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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QQT1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00104

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **4/2/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 04/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/12/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245431

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,

Kamala Fiske-Downing

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

MDH
Minnesota
Department
of Health

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,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245431 Y1	A. Building B. Wing Y2	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
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), 483.10(k)(2)	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(l)	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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	4/5/2016	10160	04/02/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/18/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245431	A. Building 01 - MAIN BUILDING 01 B. Wing	3/28/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0011	Correction Completed 03/07/2016	ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 03/07/2016	ID Prefix Reg. # NFPA 101 LSC K0054	Correction Completed 03/07/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) gpn/kfd	DATE 4/5/2016	SIGNATURE OF SURVEYOR 37008	DATE 3/28/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/17/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QQT1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00104

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **02/18/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 03/14/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/28/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
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:

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

attached deficiencies.

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	02/18/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct an assessment to determine whether a resident was capable of safely self-administering medications for 1 of 1 resident (R40) who was observed to have medications in his room. Findings include: R40's Admission Record, dated 1/25/16, indicated that the resident had diagnoses of: mild cognitive impairment; chronic obstructive pulmonary disease with acute exacerbation.	F 176	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 take medications independently will be allowed to do so after 1) an assessment has been	3/29/16

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

Electronically Signed | 03/11/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	02/18/2016

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

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F 176	Continued From page 1 During an observation on 2/16/16 at 2:56 p.m., R40 was sitting quietly in his room watching television from his recliner. Next to his recliner, perched on a bedside table was a nebulizer machine and equipment (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs). The mask and canister were observed to be connected and was sitting atop the machine. The canister (where the medication was poured) was observed to have a small amount of fluid in it. When asked about the equipment, R40 stated that he had taken the medication after the nursing staff would set it up for him. He stated that he would take it after the nursing staff had left the room. R40 then took the canister apart, turned the machine on and there was observed a mist that escaped from the bottom portion of the canister which was still connected by tubing to the machine. R40 then reapplied the canister with the mask and put it back to its original position. Next to the nebulizer equipment there was observed to be an inhaler along with a tube of hydrocortisone ointment with a prescription label on both medications. The inhaler was labeled with the name Dulera. R40 explained that he kept the hydrocortisone and the inhaler at his bedside. R40 stated that he used the inhaler, one puff in the morning. R40 stated that he used the hydrocortisone ointment for his itchy skin. R40's medication administration record (MAR), dated February 2016, indicated that the resident had been prescribed and was taking Duoneb 0.5-3 mg (milligrams) /3 ml (milliliters); ipratropium-albuterol (an inhalation solution containing the medications albuterol and ipratropium which assist with the relaxation of	F 176	done showing the resident is capable of safely self-administering medications and 2) the physician has written an order for self-administration. The care plan will reflect who will be responsible for storage, documentation, and the location of drug administration. The appropriateness of self-administration of drugs will be reviewed at least quarterly during the resident□s care conference and more often as necessary. During the March 23, 2015 mandatory meetings, the nurses and trained medication aides will be reinstructed on 1) the residents□ right to self-administer medications 2) the regulatory requirement for a physician□s order and interdisciplinary assessment of capability before a resident is permitted to self-administer medications and 3) that the care plan must reflect who will be responsible for storage, documentation, and the location of drug administration. The records of all residents who self-administer medication will be audited to assure appropriate assessments, care planning and physician orders. Resident number 40 - The resident, a cognitively intact, retired dentist was admitted to the facility December 2, 2015. On December 3, 2015 the nurse practitioner determined the resident was capable of safely self-administering medications. A self-administration assessment for nebulizer treatments set up by the nurse was completed January	

