for and other therapy; the consultation services be accomplished; he and interests of the most successful; ar to ensure best results be utilized by all per the resident. To assist comprehensive car evaluated and updation interdisciplinary tea resident's family me at least quarterly. 483.20(k)(3)(ii) SEF PERSONS/PER CA	s, sadness and interventions for the targeted behaviors. p.m., the DON verified R26's include the targeted behaviors hess and read under or for isolation. The DON is nursing assistant kardex targeted behaviors of is, sadness and interventions The DON stated she would behaviors to be care planned. e facility documents by favior is noted. are Planning, dated 4/12, ensive Care Plan: Procedure: ed plan of daily care based on hess, treatment prescribed, e goals which include: the or medication, treatments, diet the types of care and es needed; how they can best row the plan meets the needs patient; what methods are nd the modification necessary Its. Resident care plans shall rsonnel involved in the care of sure accuracy, the e plan will be reviewed, ated, as needed, by the m in participation with the ember or legal representative AVICES BY QUALIFIED ARE PLAN	F 2				3/29/16
	The services provic	led or arranged by the facility					

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245431	B. WING			02 /1	8/2016
NAME OF F	PROVIDER OR SUPPLIER		. I		REET ADDRESS, CITY, STATE, ZIP CODE		
FIELD CI	REST CARE CENTER						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	must be provided b accordance with ea care. This REQUIREMEN by: Based on observat review, the facility fa treatments as asse pressure ulcers and from developing for reviewed in the sam ulcers. Findings include: R36 was observed chair without reposi 12:52 p.m. or a tota even though R36 w	y qualified persons in ch resident's written plan of NT is not met as evidenced ion, interview, and document ailed to provided services and ssed to promote healing of d prevent new pressure ulcers 1 of 3 residents (R36) nple with current pressure (continuous) to sit in wheel tioning from 8:17 a.m. to I of 4 hours and 35 minutes	F 2		Tag F282 Services by Qualified Personnel per Care Plan Field Crest Care Center provides se that meet professional standards of quality and are delivered by approp qualified persons (e.g., licensed, ce in accordance with each resident's plan of care. The interdisciplinary ca planning team 1) uses an assessm process to develop an individualized plan for each resident that supports highest practicable level of function well-being 2) implements procedure practices as outlined in the plan 3)	f riately ertified) written are ent d care s the and	
	directed due to stag right hip. R36 was admitted t diagnosis that inclu	the facility on 10/22/14, with ded vascular dementia			reviews the plan at least quarterly a with significant changes in condition 4) makes modifications as necessa The facility has policies and proced	n and Iry. ures	
	2/17/16. The Admis diagnosis of pressu four, with onset date Document review o	f facility quarterly Minimum			for developing individualized plans of and communicates the plan to the of care givers by use of the nursing as care Kardex. The care plan policies procedures were reviewed and four appropriate.	direct ssistant s and	
	identified R36 with on admission to fac and required extension	a assessment dated 1/31/16, one stage four pressure ulcer ility, healed pressure ulcers, sive assistance of two staff for ng including bed mobility and			During the March 23, 2016 mandate meetings, the nursing staff will be reminded/instructed 1) that the resid plans of care must be followed 2) the repositioning residents according to	dents' nat	

Facility ID: 00104

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	```		E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG		COM	PLETED	
		245431	B. WING			02/*	18/2016	
NAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
FIELD CI	REST CARE CENTER	1		318 SECOND STREET NORTHEAST HAYFIELD, MN 55940				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE	
F 282	R36 continuous ob 8:17 a.m., to 12:52 From 8:17 a.m. to 12:52 From 8:17 a.m. to 12:52 From 8:17 a.m. to 12:52 From 9:38 a.m. action in her wheelchair front of the second	servations on 2/17/16, from p.m., revealed the following: 9:30 a.m. observed to be in pindependently, some rom staff, completed eating tivity aide (AA)-A moved R36 rom dining room table to cozy ctivity starting at 10:00 a.m. At cozy cove room, while R36 pm with two other residents. 11:00 a.m. R36 with five other	F2	282		e ulcers stations ng the nely ew s the nt's plan ning. d to the se a. The present lcer is healing. ulcer g and d pain. care red sults of dicates 1.5 to have nely		
cushion in whee During interview		n 2/17/16, at 1:01 p.m., NA-A 36 was to be repositioned			staff. Resident care observations v assigned by the Director of Nurses/designee for two weeks. If noncompliance is noted, additiona auditing and staff training will be d	I		

Facility ID: 00104

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED		
		BERTHIOMION NOWBER.	A. BUILDII	NG				
		245431	B. WING _			/18/2016		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
FIELD CI	REST CARE CENTER	1		318 SECOND STREET NORTHEAST HAYFIELD, MN 55940				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 282	Continued From page 12 R36's care plan initiated 11/7/14 and revised on 11/10/15, noted a stage four pressure ulcer on			82 Compliance will be reviewed April quarterly Quality Assura Performance Improvement (ance and			
	dressing changes a pressure areas thre Interventions inclue bed as flat as poss administer treatme effectiveness, asse healing weekly, me where possible, asse wound perimeter, w progress, report im the physician, do ne monitor nutritional s supplements as or odor or worsening s infection, fever, cor assistance to turn a hours more often a off right hip, rotate pillows to reposition mattress and a cus loading . The care and repositioning p every 1 to 1.5 hours pillows to position, turning and reposition	ible to reduce shear, nts as ordered and monitor for es, record, and monitor wound easure length, width and depth sess and document status of wound bed and healing provements and declines to ot position on right side, status, serve protein dered, notify hospice if foul signs and symptoms of nfusion or pain, needs and reposition every 1 to 1.5 is needed or requested, keep from back to left side, use n, requires an overlay air shion in wheelchair to aid in off plan directed staff R36 turning irogram: turn and reposition s, keep off right hip, use R36 can participate with ioning with bilateral assist bars.		meeting.				
	During interview on 2/17/16, at 1:14 p.m., director of nursing stated she expected R36 repositioned every 1 to 1 1/2 hours, according to R36's care plan.							
	dated 12/2011, reve "Residents whom a	of facility Skin Integrity policy ealed procedure #3. a. are unable to reposition a repositioning schedule						

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TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		245431	B. WING		02/-	18/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/	10/2010	
FIELD CI	REST CARE CENTER	1		818 SECOND STREET NORTHEAST HAYFIELD, MN 55940			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 282	Continued From pa implemented based assessment."	ige 13 d upon the Tissue Tolerance	F 282				
F 314 SS=D	483.25(c) TREATM	ENT/SVCS TO RESSURE SORES	F 314			3/29/16	
	resident, the facility who enters the faci does not develop p individual's clinical they were unavoida pressure sores reco	brehensive assessment of a r must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that uble; and a resident having eives necessary treatment and be healing, prevent infection and from developing.					
	by: Based on observative review, the facility finterventions to pro- pressure ulcer and of pressure ulcers for reviewed in the same Findings include: R36 sat in the whee 12:52 p.m. a total of without repositioning assessment determ repositioned every stage IV pressure of R36 was admitted for diagnosis that include	NT is not met as evidenced tion, interview, and document ailed to implement assessed mote healing of one stage four prevent further development for 1 of 3 residents (R36) nple with pressure ulcers.		Regulation 483.25(c) Tag F314 – Prevent/Heal Pressure Sores Field Crest Care Center has policie procedures to ensure that residents enter the facility without pressure so not develop pressure sores unless resident's clinical condition demons that they were unavoidable. Reside with pressure sores present at the t admission receive necessary treatm and services to promote healing, pr infection, and prevent new pressure from developing. The policies and procedures for comprehensively assessing the res skin condition and risk factors were reviewed and found appropriate. Ba	s who ores do the strates nts ime of nent revent e areas idents'		

Event ID:QQT111

Facility ID: 00104

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · ·	0938-03 SURVEY PLETED	
		245431	B. WING		02/1	8/2016	
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	02/	0/2010	
	REST CARE CENTER	3		318 SECOND STREET NORTHEAST HAYFIELD, MN 55940			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE	
F 314	Continued From pa	age 14	F 3	14			
	diagnosis of pressu four, with onset dat	ure ulcer of right hip, stage te of 9/30/15.		care plans are developed that ac skin integrity and minimize risks breakdown. The resident's repos	of skin itioning		
	Document review of facility quarterly Minimum Data Set (MDS), an assessment dated 1/31/16, identified R36 with one stage four pressure ulcer on admission to facility, healed pressure ulcers,			schedule is based on an analysis skin risk assessment, the results Bradens Scale for Predicting Pre Ulcer Risk tool, and the tissue to	of the ssure		
	and required exten	sive assistance of two staff for ring including bed mobility and		evaluation. The plans of care for services that maintain skin integr prevent pressure sores, and pro- healing of existing pressure sore	us on ity, note		
	8:17 a.m., to 12:52 From 8:17 a.m. to	servations on 2/17/16, from p.m., revealed the following: 9:30 a.m. observed to be in g independently, some		routine evaluation of the resident condition, skin risk factors, and t tolerance will continue.	's skin		
	assistance to eat fr meal at 9:30 a.m. From 9:38 a.m. act	tivity aide (AA)-A moved R36		For residents who have open ski a licensed nurse evaluates the re skin condition on a weekly basis.	esident 's The		
	cove room for an a 9:44 a.mAA-A left	rom dining room table to cozy ctivity starting at 10:00 a.m. At cozy cove room, while R36 om with two other residents.		direct care staff routinely inform charge nurse of any skin problen during cares. Observation of skir areas of the body is part of the b	ns noted n on all		
	From 9:56 a.m. to residents attended From 11:00 a.m. to dining room eating	11:00 a.m. R36 with five other church service. 12:51 p.m. R36 was in the meal, had some assistance		protocol. If skin issues are noted resident's repositioning schedule reassessed and the physician/nu practitioner notified as appropriat	, the is irse		
	asleep at 12:51 p.r	nd when R36 began to fall n. staff asked if she wanted to this time was moved to her		During the March 23, 2016 mand meetings, the certified nursing as will be reminded/instructed that residents' plans of care must be	mandatory sing assistants I that the		
	R36 to her room ar place gait belt on F transferred R36 fro	ing assistant (NA)-A moved nd then NA-A proceeded to 336. NA-A and NA-B om wheelchair to bed. NA-B		and that job performance expect include being aware of and follow plan of care. The importance of t repositioning of residents with m	ations ving the imely		
	At 12:52 p.m. nursi R36 to her room ar place gait belt on F transferred R36 fro removed incontine amount soft stool, peri-rectal care. W	nd then NA-A proceeded to R36. NA-A and NA-B		residents' plans of care must be and that job performance expect include being aware of and follow plan of care. The importance of t	followed ations ving the imely obility ed to the		