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F 176	Continued From page 2 muscles in the airways and increase air flow to the lungs), 1 vial dose nebulizer four times a day for COPD (chronic obstructive pulmonary disease). The MAR also indicated that the resident had an order and was taking Dulera 200-5 mcg (micrograms)/act (actuation) HFA (a type of propellant spray used with an inhaler); 1 puff inhaled twice daily for COPD. Specific instructions for this inhaler were to rinse the mouth after each use making sure not to swallow the rinse water. When interviewed on 2/17/16 at 2:43 p.m., Registered Nurse (RN)-A stated that R40 did use an inhaler, the nebulizer medication as well as hydrocortisone ointment in his room. RN-A stated that R40 declined to have the inhaler and hydrocortisone ointment leave his room. When interviewed on 2/17/16 at 3:01 p.m., Registered Nurse (RN)-A stated that R40 did not have an assessment in order to determine if the resident could safely self-administer medications without nursing staff present. RN-A stated that this should have been done in order for R40 to self-administer medications in his room. When interviewed on 2/17/16 at 3:37 p.m., the Director of Nursing (DON) stated that the nursing staff should have done an assessment in order to determine whether the resident could safely self-administer medications in his room. She stated that otherwise, the medications should have been locked up. Review of the facility policy titled, Policy for Self-Administration of Nebulizer Treatments (June 2003), stated that the resident would be assessed for dementia. Resident's with dementia	F 176	25, 2016. The resident who had a history of safely self-administering inhaled and topical medications was discharged to home February 18, 2016. The Director of Nurses/designee will monitor compliance with self-administration of medication requirements through observation and record review. Compliance will be monitored at the April quarterly Quality Assurance and Improvement Committee meeting.	

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F 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. Review of the facility policy titled, Bedside Medication Storage (February 2015), stated that the resident was to be instructed in the proper use of beside medications, including what the medication was used for, how it was to be used, how often it may be used, proper cleaning where applicable, proper storage of the medication and the necessity of reporting each dose used to the nursing staff. The resident should be able to repeat the instructions or demonstrate appropriate use of the medication. The completion of this instruction was to be documented in the resident's medical record. Periodic review of these instructions with the resident was to be undertaken by the nursing staff as deemed necessary.	F 176		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279		3/29/16

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F 279	Continued From page 4 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan that included a list of possible side affects from the use of an anticoagulation medication for 1 of 5 residents (R26) reviewed for unnecessary medications. Findings include: R26's physician orders dated 12/28/15, identified an order for Lovenox 120 mg (milligrams) per 0.8 ml (milliliters), give 120 mg subcutaneously (SQ) daily for history of deep vein thrombosis (DVT) and pulmonary embolism (PE). The medication administration record, dated 2/16, showed the medication was given daily per the physician orders. R26's current care plan failed to identify the use of the medication and the diagnoses of DVT and PE. On 2/17/16, at 3:18 p.m., the director of nursing (DON) confirmed R26's care plan failed to identify the use of the medication and diagnoses of DVT and PE. The DON stated she would expect the risk for bleeding to be identified on R26's care plan. The facility policy Care Planning, dated 4/12,	F 279	Tag F279 – Comprehensive Care Plans Field Crest Care Center uses the results of the comprehensive assessment to develop, review and revise the resident's comprehensive plan of care. The individualized care plan 1) includes measurable objectives and timetables to meet the resident's needs as identified in the comprehensive assessment 2) describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and 3) recognizes the residents' right to refuse cares/services. The care plan related policies/procedures and the staff responsibilities for development and revision of the comprehensive plans of care were reviewed and found appropriate. At the time of admission, a temporary care plan is implemented. Within seven days of completion of the comprehensive assessment, an interdisciplinary care plan is developed. During the March 23, 2016 mandatory meetings, the nursing staff will be 1)	

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F 279	Continued From page 5 identified Comprehensive Care Plan: Procedure: This is a personalized plan of daily care based on the nature of the illness, treatment prescribed, long and short range goals which include: the physicians orders for medication, treatments, diet and other therapy; the types of care and consultation services needed; how they can best be accomplished; how the plan meets the needs and interests of the patient; what methods are most successful; and the modification necessary to ensure best results.	F 279	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 was 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's care plan will continue to be reviewed quarterly and with significant changes in condition. As part of the quarterly care conference process, the interdisciplinary team reviews the care plans for completeness, accuracy, and relevancy. For the next quarter, the MDS Coordinator will conduct focused audits on the accuracy of the care plans of residents who are receiving 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.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280		3/29/16