		& MEDICAID SERVICES			MB NO.	APPROVE 0938-039	
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED	
		245431	B. WING		02/*	18/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
FIELD C	REST CARE CENTER			318 SECOND STREET NORTHEAST HAYFIELD, MN 55940			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 314	buttocks. A-A and I incontinent brief wa positioned R36 in b back, heel protector and bed flat. Obser cushion in wheelcha During interview on and NA-B stated re every 1 to 2 hours. Sitting/Tissue Tolera assessment dated no redness noted re healing stage four p trochanter and had will put R36 on a 1.3 schedule while sittir wheelchair cushion The quarterly Brade Risk Data Collection 1/25/16, summary, moderate risk for de The summary identified daily. Treatment dir aquacel AG and co Wound healing well required one staff a living, two staff assi incontinent of bowe Document review o revealed the right tr assessed weekly. I	NA-B verified R36's s dry of urine. NA-A and NA-B ed on left side with pillow to rs on, pillow between knees, ved air mattress on bed and air. 2/17/16, at 1:01 p.m., NA-A sident was to be repositioned ance Evaluation, an 10/30/15, summary indicated elated to test, due to R36 has pressure ulcer on right redness to coccyx previously, 5 to 2 hour repositioning ng, has a pressure reducing en Scale/ Comprehensive Skin n, an assessment dated revealed R36 was at evelopment of pressure ulcer. ified R36 has stage four ulcer (hip), measuring 0.5 y 0.3 cm by 0.4 cm. The ulcer dressing was changed ected to pack the wound with ver with foam dressing. I. The summary indicated R36 issist with activities of daily st for transfers, and	F 31	 services due to advanced dement pressure ulcer to her right hip was on admission. The resident's hip u measured weekly and is currently The nurse practitioner viewed the March 1, 2015 and verified healing that the resident has no associate The resident's skin-related plan of has been reassessed by a registe nurse and revised to reflect the re the Tissue Tolerance Test which ir a repositioning schedule of every 2.0 hours. The nursing assistants been informed of the repositioning schedule and the importance of the repositioning. Compliance with timely repositioning schedule and the direct of staff. Resident care observations assigned by the Director of Nurses/designee for two weeks. If noncompliance is noted, additiona auditing and staff training will be of Compliance will be reviewed durin April quarterly Quality Assurance a Performance Improvement Comm meeting. 	present llcer is healing. ulcer g and d pain. care red sults of ndicates 1.5 to have mely ng for ies will s are will be ul one. g the and		

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		AND HUMAN SERVICES				FORM	03/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245431	B. WING			02 / [.]	18/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FIELD C	REST CARE CENTER				18 SECOND STREET NORTHEAST IAYFIELD, MN 55940		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	depth, no tunnel 12/22/15-0.5 cm ler depth, 0.7 cm tur 2/16/16-0.5 cm leng depth, 0.7 cm tur 2/16/16-0.3 cm leng depth, no tunneli Skin/wound progress measurements reve trochanter (hip) wou measured 0.3 lengt 100 percent granula 0.7 cm undermining note indicated no si no drainage, and no intact, dry and pink tissue, no pain. R3 on 2-2.5 hour repos current treatment. R36's care plan init 11/10/15, revealed ulcer on right hip. G during dressing cha pressure areas thro Interventions includ bed as flat as possi administer treatmer effectiveness, asse healing weekly, me where possible, ass wound perimeter, w progress, report im	ing, 1.3 cm undermining; hgth, 0.5 cm wide, 1.0 cm ing, 0.7 cm undermining; gth, 0.3 cm wide, 0.6 cm hneling, no undermining; gth, 0.3 cm wide, 0.6 cm ng, 6.5 cm undermining. ss note dated 2/9/16 wound ealed the following: right und stage four healing, th by 0.3 wide, by 0.7 depth, ated tissue in wound bed, with g, no tunneling. The progress igns or symptoms of infection, to odor noted. Peri wound skin to normal color scarring 6 received supplement. R36 is sitioning schedule, continue iated 11/7/14 and revised on a focus of stage four pressure anges and not obtain any new bugh next review date.	F	314			

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		AND HUMAN SERVICES				FORM	03/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY IPLETED
		245431	B. WING			02/	18/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
FIELD CF	REST CARE CENTER				318 SECOND STREET NORTHEAST HAYFIELD, MN 55940		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314 F 329 SS=D	supplements as ord odor or worsening s infection, fever, con assistance to turn a hours more often as off right hip, rotate f pillows to reposition mattress and a cusl loading . The care p and repositioning pr every 1 to 1.5 hours pillows to position, F turning and reposition During interview on of nursing stated sh every 1 to 1 1/2 hou plan. Document review or dated 12/2011, reve "Residents whom a themselves, have a implemented based assessment." 483.25(I) DRUG RE UNNECESSARY D Each resident's drug unnecessary drugs. drug when used in e duplicate therapy); o without adequate m indications for its us adverse consequent	status, serve protein dered, notify hospice if foul signs and symptoms of offusion or pain, needs and reposition every 1 to 1.5 s needed or requested, keep from back to left side, use n, requires an overlay air hion in wheelchair to aid in off olan directed staff R36 turning rogram: turn and reposition s, keep off right hip, use R36 can participate with oning with bilateral assist bars. 2/17/16, at 1:14 p.m., director ne expected R36 repositioned urs, according to R36's care of facility Skin Integrity policy ealed procedure #3. a. are unable to reposition a repositioning schedule d upon the Tissue Tolerance EGIMEN IS FREE FROM PRUGS g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any		314			3/29/16
	combinations of the	ereasons above.					

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		AND HUMAN SERVICES	FORM APPROVED OMB NO. 0938-0391						
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI			SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED		
		245431	B. WING			02/1	8/2016		
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•=/	0/2010		
FIELD C	REST CARE CENTER			-	18 SECOND STREET NORTHEAST AYFIELD, MN 55940				
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE		
F 329	Continued From pa	ge 18	F 3	29					
	resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and c record; and residen drugs receive gradu behavioral intervent	chensive assessment of a must ensure that residents antipsychotic drugs are not inless antipsychotic drug by to treat a specific condition locumented in the clinical ts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these							
	by: Based on observat review the facility fa needed (PRN) med (R16 and R35), who medication on a sch Findings include: R16's physician ord an order for tears n eyes every four hou (PRN) for dry eyes. On 2/16/16, at 4:48 was observed to ad drops into both eyes R16's medication a dated 1/16 and 2/16	lers, dated 1/21/16, identified atural drops, one drop to both irs while awake as needed p.m., registered nurse (RN)-B lminister artificial tears two			483.25(I) Tag F329 – Unnecessary I Field Crest Care Center staff ensure each resident's drug regime is free fr unnecessary drugs. The resident's dr regime is reviewed by the staff, physi and consultant pharmacist to assure medications are not used in excessiv doses, for excessive duration, without adequate monitoring, without adequa indications, or in the presence of adv consequences which indicate the dos should be reduced or the drug discontinued. The goal is to simplify medication regimens and identify the lowest effective dose of medications. The medication related policies and procedures were reviewed and revise address as needed (PRN) medication	that rom rug ician that /e ut ate /erse se ed to			

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PRINTED: 03/14/2016

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245431 **B** WING 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **318 SECOND STREET NORTHEAST** FIELD CREST CARE CENTER HAYFIELD, MN 55940 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 329 Continued From page 19 F 329 while awake PRN and the times of a.m. and p.m. Medications are reviewed by the had been handwritten on the MAR's. R16's PRN consultant pharmacist every month, by the medication administration records, dated 1/16 attending physician/nurse practitioner and 2/16, failed to include the reason the eve during the routine 30/60 day visits and drops were administered and effectiveness of the during the resident's quarterly interdisciplinary care conferences. medication. On 2/16/16, at 5:19 p.m., RN-B confirmed R16's During the March 23, 2016 mandatory physician orders, dated 1/21/16, identified an meetings, the nurses and trained order for tears natural drops, one drop to both medication assistants will be 1) eyes every four hours while awake PRN for dry reeducated on the need to document the eyes. RN-B confirmed R16's MAR's from 1/1/16 indications, effectiveness and to current showed R16 was receiving the eve nonpharmacological interventions (when appropriate) for PRN topical medications drops twice daily however, no information as to and 2) instructed not to add specific the effectiveness of the eye drops were documented. administration times to the treatment administration records for PRN On 2/17/16, at 3:14 p.m., the director of nursing treatments. Plans are to implement (DON) stated she would expect the R16's eve electronic medication and treatment drops to be administered as ordered. records in the next six months. The electronic system will prompt the staff to R35's guarterly MDS, dated 12/19/15, identified record indications and effectiveness of R35 had severe cognitive impairment, had PRN medications and will not received as needed (PRN) pain medicaiton accommodate handwritten entries on the without indication for use, if pain medication had administration records. been affective to relieve pain or if nonpharmacological interventions had been Resident number 16 – After a registered attempted prior to use of pain medication. nurse reassessed the resident's use of artificial tears, the order was changed to R35's current care plan, identified R35 was at risk "artificial tears 2 gtts (drops) to each eye for pain related to immobility and a history of falls every AM." The resident will continue to causing back discomfort and interventions of pain be assessed for symptoms of dry, irritated is aggravated by: movement, monitor and record eves and the physician will be notified of ongoing eve-related symptoms. pain characteristics and as needed, quality (e.g. sharp, burning), severity on a scale of 1 to 10, anatomical location, onset, duration, aggravating Resident number 35 – The resident is no factors, relieving factors, monitor/document for longer receiving Biofreeze routinely. The side effects of pain medication and offer non resident will receive Biofreeze on an as pharmacological pain interventions such as ice, needed basis to treat pain symptoms. The

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 03/14/2016 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 09							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						(X3) DATE SURVEY COMPLETED	
245431		B. WING			02/18/2016		
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FIELD CREST CARE CENTER					18 SECOND STREET NORTHEAST AYFIELD, MN 55940		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329 F 356 SS=C	an order for Biofree topically four times R35's medication a dated 12/15, 1/16 a topically QID PRN a been handwritten o medication records 2/16, failed to includ reason the medicat pain level, non-phat and effectiveness o On 2/17/16, at 3:14 (DON) stated she w to be administered or evaluate if R35 w else for pain. The facility policy M dated 11/12/10, indi- pharmaceutical sert that assure the acci- dispensing, and adm biologicals to meet Procedure: 1. Pharm licensed nurse is re residents receive al during his/her work A policy for PRN me not provided. 483.30(e) POSTED	g. lers, dated 1/13/16, identified ze (pain medication), apply daily (QID) PRN for pain. dministration records (MAR's) nd 2/16, Biofreeze apply and the time HS (bedtime) had n the MAR's. R35's PRN , dated from 12/15, 1/16 and de documentation for the ion was being administered, rmalogical measures offered f the medication. p.m., the director of nursing vould expect R35's Biofreeze as written per physician orders vould benefit from something ledication Administration, icated Objective: 2. To provide vices including procedures urate acquiring, receiving, ministrating of all drugs and the needs of each resident. macy services: C. The sponsible for ensuring that I medications as ordered		329	indications for use, effectiveness of medication, and nonpharmacological interventions will be documented. The physician will be notified if the reside current pain management plan is no effective. The care plan has been reviewed and revised to reflect pharmacological pain management interventions. To monitor compliance, the Director Nursing will review the treatment rec to assure that PRN eye drops and to medications are given on as needed and that related documentation is completed according to facility policy consultant pharmacist will also revie administration patterns/documentati PRN eye drops and topical medicati noncompliance is noted, additional auditing and staff education will be c Compliance will be reviewed during April Quality Assurance and Perform Improvement Committee meeting.	al he ent's ot of cords opical d basis y. The ew the ion of ions. If done. the nance	3/29/16
	()		FG	900			3/29/16

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	-	AND HUMAN SERVICES				FORM	APPROVED		
CENTERS FOR MEDICARE & MEDICAID SERVICESSTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED				
		245431	B. WING			02/18/2016			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
FIELD C	REST CARE CENTER		318 SECOND STREET NORTHEAST HAYFIELD, MN 55940						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 356	The facility must po a daily basis: o Facility name. o The current date. o The total number by the following catuunlicensed nursing resident care per sh - Registered nu - Licensed pract vocational nurses (a - Certified nurses o Resident census. The facility must po specified above on of each shift. Data o Clear and readab o In a prominent pla residents and visito The facility must, up make nurse staffing for review at a cost standard. The facility must ma staffing data for a m required by State la This REQUIREMEN by: Based on observat review, the facility fa posting of the daily posting was current	st the following information on and the actual hours worked egories of licensed and staff directly responsible for nift: rses. tical nurses or licensed as defined under State law). a aides. st the nurse staffing data a daily basis at the beginning must be posted as follows: le format. ace readily accessible to	F 3	56	Regulation 483.30 Tag F356 – Nut Staffing Information As required Field Crest Care Cente the following information in a clear a readable format in a prominent loca	r posts and			

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PRINTED: 03/14/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
	245431		B. WING			02/18/2016			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
FIELD CREST CARE CENTER				318 SECOND STREET NORTHEAST HAYFIELD, MN 55940					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 356	Continued From pa	ge 22	F 356	3					
	Findings include:			(i) Facility name.					
		r of the facility on 2/16/16, at lity staff posting dated 2/16/16,		(ii) The current date.					
	was posted near the	e main dining room. The		(iii) The total number and the actua					
		d the facility name, staff type		hours worked by the registered nur licensed practical nurses, and certi					
		luled hours and actual hours		nursing assistants directly responsi resident care per shift.					
	However, the facility census for the current day, 2/16/16, read 35 and the actual census was 32 upon entrance to the facility.			(iv) Resident census.					
	On 2/16/16, at 12:5 (DON) stated the st responsible for posistated the staffing of nurse staff posting Don stated the staff vacation and licens	5 p.m., the director of nursing affing coordinator was ting of the census. The DON coordinator fills out the daily sheets ahead of time. The fing coordinator was on ed practical nurse (LPN)-A posting of the daily nurse		The policy and procedures for posting the staffing/census information were reviewed. The Staffing Coordinator is responsible for posting the daily staffing report; she has been reminded of the need to post the information in a timely manner with an accurate resident census The Office Manager will be responsible for posting the information in the absence of the Staffing Coordinator and has been instructed on the requirements and facility					
	census was 33 this discharged this a.m time the surveyors census was 32. Th	p.m., the DON stated the a.m., but one resident had b. The DON confirmed at the entered the building the e DON confirmed the daily dated 2/16/16, read census of		policy for timely posting of accurate staffing and census information. The Administrative Assistant will me compliance by randomly checking to date and census listed on the staffi report for two weeks. If problems a	onitor the ng re				
	posted the daily nur 2/16/16 yesterday (the next day's shee sheet posted and th	8 p.m., LPN-A stated she had rse staff posting sheet for 2/15/16). LPN-A stated I put t behind the current day's ne overnight shift pulls out the erified the 2/16/16, census		noted, additional monitoring and sta training will be done. Compliance w reviewed during the April quarterly Assurance and Performance Improvement Committee meeting.	/ill be				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 09									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
	245431		B. WING			02/18/2016			
NAME OF I	NAME OF PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE				
FIELD C	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 356 F 428 SS=D	census just got mis The facility policy, I 4/14, indicated as r Center posts the fo in a clear readable Resident census. 2 responsible for pos was reminded to up in census/staffing ir 483.60(c) DRUG R IRREGULAR, ACT The drug regimen of reviewed at least of pharmacist. The pharmacist mut the attending physic	Daily Staffing Report, dated equired Field Crest Care llowing in a prominent location format. Procedure: 1. d. The staff member ting the staffing information odate the posting with changes in a timely manner. EGIMEN REVIEW, REPORT	F 3	428			3/29/16		
	by: Based on observat review the facility fa pharmacist identifie needed (PRN) med (R16 and R35), who	NT is not met as evidenced tion, interview and record ailed to ensure the consultant ed the ongoing use of as lications for 2 of 2 residents o had received the PRN reason for giving and if			Regulation 483.60(c) Tag F428 – Dr Regimen Review The goal of Field Crest Care Center maintain the resident's highest pract level of functioning and prevent or minimize adverse consequences rela- to medication therapy. The drug regi	r is to ticable lated			

Event ID:QQT111

Facility ID: 00104

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245431 **B** WING 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **318 SECOND STREET NORTHEAST** FIELD CREST CARE CENTER HAYFIELD, MN 55940 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 428 Continued From page 24 F 428 R16's physician orders, dated 1/21/16, identified of each resident is reviewed at least once an order for tears natural drops, one drop to both a month by a licensed pharmacist. The eves every four hours while awake as needed pharmacist reports irregularities to the (PRN) for dry eyes. attending physician and the director of nursing, and these reports are acted On 2/16/16, at 4:48 p.m., registered nurse (RN)-B upon. was observed to administer artificial tears two drops into both eyes of R16. The Director of Nursing and Consultant Pharmacist discussed the policies and R16's medication administration records (MAR's) procedures for documenting and tracking dated 1/16 and 2/16, identified tears natural as needed eye drops and topical drops, one drop to both eyes every four hours medications during the February 19, 2016 while awake PRN and the times of a.m. and p.m. telephone discussion. The Consultant had been handwritten on the MAR's. R16's PRN Pharmacist and Director of Nurses meet medication administration records, dated 1/16 monthly and the administration/documentation procedures and 2/16, failed to include the reason the eye drops were administered and effectiveness of the for PRN topical medications will be medication. reviewed at the March meeting and ongoing as necessary. Topical R16's consultant pharmacist medication regimen medications will continue to be listed on reviews from 4/8/15 through 2/17/16, failed to the treatment administration record until address the PRN eye drops lack of reason for the implementation of the electronic giving and if effective nor not. medication administration records at which time this practice will be On 2/16/16, at 5:19 p.m., RN-B confirmed R16's reevaluated. The Consultant Pharmacist has agreed to review the treatment physician orders, dated 1/21/16, identified an order for tears natural drops, one drop to both administration records during the routine eves every four hours while awake PRN for dry monthly reviews of the medication eyes. Also no documentation of reason for giving administration records. The or if effective or not. documentation of administration times, indications for use, effectiveness of PRN topical medications, nonpharmacological interventions and pain level for analgesics R35's physician orders, dated 1/13/16, identified an order for Biofreeze (pain medication), apply will be audited by the pharmacist. topically four times daily (QID) PRN for pain. During the March 23, 2016 mandatory meetings, the nurses and trained R35's medication administration records (MAR's) dated 12/15, 1/16 and 2/16, Biofreeze apply medication assistants will be 1) topically QID PRN. R35's PRN medication reeducated on the need to document the

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00104

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245431 **B** WING 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **318 SECOND STREET NORTHEAST** FIELD CREST CARE CENTER HAYFIELD, MN 55940 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 428 Continued From page 25 F 428 records, dated from 12/15, 1/16 and 2/16, failed indications, effectiveness and to include documentation for the reason the nonpharmacological intervention for PRN medication was being administered, pain level, topical medications and 2) instructed not non-pharmalogical measures offered and to add specific administration times to the effectiveness of the medication. medication and treatment administration records for PRN medications/treatments. R35's consultant pharmacist medication regimen Plans are to implement electronic reviews monthly from 4/8/15 through 2/17/16, medication and treatment records in the failed to address the PRN Biofreeze lack of next six months. The electronic system documentation for the reason the medication was will prompt the staff to record indications being administered, pain level, non-pharmalogical and effectiveness of PRN medications measures offered and effectiveness of the and will not accommodate handwritten medication. entries on the administration records. On 2/17/16, at 3:14 p.m., the director of nursing Resident number 16 – After a registered (DON) stated she would expect the R16's eye nurse reassessed the resident's use of drops and R35's Biofreeze to be administered as artificial tears, the order was changed to written per physician orders. Also to document "artificial tears 2 gtts (drops) to each eve every AM." The resident will continue to reason for giving and if effective or not. be assessed for symptoms of dry, irritated The facility policy Consultant Pharmacist Services eyes and the physician will be notified of Provider Requirements, dated 2/15, indicated ongoing eye-related symptoms. Procedures, F. Specific activities that the consultant pharmacist performs includes, but is Resident number 35 - The resident is no not limited to: 2) communicating to the longer receiving Biofreeze routinely. The responsible prescriber and the facility leadership resident will receive Biofreeze on an as potential or actual problems detected and other needed basis to treat pain symptoms. The findings relating to medication therapy orders indications for use, effectiveness of the including recommendations for changes in medication, and any nonpharmacological medication therapy and monitoring of medication interventions will be documented. The therapy as well as regulatory compliance issues physician will be notified if the resident's at least monthly. current pain management plan is not effective. The care plan has been reviewed and revised to reflect pharmacological pain management interventions. To monitor compliance, the Director of Nursing will review the treatment records

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PRINTED: 03/14/2016

		AND HUMAN SERVICES			F	FORM	03/14/2016 APPROVED 0938-0391
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245431	B. WING			02/18/2016	
NAME OF	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
FIELD C	REST CARE CENTER			-	18 SECOND STREET NORTHEAST AYFIELD, MN 55940		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428 F 441 SS=D	483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and c to help prevent the of disease and infer (a) Infection Contro The facility must es Program under whi (1) Investigates, co in the facility; (2) Decides what pr should be applied to (3) Maintains a reco actions related to in (b) Preventing Spre (1) When the Infect determines that a re prevent the spread isolate the resident.	I CONTROL, PREVENT tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective affections. ead of Infection ion Control Program esident needs isolation to of infection, the facility must	F 4		to assure that PRN eye drops and to medications are given on as needed and that related documentation is completed according to facility policy, consultant pharmacist will also review administration patterns/documentation as needed eye drops and topical medications. If noncompliance is not additional auditing and staff education be done. Compliance will be reviewed during the April Quality Assurance an Performance Improvement Committee meeting.	basis . The w the on of ed, n will d nd ee	3/29/16