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F 280	Continued From page 6 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to revise the care plan to include a fall intervention for 1 of 2 residents (R35) reviewed for accidents. In addition, the facility failed to include identified targeted mood symptoms for 1 of 5 residents (R26) reviewed for unnecessary medications. Finding include: R35's care plan, dated revision 9/28/15, identified the resident has had multiple falls related to poor balance and poor safety awareness with interventions of allow resident to have door partially shut when hallway is noisy, assess noise level when leaving room, keep door cracked, do not shut all of the way due to safety concerns, bed height should be at knee level, Dycem	F 280	Regulation 483.20 (d)(3) 483.10(k)(2) Tag F280 Comprehensive Care Plans Field Crest Care Center staff develop comprehensive care plans within seven days after the completion of the comprehensive assessment. Care plans are prepared by an interdisciplinary team, which includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff. Professional disciplines work together to plan and provide necessary services to enhance the residents' functional abilities and quality of life. The residents and their families/legal representative are encouraged to participate in the care	

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F 280	Continued From page 7 (non-slip pad) to wheelchair to reduce/prevent sliding down in chair, keep bathroom door shut when resident is not in the bathroom, perimeter mattress to bed, auto locking brakes on wheelchair, offer toileting every two hours while awake, first and second rounds and as needed (PRN) to prevent the need for self-transferring, soft touch call light attached to call cord, keep soft touch near edge of bed when leaving room when resident is in bed and wheelchair within reach at bedside when resident in bed. R35's Fall Scene Investigation Report and Progress Notes, dated 2/4/16 and 2/5/16, identified R35 was found on knees with upper body half way on bed. Falls team reviewed and intervention implemented was resident is not to be left in room alone when in wheelchair during an agitation episode. R35's care plan failed to include the intervention of resident is not to be left in room alone when in wheelchair during an agitation episode. In addition, the nursing assistant resident kardex, dated 2/17/16, failed to include the intervention. R35's fall risk assessment dated 12/15/15, identified a score of 10, a high risk for falls. On 2/17/16, at 3:24 p.m., the director of nursing (DON) verified R35's care plan failed to include the intervention of the resident is not to be left in room alone when in wheelchair during an agitation episode and she would expect the care plan to be updated. The DON stated R35's care plan would need to be updated by the nurse to include the intervention in order for the intervention to be on the nursing assistant kardex. The facility policy Fall Risk, dated 1/28/10,	F 280	planning process and the quarterly care 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. The care plan policies and procedures were reviewed and found appropriate. During March 23, 2016 mandatory meetings, the nursing staff will be 1) informed of the regulatory requirement that the residents' care plans be current at all times 2) reinstructed on the facility policies for care plan reviews and updates and 3) reminded of the importance of identifying mood symptoms and risk of falls/related safety interventions in the plan of care. Resident number 35 – A registered nurse reassessed the resident's fall related plan of care including safety interventions February 22, 2016. The intervention that the resident is not to be left alone in his room during periods of agitation has been added to the care plan and to the nursing assistant resident Kardex. The resident's safety needs will continue to be reassessed as least quarterly and the care plan updated as necessary reflect current safety interventions. Resident number 26 - The resident was admitted to the facility September 3, 2014. He is currently receiving hospice services due to end-stage disease related to a brain tumor. The resident has a diagnosis	

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F 280	Continued From page 8 indicated Procedure: 3. Residents at risk will be identified on the care plan with specific interventions to minimize the risk. 5. The residents care plan will be reviewed/revised to indicate the resident is at risk for falls and specific interventions in place. R26's physician order dated 1/7/16, identified an order for Celexa 5 mg (milligrams) daily. R26's medication administration record dated 2/16, showed R26 received the medication daily as per physician orders. R26's Psychotropic Med Review, dated 12/7/15, indicated specific targeted behaviors were isolation, tearfulness and sadness. R26's care plan, dated revision 12/15/15, identified the resident uses antidepressant medication Celexa related to Depression. At risk for depressed mood related to terminal diagnosis, with interventions of administer antidepressant medication as ordered by physician, monitor/document side effects and effectiveness, assist the resident in developing a program of activities that is meaningful and of interest (hunting, socializing with others), encourage and provide opportunities for exercise, physical activity, assist the resident, family, caregivers to identify strengths, positive coping skills and reinforce these, monitor for signs of depression, isolation, lack of appetite and loss of interest. R26's care plan failed to include the targeted behaviors of tearfulness and sadness and interventions to be implemented for the target behaviors. In addition, R26's nursing assistant kardex failed to include the targeted behaviors of	F 280	of depression currently being treated with Celexa. The resident's mood/depressive symptoms will continue to be assessed quarterly and with significant changes in condition. The care plan has been 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 been added to the nursing assistant resident Kardex. The physician/hospice agency will be notified of increased target behaviors and depressed mood. To monitor compliance the Nurse Manager/designee will audit the care plans of residents who have fallen in the past 30 days to assure that all safety interventions are included and the social worker will audit the care plans of residents receiving antidepressants to assure the related target behaviors are reflected in the care plan and the nursing assistant Kardex. If care plan omissions or inaccuracies are identified, additional care plan audits and staff training will be done. The interdisciplinary team will continue to review care plans for completeness, accuracy, and relevancy during the residents' quarterly care conferences, with significant changes in condition, and more often if necessary. Compliance will be reviewed at the quarterly April Quality Assurance and Performance Improvement Committee meeting.	

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F 280	Continued From page 9 isolation, tearfulness, sadness and interventions to be implemented for the targeted behaviors. On 2/17/16, at 3:18 p.m., the DON verified R26's care plan failed to include the targeted behaviors of sadness, tearfulness and read under interventions monitor for isolation. The DON confirmed the R26's nursing assistant kardex failed to include the targeted behaviors of isolation, tearfulness, sadness and interventions to be implemented. The DON stated she would expect the targeted behaviors to be care planned. The DON stated the facility documents by exception if the behavior is noted. The facility policy Care Planning, dated 4/12, identified Comprehensive Care Plan: Procedure: This is a personalized plan of daily care based on the nature of the illness, treatment prescribed, long and short range goals which include: the physicians orders for medication, treatments, diet and other therapy; the types of care and consultation services needed; how they can best be accomplished; how the plan meets the needs and interests of the patient; what methods are most successful; and the modification necessary to ensure best results. Resident care plans shall be utilized by all personnel involved in the care of the resident. To assure accuracy, the comprehensive care plan will be reviewed, evaluated and updated, as needed, by the interdisciplinary team in participation with the resident's family member or legal representative at least quarterly.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		3/29/16

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F 282	Continued From page 10 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provided services and treatments as assessed to promote healing of pressure ulcers and prevent new pressure ulcers from developing for 1 of 3 residents (R36) reviewed in the sample with current pressure ulcers. Findings include: R36 was observed (continuous) to sit in wheel chair without repositioning from 8:17 a.m. to 12:52 p.m. or a total of 4 hours and 35 minutes even though R36 was assessed to be repositioned very 1 to 1 1/2 hours as care plan directed due to stage IV pressure ulcer located on right hip. R36 was admitted to the facility on 10/22/14, with diagnosis that included vascular dementia according to facility Admission Record dated 2/17/16. The Admission Record identified other diagnosis of pressure ulcer of right hip, stage four, with onset date of 9/30/15. 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, and required extensive assistance of two staff for activities of daily living including bed mobility and transfers.	F 282	Tag F282 Services by Qualified Personnel per Care Plan Field Crest Care Center provides services that meet professional standards of quality and are delivered by appropriately qualified persons (e.g., licensed, certified) in accordance with each resident's written plan of care. The interdisciplinary care planning team 1) uses an assessment process to develop an individualized care plan for each resident that supports the highest practicable level of function and well-being 2) implements procedures and practices as outlined in the plan 3) reviews the plan at least quarterly and with significant changes in condition and 4) makes modifications as necessary. The facility has policies and procedures for developing individualized plans of care and communicates the plan to the direct care givers by use of the nursing assistant care Kardex. The care plan policies and procedures were reviewed and found appropriate. During the March 23, 2016 mandatory meetings, the nursing staff will be reminded/instructed 1) that the residents' plans of care must be followed 2) that repositioning residents according to their	