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM A	03/14/2016 APPROVED 0938-0391
STATEMENT OF AND PLAN OF CO	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	
		245431	B. WING _		02/1	8/2016
NAME OF PROV	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FIELD CRES	T CARE CENTER			318 SECOND STREET NORTHEAST HAYFIELD, MN 55940		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
co fro dir (3) ha ha pro (c) Pe tra infi Th by Ba rev infi wh (R ad sto 3 c reo Fir LA ON R1 wh a c glo glu Th	m direct contact will tra- ect contact will tra- o The facility must inds after each dir nd washing is ind ofessional practic Linens ersonnel must har insport linens so a ection. is REQUIREMEN ased on observat view, the facility fa- ection control pra- dition the facility fa- ection control pra- nen sanitizing a gl 18) observed for dition the facility fa- pre nebulizer equi- of 4 residents revi- ceived inhalation andings include: ACK OF PROPER N GLUCOMETER 8 was observed on en licensed pract glucose test. LPN oves and cleansed acometer with an an an a	ase or infected skin lesions with residents or their food, if ansmit the disease. trequire staff to wash their rect resident contact for which licated by accepted e. adle, store, process and as to prevent the spread of NT is not met as evidenced ion, interview and document ailed to ensure proper actices were implemented ucometer for 1 of 1 resident blood glucose monitoring. In failed to properly clean and ipment to prevent infection for iewed (R40, R56 & R53) who therapy. SANITIZING AGENT USED AFTER USE: on 2/17/16, at 11:13 a.m., tical nurse (LPN)-A completed -A was observed to remove d the entire outside of R18's	F 44	Regulation 483.65 Tag F441 Infection Control Field Crest Care Center has establia and maintains an infection control program designed to provide a safe sanitary, and comfortable environm the residents and to prevent the development and transmission of di and infection. The infection control program 1) investigates, controls, a prevents infections in the facility 2) determines the appropriate procedu any, that will be implemented (such isolation) for each resident with an infectious disease and 3) maintains record of incidences of infections ar tracks any alternative actions taken related to infection control. The facility has comprehensive infe control policies and procedures con	ent for isease nd ures, if as a nd	

Facility ID: 00104

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY
	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG _		COMP	LETED
		245431	B. WING			02/1	8/2016
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
FIELD C	REST CARE CENTER	2		-	8 SECOND STREET NORTHEAST AYFIELD, MN 55940		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 441	detergent/soap or water. Never put M liquids to enter Tes clean Meter. Clean WILL cause damag During interview or stated she typically alcohol wipe. LPN- germicidal (super S cleaning of glucom use an alcohol wip LPN-A verified she with an alcohol wip LPN-A verified she with an alcohol wip sugar. LPN-A verifi and then had clear stated I should hav clean gloves and th During interview or director of nursing super Sani-cloth (g sanitize the glucom gloves to be worn w The facility policy E and Care dated 9/6 Checking Blood Gl stick place used la used test strip in sł gloves; wash hand alcohol-based hand Disinfect blood glu	n dampened with mild 10% household bleach and leter in liquids or allow any t Port. Do not use alcohol to ing the Meter with alcohol	F 4	41	with the current state and federal infe control regulations and recommenda The policies address the surveillance investigation of infections and the maintenance of accurate and comprehensive records of resident/employee infections. The policies and procedures for cleat blood glucose machines was review and found appropriate; the procedure cleaning the nebulizer machines was revised to specify cleaning after each During the March 23, 2016 mandato meetings, the licensed nurses were reinstructed on the procedures for sanitizing glucometer machines and cleaning nebulizer machines. Compliance will be monitored by the Director of Nurses/designee through direct observation of the nurses glucometer sanitizing and nebulizer cleaning techniques. Random observations will be done for two we noncompliance is noted, additional monitoring and staff education will be done. Compliance will be reviewed a April quarterly Quality Assurance an Performance Improvement Committe meeting.	ations. e and aning ed e for s h use. ry eks. If e at the id	

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		AND HUMAN SERVICES				FORM	03/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245431	B. WING			02 / [.]	18/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
FIELD C	REST CARE CENTER	ł			18 SECOND STREET NORTHEAST IAYFIELD, MN 55940		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	TO PREVENT INFI DEVELOPING: R40 was observed room watching tele equipment on a bee resident. The mask connected by tubing medication canister small amount of liq that the nursing sta equipment in place When interviewed of R40 present, Regis she would expect th nebulizer mask and each use. She state were to be cleaned and left there until t condensation prese medication canister with RN-A. R40 sta would clean the equ R40's medication a from 2/1/16 through resident Duoneb 0. ipratropium-albuter times a day for chro disease. R56's physician oro that the resident ha ipratropium-albuter as needed for short	G NEBULIZER EQUIPMENT ECTION/S FROM on 2/16/16 at 2:56 p.m., in his vision. The nebulizer dside table next to the a and medication canister were g to the machine. The r was observed to contain a uid in the canister. R40 stated iff would usually leave the like that. on 2/17/16 at 2:43 p.m., with stered Nurse (RN)-A stated that he nursing staff to clean the d medication canister after ed that the mask and canister and dried on a piece of paper the next use. There was ent on the inner walls of the r at the time of this interview ted that the nursing staff uipment every evening. dministration record, dated n 2/18/16, indicated that the 5-3 mg/3 ml; ol; 1 vial dose nebulizer four onic obstructive pulmonary	F	141			

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		AND HUMAN SERVICES				FORM	03/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245431	B. WING			02/	18/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
FIELD CI	REST CARE CENTER				18 SECOND STREET NORTHEAST HAYFIELD, MN 55940		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	Continued From para nebulizer machine and medication can machine. They were observed to be con the medication can R53's room was chep.m., during the init nebulizer equipmer mask and canister to the machine. The on the inner walls of R53's physician or of that the resident had ipratropium-albuter and every four hour shortness of breath R53's medication and ated 2/1/16 throug resident had been medication. When interviewed of Registered Nurse (nebulizer equipmer use there was alwa infection. When interviewed of Director of Nursing have expected the cleaned after each	ge 30 at the bedside table. A mask hister was connected to the e both intact. There was densation on the inner walls of ister. ecked on 2/16/16 at 12:06 ial tour of the facility, to have ht near the bed. The nebulizer were connected by the tubing ere was visible condensation f the canister. Hers, dated 1/13/16, indicated d been prescribed Duoneb; ol; 1 vial dose four times a day rs as needed for cough,	F 4				
	Procedure for Clea	ment titled, Policy and ning Nebulizer Equipment (no all equipment with tepid tap					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 03/14/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (X3) DAT	E SURVEY IPLETED
		245431	B. WING	i	02	/18/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
FIELD CI	REST CARE CENTER				18 SECOND STREET NORTHEAST IAYFIELD, MN 55940	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441 F 465 SS=C	paper towel to air di week. Review of the facilit Medications (Febru medications were to and properly followi recommendations of 483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pro	y policy titled, Storage of ary 2015), it stated that b be stored safely, securely ng the manufacturer's or those of the supplier. L/SANITARY/COMFORTABL		441		3/29/16
	by: Based on observat review, the facility fa environment in a sta fires when using the potential to affect di person using the co for all residents resi Findings include: Observations of the at 12:06 p.m., with o revealed thick dust pipes located above on the stove hood s stove hood, and sto side of the stove wa	IT is not met as evidenced ion, interview, and document ailed to maintain dietary ate of cleanliness to prevent e cook stove. This had the etary staff especially the ok stove to make meals. Also ding in the facility.			 483. 70(h) Tag F456 – Safe, Sanitary, Comfortable Environment Field Crest Care Center staff 1) maintain all essential mechanical, electrical, and patient care equipment in safe operating condition and 2) provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The cleaning schedule for the hood area over the stove was changed from monthly to weekly. During the mandatory meeting March 1, 2016, the dietary staff was reeducated on the hood area cleaning procedure which includes cleaning of filters, sprinkler pipes, and all 	

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		AND HUMAN SERVICES				FORM	03/14/2016 APPROVED 0938-0391
STATEMENT OF DEFIC	IENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245431	B. WING			02 / ⁻	18/2016
NAME OF PROVIDER	OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FIELD CREST CA	RE CENTER				18 SECOND STREET NORTHEAST AYFIELD, MN 55940		
	CH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
areas of sprinkle During stated s cleaned Docum schedu cleaned vents w 2/16/16 Docum Cleanir read, re cycle, r hood w rinse w	ers were clea interview on she expected d every two v ent review o d monthly. D vere cleaned b ent review o ng Hood Filte emove scree emove scree eth degrease ell, wipe or s	and debris. DM-A stated the aned once a month. 2/17/16, at 11:37 a.m., DM-A d the stove hood screens to be	F 4	165	interior/exterior surfaces. Annually hood area including the flue is deep cleaned by a professional hood clea service company. The dietary manager will monitor compliance through routine observa- the cleanliness of the hood area an review of the cleaning schedule che lists. Compliance will be reviewed of the April quarterly Quality Assurance Performance Improvement Commi- meeting.	aning ation of d by eck during e and	

Facility ID: 00104

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

F5431024

PRINTED: 03/24/2016 FORM APPROVED AD NO 0029 0201

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPL	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	ABUILD	NG (01 - MAIN BUILDING 01		PLETED
		245431	B. WING	_		02/	17/2016
	PROVIDER OR SUPPLIER	2		3	TREET ADDRESS, CITY, STATE, ZIP CODE 18 SECOND STREET NORTHEAST AYFIELD, MN 55940		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	K	000			
	FIRE SAFETY						
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM VERIFICATION OF UPON RECEIPT C ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS H/ ACCORDANCE W	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE				>	
2	Minnesota Departn Fire Marshal Divisi of this survey, Field not in substantial c requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National	nent of Public Safety - State on on Feb 17,2016. At the time dcrest Care Center was found ompliance with the articipation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),					
2	PLEASE RETURN CORRECTION FO DEFICIENCIES (K Health Care Fire In State Fire Marshal 445 Minnesota St., St Paul, MN 55101 By email to:	R THE FIRE SAFETY -TAGS) TO: spections Division Suite 145			EPOC		•
		DER/SUPPLIER REPRESENTATIVE'S SIG			TITLE		(X6) DATE
	nically Signed	DEMOUFFLIER REFREGENTATIVE 3 31G	IN UKE		11166		03/11/2016

Electronically Signed

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.