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F 282	Continued From page 11 R36 continuous observations on 2/17/16, from 8:17 a.m., to 12:52 p.m., revealed the following: From 8:17 a.m. to 9:30 a.m. observed to be in dining room, eating independently, some assistance to eat from staff, completed eating meal at 9:30 a.m. From 9:38 a.m. activity aide (AA)-A moved R36 in her wheelchair from dining room table to cozy cove room for an activity starting at 10:00 a.m. At 9:44 a.m.-AA-A left cozy cove room, while R36 remained in the room with two other residents. From 9:56 a.m. to 11:00 a.m. R36 with five other residents attended church service. From 11:00 a.m. to 12:51 p.m. R36 was in the dining room eating meal, had some assistance from staff to eat, and when R36 began to fall asleep at 12:51 p.m. staff asked if she wanted to go to bed which at this time was moved to her room. At 12:52 p.m. nursing assistant (NA)-A moved R36 to her room and then NA-A proceeded to place gait belt on R36. NA-A and NA-B transferred R36 from wheelchair to bed. NA-B removed incontinent brief, incontinent of small amount soft stool, no urine, and provided peri-rectal care. Wound dressing on right hip was clean, dry, and intact. No redness or wrinkles on buttocks. A-A and NA-B verified R36's incontinent brief was dry of urine. NA-A and NA-B positioned R36 in bed on left side with pillow to back, heel protectors on, pillow between knees, and bed flat. Observed air mattress on bed and cushion in wheelchair. During interview on 2/17/16, at 1:01 p.m., NA-A and NA-B stated R36 was to be repositioned every 1 to 2 hours.	F 282	plan of care is essential to preserve skin integrity and prevent/treat pressure ulcers and 3) that job performance expectations include being aware of and following the resident's plan of care including timely repositioning. The orientation for new employees will continue to address the importance of following the resident's plan of care for activities of daily living including assistance with repositioning. Resident number 36 was admitted to the facility October 22, 2014 on hospice services due to advanced dementia. The pressure ulcer to her right hip was present on admission. The resident's hip ulcer is measured weekly and is currently healing. The nurse practitioner viewed the ulcer March 1, 2015 and verified healing and that the resident has no associated pain. The resident's skin-related plan of care has been reassessed by a registered nurse and revised to reflect the results of the Tissue Tolerance Test which indicates a repositioning schedule of every 1.5 to 2.0 hours. The nursing assistants have been informed of the repositioning schedule and the importance of timely repositioning. Compliance with timely repositioning for residents with mobility dependencies will be monitored by the charge nurses through observation of the direct care staff. Resident care observations will be assigned by the Director of Nurses/designee for two weeks. If noncompliance is noted, additional auditing and staff training will be done.	

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	245431	A. BUILDING _____ B. WING _____	02/18/2016

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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 right hip. Goal was to be comfortable during dressing changes and not obtain any new pressure areas through next review date. Interventions included the following: bed as flat as possible to reduce shear, administer treatments as ordered and monitor for effectiveness, asses, record, and monitor wound healing weekly, measure length, width and depth where possible, assess and document status of wound perimeter, wound bed and healing progress, report improvements and declines to the physician, do not position on right side, monitor nutritional status, serve protein supplements as ordered, notify hospice if foul odor or worsening signs and symptoms of infection, fever, confusion or pain, needs assistance to turn and reposition every 1 to 1.5 hours more often as needed or requested, keep off right hip, rotate from back to left side, use pillows to reposition, requires an overlay air mattress and a cushion in wheelchair to aid in off loading . The care plan directed staff R36 turning and repositioning program: turn and reposition every 1 to 1.5 hours, keep off right hip, use pillows to position, R36 can participate with turning and repositioning with bilateral assist bars. 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. Document review of facility Skin Integrity policy dated 12/2011, revealed procedure #3. a. "Residents whom are unable to reposition themselves, have a repositioning schedule	F 282	Compliance will be reviewed during the April quarterly Quality Assurance and Performance Improvement Committee meeting.	

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F 282	Continued From page 13 implemented based upon the Tissue Tolerance assessment."	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement assessed interventions to promote healing of one stage four pressure ulcer and prevent further development of pressure ulcers for 1 of 3 residents (R36) reviewed in the sample with pressure ulcers. Findings include: R36 sat in the wheelchair form 8:17 a.m. until 12:52 p.m. a total of 4 hours and 35 minutes without repositioning even though R36 skin assessment determined she should be repositioned every 1.5 hours to 2 hours due to a stage IV pressure ulcer located on hip. R36 was admitted to the facility on 10/22/14, with diagnosis that included vascular dementia according to facility Admission Record dated 2/17/16. The Admission Record identified other	F 314	Regulation 483.25(c) Tag F314 – Prevent/Heal Pressure Sores Field Crest Care Center has policies and procedures to ensure that residents who enter the facility without pressure sores do not develop pressure sores unless the resident's clinical condition demonstrates that they were unavoidable. Residents with pressure sores present at the time of admission receive necessary treatment and services to promote healing, prevent infection, and prevent new pressure areas from developing. The policies and procedures for comprehensively assessing the residents' skin condition and risk factors were reviewed and found appropriate. Based on the comprehensive skin assessment,	3/29/16