		AND HUMAN SERVICES			FORM): 03/24/201 /I APPROVE). 0938-039	
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DA	TE SURVEY MPLETED	
		245431	B. WING		02/17/2016		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 318 SECOND STREET NORTH HAYFIELD, MN 55940	DRESS, CITY, STATE, ZIP CODE ID STREET NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIO DATE	
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of w to correct the defici 2. The actual, or pro- 3. The name and/or responsible for corre- prevent a reoccurred The Fieldcrest Care The original building was determined to construction, with a addition was constrible of Type II (111) of basement. In 1995, and was determine construction, with n The facility is fully s alarm system with f and spaces open to	tate.mn.us and @state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. e Center is a 1-story building. g was constructed in 1969 and be of Type II (111) partial basement. In 1972, an ucted and was determined to construction, with a full an addition was constructed d to be of Type II (111)		00			
	The facility has a ca census of 33 at the	-					
K 011	NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD	кo)11		3/7/16	

Facility ID: 00104

If continuation sheet Page 2 of 5

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/24/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE	SURVEY
		245431	B. WING			02/1	7/2016
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
FIELD CF	REST CARE CENTER				B SECOND STREET NORTHEAST AYFIELD, MN 55940		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 011 SS=F	nonconforming buil barrier having at lea rating constructed of addition. Communit corridors and shall self-closing fire doo resistance rating 18.1.1.4.1, 18.1.1.4 19.1.1.4.2 This STANDARD is Based on observat has failed to proper required 2-hour fire with NFPA 101 (200 19.1.1.4 and 19.1.2 deficient practice of of 33 residents. FINDINGS INCLUE During the facility to AM and 12:30 PM of that the 2 hour fire Nursing facility and penetrations above	a common wall with a ding, the common wall is a fire ast a two hour fire resistance of materials as required for the cating openings occur only in be protected by approved rs with at least 1 1/2 hour fire .2, 18.2.3.2, 19.1.1.4.1, s not met as evidenced by: ions and interview, the facility ly construct and maintain a separation, in accordance 00), Chapter 19, Sections .1. In a fire emergency, this build adversely affect the safety	ΚO	11	K011 The open penetration around the co in the fire separation wall above the ceiling between the nursing home at Assisted Living Unit were sealed wit intumescent fire barrier caulk and fir wool on March 7, 2016. The Maintenance Director is respon for monitoring compliance.	drop nd the th re	
K 025 SS=F	Supervisor at the til NFPA 101 LIFE SA Smoke barriers sha least a one half hou constructed in acco barriers shall be pe	nfirmed with the Maintenance me of discovery. FETY CODE STANDARD all be constructed to provide at ur fire resistance rating and ordance with 8.3. Smoke rmitted to terminate at an ws shall be protected by	КO)25			3/7/16

Event ID: QQT121

Facility ID: 00104

If continuation sheet Page 3 of 5

	A PERSON NEEDED TO COMPANY AND A REAL PROPERTY	AND HUMAN SERVICES			APPROVE	
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION (X3) DA	TE SURVEY MPLETED	
		245431	B, WING	02	02/17/2016	
AME OF F	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
IELD CI	REST CARE CENTER	2	:			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
K 025	steel frames. 8.3, 19.3.7.3, 19.3. This STANDARD i Based on observa facility failed to mai accordance with th 2000 edition, Section and 8.3.6. This de 33 residents within Findings include: On facility tour betw on 02/17/2016, it w penetrations that th	r by wired glass panels and 7.5 is not met as evidenced by: tion and staff interview, the intain the smoke barrier in e requirements of NFPA 101 - ons 19.3.7, 19.3.7.3, 8.3, 8.3.2 eficient practice could affect all the smoke compartments. ween 09:00 AM and 12:30 PM ras observed that all wings had he smoke barrier doors above wires, conducts and ducts in ons: arrier parrier	K 025	K025 The open penetrations in the smoke barrier walls/doors above the drop ceiling in Wings I, II, and III were sealed on Marci 7, 2016 with intumescent fire barrier cault and fire wool. The Maintenance Director is responsible for monitoring compliance.	า	
K 054 SS=F	Superior at the time NFPA 101 LIFE SA All required smoke activating door hold maintained, inspec with the manufactu This STANDARD is Based on staff inte documentation, the conducting sensitiv detectors on the fir	FETY CODE STANDARD detectors, including those d-open devices, are approved, ted and tested in accordance irrer's specifications. 9.6.1.3 is not met as evidenced by: erview and review of available a facility has not been vity testing of the smoke e alarm system in accordance Sec. 7-3.2.1. This deficient	K 054	K054 The Tech One Company performed the required alarm sensitivity test on March 3 and 4, 2016. To assure that timely testing is done, the need for testing will be added	I	

Event ID: QQT121

Facility ID: 00104

If continuation sheet Page 4 of 5

NAME OF PRO FIELD CRES (X4) ID PREFIX TAG K 054 Co Fii Oi or fir fa	DEFICIENCIES CORRECTION OVIDER OR SUPPLIER ST CARE CENTER SUMMARY STA	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245431	l ' '		CONSTRUCTION 1 - MAIN BUILDING 01		E SURVEY PLETED
FIELD CRES	ST CARE CENTER	245431	B, WING				
FIELD CRES	ST CARE CENTER					02/*	17/2016
(X4) ID PREFIX TAG K 054 Co Fin Or or fir fa	SUMMARY STA				REET ADDRESS, CITY, STATE, ZIP CODE		
K 054 Co Fin On or fin fa					8 SECOND STREET NORTHEAST AYFIELD, MN 55940		
Fi Or fir fa		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
Tł	n 2/17/2016, a rev re alarm test docu acility failed to con est of each smoke	veen 9:00 AM and 12:30 PM view of the facility's available imentation revealed that the ducted the required sensitivity detector. ice was verified by the	κo	054	The Maintenance Director will mo compliance.	nitor for	
	(02-99) Previous Versions	s Obsolete Event ID: QQT12			ility ID: 00104 If conti		eet Page 5 o

PRINTED: 03/24/2016



Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted March 2, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5431027

Dear Ms. Gustason:

The above facility was surveyed on February 16, 2016 through February 18, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. Field Crest Care Center March 2, 2016 Page 2

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731.

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

Please 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.

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

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

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00104	B. WING		02/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FIELD C	REST CARE CENTER		ND STREET), MN 55940	TNORTHEAST)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department with notice of assessme	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	
	epartment of Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

Electronically Signed

STATE FORM

6899

If continuation sheet 1 of 29

03/11/16

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00104	B. WING		02/18/2016	
	PROVIDER OR SUPPLIER	318 SECO		STATE, ZIP CODE F NORTHEAST)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm On 2/16/16, 2/17/16 Department's staff, the following correct Please indicate in y correction that you	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the	2 000	The assigned tag number a far left column entitled "ID The state statute/rule out of listed in the "Summary State Deficiencies" column and re Comply" portion of the correc This column also includes t which are in violation of the after the statement, "This R as evidence by." Following findings are the Suggested Correction and Time period PLEASE DISREGARD THE THE FOURTH COLUMN W STATES, "PROVIDER'S PL CORRECTION." THIS APP FEDERAL DEFICIENCIES WILL APPEAR ON EACH F THERE IS NO REQUIREM SUBMIT A PLAN OF CORF VIOLATIONS OF MINNESO STATUTES/RULES.	Prefix Tag." f compliance is ement of eplaces the "To ection order. he findings state statute tule is not met the surveyors Method of for Correction. E HEADING OF /HICH AN OF PLIES TO ONLY. THIS PAGE. ENT TO RECTION FOR	
2 560	Plan of Care; Contents Subp. 2. Contents comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The c must include the inc	of plan of care. The n of care must list measurable stables to meet the resident's n goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557,	2 560			3/29/16

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00104	B. WING		02/18/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
FIELD C	REST CARE CENTER		DND STREE D, MN 5594	T NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 560	Continued From pa	ige 2	2 560			
	by: Based on interview facility failed to dev plan that included a from the use of an 1 of 5 residents (R2 medications. Findings include: R26's physician ord an order for Lovend ml (milliliters), give daily for history of d and pulmonary eml	ent is not met as evidenced and document review, the elop a comprehensive care a list of possible side affects anticoagulation medication for 26) reviewed for unnecessary ders dated 12/28/15, identified bx 120 mg (milligrams) per 0.8 120 mg subcutaneously (SQ) deep vein thrombosis (DVT) bolism (PE). The medication rd, dated 2/16, showed the		See corresponding F tag		
	orders. R26's current care	en daily per the physician plan failed to identify the use nd the diagnoses of DVT and				
	On 2/17/16, at 3:18 (DON) confirmed F the use of the med and PE. The DON	p.m., the director of nursing R26's care plan failed to identify ication and diagnoses of DVT stated she would expect the be identified on R26's care				
	identified Compreh This is a personaliz the nature of the illu long and short rang physicians orders f and other therapy; consultation service	care Planning, dated 4/12, ensive Care Plan: Procedure: red plan of daily care based on ness, treatment prescribed, ge goals which include: the or medication, treatments, diet the types of care and es needed; how they can best now the plan meets the needs				

If continuation sheet 3 of 29

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00104	B. WING		02/18/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
	REST CARE CENTER		OND STREET D, MN 55940	T NORTHEAST)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETI DATE
2 560	Continued From pa	age 3	2 560			
		e patient; what methods are nd the modification necessary Ilts.				
	The director of nurs develop, review, an procedures to ensu- plans to address to concerns. The director of nurs educate all appropri procedures. The director of nurs	THOD OF CORRECTION: sing (DON) or designee could ind/or revise policies and ure the facility develop care address resident specific sing (DON) or designee could riate staff on the policies and sing (DON) or designee could systems to ensure ongoing				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one	,			
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			3/29/16
		omprehensive plan of care I personnel involved in the t.				
	by: Based on observat review, the facility f treatments as asse pressure ulcers and from developing for	ent is not met as evidenced ion, interview, and document failed to provided services and essed to promote healing of d prevent new pressure ulcers r 1 of 3 residents (R36) nple with current pressure		See corresponding F tag		

Minnesota Department of Health STATE FORM

6899

QQT111

If continuation sheet 4 of 29

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00104	B. WING		02/18/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FIELD C	REST CARE CENTER	2	OND STREET	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 4	2 565			
	Findings include:					
	chair without repos 12:52 p.m. or a tota even though R36 w repositioned very 1	(continuous) to sit in wheel itioning from 8:17 a.m. to al of 4 hours and 35 minutes vas assessed to be to 1 1/2 hours as care plan ge IV pressure ulcer located or	n			
	diagnosis that inclu according to facility 2/17/16. The Admi	to the facility on 10/22/14, with ided vascular dementia Admission Record dated ission Record identified other ure ulcer of right hip, stage te of 9/30/15.				
	Data Set (MDS), and identified R36 with on admission to face and required exten	of facility quarterly Minimum in assessment dated 1/31/16, one stage four pressure ulcer cility, healed pressure ulcers, sive assistance of two staff for ring including bed mobility and				
	8:17 a.m., to 12:52 From 8:17 a.m. to 9 dining room, eating assistance to eat fr meal at 9:30 a.m.	servations on 2/17/16, from p.m., revealed the following: 9:30 a.m. observed to be in 9 independently, some rom staff, completed eating				
	in her wheelchair fr cove room for an a 9:44 a.mAA-A left remained in the roo	tivity aide (AA)-A moved R36 rom dining room table to cozy ctivity starting at 10:00 a.m. At c cozy cove room, while R36 om with two other residents. 11:00 a.m. R36 with five other church service.				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00104	B. WING		02/18/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
		318 SEC	OND STREET	NORTHEAST		
FIELD C	REST CARE CENTER		D, MN 55940			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ige 5	2 565			
	from staff to eat, ar asleep at 12:51 p.m	meal, had some assistance nd when R36 began to fall n. staff asked if she wanted to this time was moved to her				
	R36 to her room ar place gait belt on R transferred R36 fro removed incontiner amount soft stool, r peri-rectal care. We clean, dry, and inta buttocks. A-A and incontinent brief wa positioned R36 in b back, heel protecto and bed flat. Obser cushion in wheelch During interview on and NA-B stated R3	2/17/16, at 1:01 p.m., NA-A 36 was to be repositioned				
	11/10/15, noted a s right hip. Goal was dressing changes a pressure areas thro Interventions includ bed as flat as possi administer treatmen effectiveness, asse healing weekly, me where possible, ass wound perimeter, w progress, report im	iated 11/7/14 and revised on stage four pressure ulcer on to be comfortable during and not obtain any new bugh next review date.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00104	B. WING		00/40/0040	
		00104			02/18/2016	
		318 SEC	DDRESS, CITY, ST OND STREET			
-IELD C	REST CARE CENTER	HAYFIEL	D, MN 55940			1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 6	2 565			
	supplements as ore odor or worsening s infection, fever, cor assistance to turn a hours more often a off right hip, rotate pillows to reposition mattress and a cus loading . The care p and repositioning p every 1 to 1.5 hours pillows to position, turning and repositi During interview on of nursing stated sh every 1 to 1 1/2 hou plan. Document review of dated 12/2011, reve "Residents whom a themselves, have a implemented based assessment." SUGGESTED MET The director of nurs and/or revise polici- the facility followed according to the res	dered, notify hospice if foul signs and symptoms of infusion or pain, needs and reposition every 1 to 1.5 s needed or requested, keep from back to left side, use n, requires an overlay air shion in wheelchair to aid in off plan directed staff R36 turning rogram: turn and reposition s, keep off right hip, use R36 can participate with toning with bilateral assist bars a 2/17/16, at 1:14 p.m., director ne expected R36 repositioned urs, according to R36's care of facility Skin Integrity policy ealed procedure #3. a. are unable to reposition a repositioning schedule d upon the Tissue Tolerance FHOD OF CORRECTION: sing could develop, review, es and procedures to ensure care plan interventions sident's individualized needs. sing could educate all				
	to follow care plan nursing could moni compliance.	n the policies and procedures interventions. The director of tor to ensure ongoing R CORRECTION: Twenty-one				

	ta Department of He	ealth			FORM APPROV	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00104	B. WING		02/18/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
FIELD C	REST CARE CENTER		OND STREE ⁻ D, MN 5594(ΓNORTHEAST)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLE	
2 570	Continued From pa	ige 7	2 570			
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570		3/29/16	
	interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p participation of the guardian or chosen quarterly and within	wed and revised by an im that includes the attending red nurse with responsibility d other appropriate staff in rmined by the resident's needs, oracticable, with the resident, the resident's legal representative at least a seven days of the revision of resident assessment required subpart 3, item B.				
	by: Based on interview failed to revise the intervention for 1 of for accidents. In ad include identified ta	ent is not met as evidenced and record review, the facility care plan to include a fall f 2 residents (R35) reviewed dition, the facility failed to rrgeted mood symptoms for 1) reviewed for unnecessary		See corresponding F tag		
	Finding include:					
	the resident has has balance and poor s interventions of allo partially shut when level when leaving not shut all of the w bed height should b (non-slip pad) to wh	ted revision 9/28/15, identified d multiple falls related to poor afety awareness with w resident to have door hallway is noisy, assess noise room, keep door cracked, do vay due to safety concerns, be at knee level, Dycem neelchair to reduce/prevent ir, keep bathroom door shut				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00104	B. WING		02/18/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
FIELD C	REST CARE CENTER	2	OND STREET D, MN 55940	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 570	when resident is no mattress to bed, a wheelchair, offer to awake, first and se (PRN) to prevent th soft touch call light soft touch near edg when resident is in reach at bedside w R35's Fall Scene In Progress Notes, da identified R35 was body half way on b intervention implem be left in room alor an agitation episod R35's care plan fai of resident is not to wheelchair during a addition, the nursin dated 2/17/16, faile R35's fall risk asse identified a score o On 2/17/16, at 3:24 (DON) verified R35 the intervention of room alone when in	ot in the bathroom, perimeter uto locking brakes on bileting every two hours while cond rounds and as needed the need for self-transferring, attached to call cord, keep ge of bed when leaving room bed and wheelchair within when resident in bed. Investigation Report and ated 2/4/16 and 2/5/16, found on knees with upper ed. Falls team reviewed and nented was resident is not to ne when in wheelchair during	2 570			
	plan would need to include the interven intervention to be o The facility policy F indicated Procedur	. The DON stated R35's care be updated by the nurse to ntion in order for the on the nursing assistant kardex Fall Risk, dated 1/28/10, re: 3. Residents at risk will be ure plan with specific				

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00104	B. WING		02/18/2016		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE, ZIP CODE				
FIELD CI	REST CARE CENTER	4	OND STREET D, MN 55940	NORTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
2 570	Continued From pa	age 9	2 570				
		n will be reviewed/revised to nt is at risk for falls and specific Ice.					
	order for Celexa 5 medication adminis	der dated 1/7/16, identified an mg (milligrams) daily. R26's stration record dated 2/16, ved the medication daily as per					
		c Med Review, dated 12/7/15, argeted behaviors were ss and sadness.					
	identified the reside medication Celexa for depressed moo with interventions of medication as orde monitor/document assist the resident activities that is me (hunting, socializing provide opportuniti activity, assist the identify strengths, p reinforce these, mo	ated revision 12/15/15, ent uses antidepressant related to Depression. At risk od related to terminal diagnosis, of administer antidepressant ered by physician, side effects and effectiveness, in developing a program of eaningful and of interest g with others), encourage and es for exercise, physical resident, family, caregivers to positive coping skills and onitor for signs of depression, opetite and loss of interest.					
	behaviors of tearfu interventions to be behaviors. In additi kardex failed to inc isolation, tearfulnes	iled to include the targeted Iness and sadness and implemented for the target ion, R26's nursing assistant clude the targeted behaviors of ss, sadness and interventions I for the targeted behaviors.					
		8 p.m., the DON verified R26's include the targeted behaviors					

If continuation sheet 10 of 29

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00104	B. WING		02/	18/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
FIELD C	REST CARE CENTER		DND STREET D, MN 55940	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	of sadness, tearfulr interventions monitic confirmed the R26's failed to include the isolation, tearfulness to be implemented. expect the targeted The DON stated the exception if the beh The facility policy C identified Comprehe This is a personaliz the nature of the illr long and short rang physicians orders for and other therapy; if consultation services be accomplished; h and interests of the most successful; ar to ensure best result be utilized by all pe the resident. To ass comprehensive car evaluated and updat interdisciplinary tea resident's family me at least quarterly. SUGGESTED MET The director of nursi develop and impler related to care plan designee, could pro- staff related to the t	hess and read under or for isolation. The DON is nursing assistant kardex e targeted behaviors of iss, sadness and interventions The DON stated she would I behaviors to be care planned. e facility documents by havior is noted. Fare Planning, dated 4/12, ensive Care Plan: Procedure: ted plan of daily care based on hess, treatment prescribed, je goals which include: the or medication, treatments, diet the types of care and es needed; how they can best how the plan meets the needs patient; what methods are nd the modification necessary lts. Resident care plans shall rsonnel involved in the care of sure accuracy, the e plan will be reviewed, ated, as needed, by the m in participation with the ember or legal representative THOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures or revisions. The DON or ovide training for all nursing timeliness of care plan ity assessment and assurance erform random audits to	2 570			

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE SURVEY COMPLETED	
		00104	B. WING		02/18/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
FIELD C	REST CARE CENTER		DND STREE D, MN 5594	T NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	
2 570	Continued From pa	ige 11	2 570			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900		3/29/16	
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	who has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: Based on observati review, the facility f interventions to pro pressure ulcer and of pressure ulcers f	ent is not met as evidenced ion, interview, and document ailed to implement assessed mote healing of one stage four prevent further development for 1 of 3 residents (R36) nple with pressure ulcers.		See corresponding F tag		
	Findings include:					
	12:52 p.m. a total o without repositionin	elchair form 8:17 a.m. until f 4 hours and 35 minutes g even though R36 skin nined she should be				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00104	B. WING		02/18/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
FIELD CI	REST CARE CENTER	2	OND STREET D, MN 55940	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	stage IV pressure of R36 was admitted diagnosis that inclu according to facility 2/17/16. The Admit diagnosis of presso four, with onset dat Document review of Data Set (MDS), and identified R36 with on admission to face and required exten activities of daily live transfers. R36 continuous ob 8:17 a.m., to 12:52 From 8:17 a.m. to 12:52 From 8:17 a.m. to 12:52 From 8:17 a.m. to 12:52 From 9:38 a.m. act in her wheelchair fr cove room for an a 9:44 a.mAA-A left remained in the roof From 9:56 a.m. to residents attended From 11:00 a.m. to dining room eating from staff to eat, ar asleep at 12:51 p.m.	 1.5 hours to 2 hours due to a ulcer located on hip. to the facility on 10/22/14, with uded vascular dementia / Admission Record dated ission Record identified other ure ulcer of right hip, stage te of 9/30/15. of facility quarterly Minimum n assessment dated 1/31/16, one stage four pressure ulcer cility, healed pressure ulcers, isive assistance of two staff for <i>r</i> ing including bed mobility and eservations on 2/17/16, from the p.m., revealed the following: 9:30 a.m. observed to be in g independently, some rom staff, completed eating tivity aide (AA)-A moved R36 rom dining room table to cozy uctivity starting at 10:00 a.m. At to cozy cove room, while R36 pm with two other residents. 11:00 a.m. R36 with five other 				
	room. At 12:52 p.m. nursi	ing assistant (NA)-A moved nd then NA-A proceeded to				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00104	B. WING		02/18/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE		
FIELD C	REST CARE CENTER		ND STREET), MN 55940	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 900	place gait belt on R transferred R36 fro removed incontiner amount soft stool, r peri-rectal care. Wo clean, dry, and inta buttocks. A-A and incontinent brief wa positioned R36 in b back, heel protecto and bed flat. Obser cushion in wheelch During interview on and NA-B stated re every 1 to 2 hours. Sitting/Tissue Toler assessment dated no redness noted re healing stage four p trochanter and had will put R36 on a 1. schedule while sittin wheelchair cushion The quarterly Brade Risk Data Collectio 1/25/16, summary, moderate risk for d The summary identified daily. Treatment dir aquacel AG and co Wound healing wel required one staff a	36. NA-A and NA-B m wheelchair to bed. NA-B m wheelchair to bed. NA-B nt brief, incontinent of small no urine, and provided bund dressing on right hip was ct. No redness or wrinkles on NA-B verified R36's as dry of urine. NA-A and NA-B red on left side with pillow to rs on, pillow between knees, ved air mattress on bed and air. 2/17/16, at 1:01 p.m., NA-A sident was to be repositioned ance Evaluation, an 10/30/15, summary indicated elated to test, due to R36 has pressure ulcer on right redness to coccyx previously, 5 to 2 hour repositioning ng, has a pressure reducing en Scale/ Comprehensive Skin n, an assessment dated revealed R36 was at evelopment of pressure ulcer. tified R36 has stage four ulcer (hip), measuring 0.5 y 0.3 cm by 0.4 cm. The ulcer dressing was changed ected to pack the wound with ver with foam dressing. I. The summary indicated R36 issist with activities of daily ist for transfers, and	2 900			

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
		00104	B. WING		02/18/2			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE					
		318 SEC	OND STREET					
FIELD CI	REST CARE CENTER	HAYFIEL	D, MN 55940					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
2 900	Continued From pa	age 14	2 900					
	revealed the right tr assessed weekly. revealed the follow 11/24/15-1.3 cm ler depth, no tunne 12/22/15-0.5 cm ler depth, 0.7 cm tu 2/16/16-0.5 cm ler depth, 0.7 cm tu 2/16/16-0.3 cm ler depth, no tunneli Skin/wound progre measurements rev trochanter (hip) wo measured 0.3 lerg 100 percent granul 0.7 cm undermining note indicated no s	of facility Wound Tracking, rochanter (hip) wound was Review of the wound tracking ing monthly assessments: ngth, 1.5 cm wide, 2.1 cm ling, 1.3 cm undermining; ngth, 0.5 cm wide, 1.0 cm ling, 0.7 cm undermining; gth, 0.3 cm wide, 0.6 cm nneling, no undermining; gth, 0.3 cm wide, 0.6 cm ing, 6.5 cm undermining. ss note dated 2/9/16 wound ealed the following: right und stage four healing, th by 0.3 wide, by 0.7 depth, ated tissue in wound bed, with g, no tunneling. The progress igns or symptoms of infection,						
	intact, dry and pink tissue, no pain. R3	o odor noted. Peri wound skin to normal color scarring 6 received supplement. R36 is sitioning schedule, continue						
	11/10/15, revealed ulcer on right hip. C during dressing cha pressure areas thro Interventions includ		,					
	administer treatme effectiveness, asse	ible to reduce shear, nts as ordered and monitor for es, record, and monitor wound easure length, width and depth						

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00104	B. WING		02/18/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		318 SEC		NORTHEAST		
FIELD C	REST CARE CENTER	HAYFIEL	D, MN 55940			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 15	2 900	DEFICIENC	, Y)	
	wound perimeter, w progress, report im the physician, do n monitor nutritional supplements as or odor or worsening infection, fever, cor assistance to turn a hours more often a off right hip, rotate pillows to reposition mattress and a cus loading . The care and repositioning p every 1 to 1.5 hour pillows to position, turning and reposit During interview or of nursing stated sl	sess and document status of vound bed and healing provements and declines to ot position on right side, status, serve protein dered, notify hospice if foul signs and symptoms of nfusion or pain, needs and reposition every 1 to 1.5 us needed or requested, keep from back to left side, use n, requires an overlay air shion in wheelchair to aid in off plan directed staff R36 turning program: turn and reposition s, keep off right hip, use R36 can participate with ioning with bilateral assist bars.				
	dated 12/2011, rev "Residents whom a themselves, have a implemented based assessment." SUGGESTED MET The director of nurs policies and procee	of facility Skin Integrity policy ealed procedure #3. a. are unable to reposition a repositioning schedule d upon the Tissue Tolerance THOD OF CORRECTION: sing could review and revise dures to ensure the facility				
	to the resident's inc director of nursing risk for pressure u the necessary treat	ulcer interventions according dividualized needs. The could review all residents at lcers to assure they received tment to prevent pressure ping and to promote healing of				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVE COMPLETED	
		00104	B. WING		02/18/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	REST CARE CENTER		OND STREET .D, MN 55940	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 900	in-service all appro	e director of nursing could priate staff on appropriate	2 900			
	nursing could cond	ventions. The director of uct random audits of the ensure appropriate care and emented.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21390		0 Subp. 4 A-I Infection Control				3/29/16
	control program mu procedures which p A. surveillance collection to identify residents;	and procedures. The infection ust include policies and provide for the following: based on systematic data r nosocomial infections in				
	control of outbreaks C. isolation and reduce risk of trans	r detection, investigation, and s of infectious diseases; d precautions systems to mission of infectious agents; ducation in infection trol:				
	E. a resident h immunization progr defined in part 465 procedures of resid	ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections;	3			
	F. the developr employee health po practices, including defined in part 4658	nent and implementation of blicies and infection control a tuberculosis program as 3.0815;				
	H. a system for					
		maintaining awareness of				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00104	B. WING		02/18/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	REST CARE CENTER	2	OND STREE D, MN 5594	T NORTHEAST 0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
21390	Continued From pa	age 17	21390			
	current standards o	of practice in infection control.				
	by: Based on observat review, the facility f infection control pra when sanitizing a g (R18) observed for addition the facility store nebulizer equ 3 of 4 residents rev received inhalation Findings include: LACK OF PROPER ON GLUCOMETED R18 was observed when licensed prace a glucose test. LPN	R SANITIZING AGENT USED R AFTER USE: on 2/17/16, at 11:13 a.m., ctical nurse (LPN)-A completed N-A was observed to remove ed the entire outside of R18's		See corresponding F tag		
	The manufacturer by the facility, read clean, lint-free cloth detergent/soap or water. Never put M liquids to enter Tes clean Meter. Clean WILL cause damag During interview or	Turneries instructions provided "Meter Care Wipe Meter with n dampened with mild 10% household bleach and leter in liquids or allow any t Port. Do not use alcohol to ing the Meter with alcohol				
	alcohol wipe. LPN- germicidal (super S cleaning of glucom	A stated the facility also had Sani-cloth) wipes used for eters. LPN-A stated if I do not e I use the germicidal wipe.				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00104	B. WING		02/18/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
		318 SEC	OND STREET	NORTHEAST		
	REST CARE CENTER	HAYFIEL	D, MN 55940			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 18	21390			
	with an alcohol wip sugar. LPN-A verifi- and then had clean stated I should hav clean gloves and the During interview on director of nursing s super Sani-cloth (g sanitize the glucom gloves to be worn v The facility policy B and Care dated 9/6 Checking Blood Glu stick place used lar used test strip in sh gloves; wash hands alcohol-based hand Disinfect blood glud wiping with approve and allow drying. F 4. B. Meter Care: C with approved sanit	had cleansed the glucometer e after checking R18's blood ed she had removed gloves used the glucometer. LPN-A e washed my hands, applied hen cleansed the glucometer. A 2/17/16, at 3:12 p.m., the stated staff should use the ermicidal disinfecting wipe) to beter and she would expect when cleaning the glucometer. Blood Glucose Testing/Cleaning b/11, indicated Procedure: 2. ucose: C. Following the finger neet in sharps container; place harps container. D. Remove s with soap and water or d rub; apply new gloves. E. cose meter after each use by ed sanitizer per label directions . Remove gloves; wash hands. Cleaning the meter. Wipe Meter tizer. Do not use alcohol to so will cause damage.				
	LACK OF STORIN TO PREVENT INF DEVELOPING:	G NEBULIZER EQUIPMENT ECTION/S FROM				
	room watching tele equipment on a bear resident. The mask connected by tubin medication canister small amount of liq	on 2/16/16 at 2:56 p.m., in his vision. The nebulizer dside table next to the and medication canister were g to the machine. The r was observed to contain a uid in the canister. R40 stated iff would usually leave the like that.				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00104	B. WING		02/18/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
FIELD CI	REST CARE CENTER	2	OND STREET D, MN 55940	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 19	21390			
	When interviewed on 2/17/16 at 2:43 p.m., with R40 present, Registered Nurse (RN)-A stated that she would expect the nursing staff to clean the nebulizer mask and medication canister after each use. She stated that the mask and canister were to be cleaned and dried on a piece of paper and left there until the next use. There was condensation present on the inner walls of the medication canister at the time of this interview with RN-A. R40 stated that the nursing staff would clean the equipment every evening. R40's medication administration record, dated from 2/1/16 through 2/18/16, indicated that the resident Duoneb 0.5-3 mg/3 ml; ipratropium-albuterol; 1 vial dose nebulizer four times a day for chronic obstructive pulmonary disease.		t			
	that the resident ha	ders, dated 2/1/16, indicated ad been prescribed Duoneb; rol; 1 vial dose four times a day thess of breath.				
	the facility R56's ro nebulizer machine and medication can machine. They we	6 p.m., during the initial tour of oom was observed to have a at the bedside table. A mask nister was connected to the re both intact. There was indensation on the inner walls of nister.				
	p.m., during the init nebulizer equipment mask and canister	necked on 2/16/16 at 12:06 tial tour of the facility, to have nt near the bed. The nebulizer were connected by the tubing ere was visible condensation of the canister.				
	R53's physician or	ders, dated 1/13/16, indicated				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00104	B. WING		02/	02/18/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
FIELD C	REST CARE CENTER	2	DND STREET D, MN 55940	NORTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21390	Continued From pa	age 20	21390				
	that the resident had been prescribed Duoneb; ipratropium-albuterol; 1 vial dose four times a day and every four hours as needed for cough, shortness of breath.						
	dated 2/1/16 throug	administration record (MAR), gh 2/16/16, indicated that the receiving the Duoneb					
	Registered Nurse (nebulizer equipme	on 2/17/16 at 3:01 p.m., (RN)-A stated that if the nt was not cleaned after each ays the potential to introduce					
	Director of Nursing have expected the cleaned after each	on 2/17/16 at 3:37 p.m., the (DON) stated that she would nebulizer equipment to be use. She stated that there tial for infection if not.					
	Procedure for Clea date), stated rinse water; invert the cu	ument titled, Policy and aning Nebulizer Equipment (no all equipment with tepid tap up and place equipment on dry; change all tubing once a					
	Medications (Febru medications were t and properly follow	ity policy titled, Storage of uary 2015), it stated that to be stored safely, securely ring the manufacturer's or those of the supplier.					
	administrator or de and procedures to control techniques	l of Correction: The signee could review policies ensure proper infection regarding blood glucose aning of nebulizer equipment					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		e survey IPleted
		00104	B. WING		02/18/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
FIELD C	REST CARE CENTER		DND STREET D, MN 55940	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21390	Continued From page 21		21390			
		y staff could be reeducated tem developed to ensure				
	Time Period for Co days.	rrection: Twenty one (21)				
21530	MN Rule 4658.1310) A.B.C Drug Regimen Review	21530			3/29/16
	reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of H Health Care Financ This standard is ind available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upor physician visit, or so pharmacist. For pu upon" means the act report and the signi of nursing services C. If the attend with the pharmacist not provide adequa pharmacist believes being adversely affer refer the matter to t if the medical direct physician. If the medical	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, ing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports to by the time of the next boner, if indicated by the rposes of this part, "acted cceptance or rejection of the ng or initialing by the director and the attending physician. ing physician does not concur 's recommendation, or does te justification, and the s the resident's quality of life is ected, the pharmacist must he medical director for review for is not the attending edical director determines that cian does not have adequate				

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00104	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
FIELD C	REST CARE CENTER		OND STREE D, MN 55940			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	i.	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLET DATE
21530	Continued From pa	ge 22	21530			
	physician does not must be referred fo assessment and as by part 4658.0070. the medical director must refer the matt	order and if the attending change the order, the matter r review to the quality surance committee required If the attending physician is or, the consulting pharmacist er directly to the quality surance committee.				
	by: Based on observati review the facility fa pharmacist identifie needed (PRN) med (R16 and R35), who	ent is not met as evidenced ion, interview and record ailed to ensure the consultant ed the ongoing use of as lications for 2 of 2 residents o had received the PRN reason for giving and if		See corresponding F tag		
	Findings include:					
	an order for tears n	lers, dated 1/21/16, identified atural drops, one drop to both urs while awake as needed				
		p.m., registered nurse (RN)-B Iminister artificial tears two s of R16.				
	dated 1/16 and 2/10 drops, one drop to while awake PRN a had been handwritt medication adminis and 2/16, failed to i	dministration records (MAR's) 6, identified tears natural both eyes every four hours and the times of a.m. and p.m. en on the MAR's. R16's PRN stration records, dated 1/16 nclude the reason the eye stered and effectiveness of the				

Minnesota Department of Health STATE FORM

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/18/2016	
		00104	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	REST CARE CENTER	2	OND STREET .D, MN 55940	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21530	Continued From pa	age 23	21530			
	R16's consultant pharmacist medication regimen reviews from 4/8/15 through 2/17/16, failed to address the PRN eye drops lack of reason for giving and if effective nor not.					
	physician orders, d order for tears natu eyes every four ho	9 p.m., RN-B confirmed R16's lated 1/21/16, identified an ural drops, one drop to both urs while awake PRN for dry umentation of reason for giving t.				
	an order for Biofree	ders, dated 1/13/16, identified eze (pain medication), apply daily (QID) PRN for pain.				
	dated 12/15, 1/16 a topically QID PRN. records, dated from to include documen medication was be	administration records (MAR's) and 2/16, Biofreeze apply R35's PRN medication n 12/15, 1/16 and 2/16, failed ntation for the reason the ing administered, pain level, measures offered and e medication.				
	reviews monthly fro failed to address the documentation for being administered	harmacist medication regimen om 4/8/15 through 2/17/16, ne PRN Biofreeze lack of the reason the medication was I, pain level, non-pharmalogica and effectiveness of the				
	(DON) stated she w drops and R35's Bi written per physicia	4 p.m., the director of nursing would expect the R16's eye iofreeze to be administered as an orders. Also to document nd if effective or not.				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00104	B. WING		02/	18/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, ST	TATE, ZIP CODE		
FIELD C	REST CARE CENTER		OND STREET D, MN 55940	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21530	Continued From pa	age 24	21530			
	Provider Requirem Procedures, F. Speconsultant pharmac not limited to: 2) corresponsible prescripotential or actual p findings relating to including recomme medication therapy therapy as well as a at least monthly.	Consultant Pharmacist Services ents, dated 2/15, indicated ecific activities that the cist performs includes, but is immunicating to the ber and the facility leadership problems detected and other medication therapy orders indations for changes in and monitoring of medication regulatory compliance issues				
	administrator, direct consulting pharmac policies and procect medication usage. educated as neces pharmacist's review with the pharmacis reviews on a regula	tor of nursing (DON) and cist could review and revise dures for proper monitoring of Nursing staff could be sary to the importance of the w. The DON or designee, along t, could audit medication ar basis to ensure compliance.				
	(21) days.	R CORRECTION: Twenty-one				
21535	MN Rule4658.1315 Drug Usage; Gene	5 Subp.1 ABCD Unnecessary ral	21535			3/29/16
	must be free from unnecessary drug i A. in excessive therapy; B. for excessive C. without ade D. in the prese	al. A resident's drug regimen unnecessary drugs. An is any drug when used: e dose, including duplicate drug re duration; quate indications for its use; or once of adverse consequences dose should be reduced or				

Minnesota Department of Health STATE FORM

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If continuation sheet 25 of 29

		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00104	B. WING		02/	18/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
FIELD CI	REST CARE CENTER	2	OND STREE D, MN 5594	T NORTHEAST 0		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLET DATE
21535	discontinued. In addition to the opart 4658.1310, th with provisions in the Code of Federal Re 483.25 (1) found in Operations Manua Long-Term Care Fa Department of Hea Health Care Finand This standard is ind available through the system and the Sta subject to frequent This MN Requirem by: Based on observat review the facility fa needed (PRN) med (R16 and R35), wh medication on a so Findings include: R16's physician ord an order for tears r eyes every four ho (PRN) for dry eyes On 2/16/16, at 4:48	drug regimen review required in the nursing home must comply the Interpretive Guidelines for egulations, title 42, section a Appendix P of the State I, Guidance to Surveyors for acilities, published by the alth and Human Services, cing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan ate Law Library. It is not change. tent is not met as evidenced tion, interview and record ailed to evaluate the use of as dications for 2 of 2 residents to had received the PRN theduled basis. ders, dated 1/21/16, identified natural drops, one drop to both urs while awake as needed B p.m., registered nurse (RN)-B dminister artificial tears two	21535	See corresponding F tag		
	dated 1/16 and 2/1 drops, one drop to while awake PRN a	administration records (MAR's) 6, identified tears natural both eyes every four hours and the times of a.m. and p.m. ten on the MAR's. R16's PRN				

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00104	B. WING		02/	18/2016
PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
REST CARE CENTER	2		NORTHEAST		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	age 26	21535			
medication administration records, dated 1/16 and 2/16, failed to include the reason the eye drops were administered and effectiveness of the medication.					
physician orders, d order for tears natu eyes every four hor eyes. RN-B confirm to current showed drops twice daily ho	lated 1/21/16, identified an ural drops, one drop to both urs while awake PRN for dry ned R16's MAR's from 1/1/16 R16 was receiving the eye owever, no information as to				
(DON) stated she w	would expect the R16's eye				
R35 had severe co received as needed without indication for been affective to re nonpharmacologica	gnitive impairment, had d (PRN) pain medicaiton or use, if pain medication had elieve pain or if al interventions had been				
for pain related to i causing back disco is aggravated by: n pain characteristics sharp, burning), se anatomical location factors, relieving fa side effects of pain pharmacological pa	mmobility and a history of falls omfort and interventions of pain novement, monitor and record s and as needed, quality (e.g. verity on a scale of 1 to 10, n, onset, duration, aggravating actors, monitor/document for medication and offer non ain interventions such as ice,				
	OF CORRECTION PROVIDER OR SUPPLIER REST CARE CENTER SUMMARY ST/ (EACH DEFICIENC REGULATORY OR I Continued From pa medication adminis and 2/16, failed to drops were adminis medication. On 2/16/16, at 5:19 physician orders, do order for tears naturely severy four ho- eyes. RN-B confirm to current showed drops twice daily ho- the effectiveness of documented. On 2/17/16, at 3:14 (DON) stated she without indication for Basis and severe cor- received as needed without indication for been affective to re- nonpharmacological attempted prior to to R35's current care for pain related to in causing back disco- is aggravated by: m- pain characteristics sharp, burning), se anatomical location factors, relieving fa- side effects of pain pharmacological pain pharmacological pain	OF CORRECTION IDENTIFICATION NUMBER: 00104 00104 PROVIDER OR SUPPLIER STREET AT REST CARE CENTER 318 SEC HAYFIEL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 26 medication administration records, dated 1/16 and 2/16, failed to include the reason the eye drops were administered and effectiveness of the medication. On 2/16/16, at 5:19 p.m., RN-B confirmed R16's physician orders, dated 1/21/16, identified an order for tears natural drops, one drop to both eyes every four hours while awake PRN for dry eyes. RN-B confirmed R16's MAR's from 1/1/16 to current showed R16 was receiving the eye drops twice daily however, no information as to the effectiveness of the eye drops were documented. On 2/17/16, at 3:14 p.m., the director of nursing (DON) stated she would expect the R16's eye drops to be administered as ordered. R35's quarterly MDS, dated 12/19/15, identified R35 had severe cognitive impairment, had received as needed (PRN) pain medication without indication for use, if pain medication had been affective to relieve pain or if nonpharmacological interventions had been attempted prior to use of pain medication. R35's current care plan, identified R35 was at risk for pain related to immobility and a history of falls	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00104 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE REST CARE CENTER 318 SECOND STREET NORTHEAST HAYFIELD, MN 55940 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 26 21535 medication administration records, dated 1/16 and 2/16, failed to include the reason the eye drops were administered and effectiveness of the medication. On 2/16/16, at 5:19 p.m., RN-B confirmed R16's physician orders, dated 1/21/16, identified an order for tears natural drops, one drop to both eyes every four hours while awake PRN for dry eyes. RN-B confirmed R16's MAR's from 1/1/16 to current showed R16 was receiving the eye drops twice daily however, no information as to the effectiveness of the eye drops were documented. On 2/17/16, at 3:14 p.m., the director of nursing (DON) stated she would expect the R16's eye drops to be administered as ordered. R35's quarterly MDS, dated 12/19/15, identified R35 had severe cognitive impairment, had received as needed (PRN) pain medication without indication for use of pain medication had been affective to relieve pain or if nonpharmacological interventions had been attempted prior to use of pain medication. R35's current care plan, identified R35 was at risk for pain related to immobility and a history of falls causing back discomfort and interventions of pain is aggravated by: movement, monitor and	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 00104 B. WING 02/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 318 SECOND STREET NORTHEAST HAYFIELD, MN 55940 HAYFIELD, MN 55940 PROVIDERS PLAN OF CORRECTION AUGULD BE (EACH OBERCENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFYING INFORMATION) ID PREFX PROVIDERS PLAN OF CORRECTION AUGULD BE (EACH OBERCETIVE AUTOR SHOULD BE (EACH OBERCETIVE AUTOR SHOUL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00104	B. WING		02/	18/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	REST CARE CENTER		OND STREET D, MN 55940	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 27	21535			
		eze (pain medication), apply daily (QID) PRN for pain.				
	dated 12/15, 1/16 a topically QID PRN a been handwritten o medication records 2/16, failed to inclu reason the medicat pain level, non-pha and effectiveness o On 2/17/16, at 3:14	p.m., the director of nursing				
	to be administered	vould expect R35's Biofreeze as written per physician orders would benefit from something	3			
	dated 11/12/10, ind pharmaceutical ser that assure the acc dispensing, and ad biologicals to meet Procedure: 1. Phar licensed nurse is re	Medication Administration, licated Objective: 2. To provide rvices including procedures surate acquiring, receiving, ministrating of all drugs and the needs of each resident. macy services: C. The esponsible for ensuring that Il medications as ordered a period.				
	A policy for PRN m not provided.	edications was requested, but				
	director of nursing staff responsible fo to include reason fo	THOD OF CORRECTION: The or pharmacist could in-service r giving as needed medication or giving the medication and if dication is effective or not.				
	TIME PERIOD FOI	R CORRECTION: Twenty-one				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00104	B. WING	·····	02/	18/2016
AME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	TATE, ZIP CODE		
IELD CI	REST CARE CENTER		COND STREET LD, MN 55940	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 28	21535			
	(21) days.					