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F 314	Continued From page 14 diagnosis of pressure ulcer of right hip, stage four, with onset date of 9/30/15. 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, and required extensive assistance of two staff for activities of daily living including bed mobility and transfers. R36 continuous observations on 2/17/16, from 8:17 a.m., to 12:52 p.m., revealed the following: From 8:17 a.m. to 9:30 a.m. observed to be in dining room, eating independently, some assistance to eat from staff, completed eating meal at 9:30 a.m. From 9:38 a.m. activity aide (AA)-A moved R36 in her wheelchair from dining room table to cozy cove room for an activity starting at 10:00 a.m. At 9:44 a.m.-AA-A left cozy cove room, while R36 remained in the room with two other residents. From 9:56 a.m. to 11:00 a.m. R36 with five other residents attended church service. From 11:00 a.m. to 12:51 p.m. R36 was in the dining room eating meal, had some assistance from staff to eat, and when R36 began to fall asleep at 12:51 p.m. staff asked if she wanted to go to bed which at this time was moved to her room. At 12:52 p.m. nursing assistant (NA)-A moved R36 to her room and then NA-A proceeded to place gait belt on R36. NA-A and NA-B transferred R36 from wheelchair to bed. NA-B removed incontinent brief, incontinent of small amount soft stool, no urine, and provided peri-rectal care. Wound dressing on right hip was clean, dry, and intact. No redness or wrinkles on	F 314	care plans are developed that address skin integrity and minimize risks of skin breakdown. The resident's repositioning schedule is based on an analysis of the skin risk assessment, the results of the Bradens Scale for Predicting Pressure Ulcer Risk tool, and the tissue tolerance evaluation. The plans of care focus on services that maintain skin integrity, prevent pressure sores, and promote healing of existing pressure sores. The routine evaluation of the resident's skin condition, skin risk factors, and tissue tolerance will continue. For residents who have open skin lesions, a licensed nurse evaluates the resident 's skin condition on a weekly basis. The direct care staff routinely inform the charge nurse of any skin problems noted during cares. Observation of skin on all areas of the body is part of the bathing protocol. If skin issues are noted, the resident's repositioning schedule is reassessed and the physician/nurse practitioner notified as appropriate. During the March 23, 2016 mandatory meetings, the certified nursing assistants will be reminded/instructed that the residents' plans of care must be followed and that job performance expectations include being aware of and following the plan of care. The importance of timely repositioning of residents with mobility impairments was stressed. Resident number 36 was admitted to the facility October 22, 2014 on hospice	

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F 314	Continued From page 15 buttocks. A-A and NA-B verified R36's incontinent brief was dry of urine. NA-A and NA-B positioned R36 in bed on left side with pillow to back, heel protectors on, pillow between knees, and bed flat. Observed air mattress on bed and cushion in wheelchair. During interview on 2/17/16, at 1:01 p.m., NA-A and NA-B stated resident was to be repositioned every 1 to 2 hours. Sitting/Tissue Tolerance Evaluation, an assessment dated 10/30/15, summary indicated no redness noted related to test, due to R36 has healing stage four pressure ulcer on right trochanter and had redness to coccyx previously, will put R36 on a 1.5 to 2 hour repositioning schedule while sitting, has a pressure reducing wheelchair cushion. The quarterly Braden Scale/ Comprehensive Skin Risk Data Collection, an assessment dated 1/25/16, summary, revealed R36 was at moderate risk for development of pressure ulcer. The summary identified R36 has stage four ulcer on right trochanter (hip), measuring 0.5 centimeters (cm) by 0.3 cm by 0.4 cm. The summary identified ulcer dressing was changed daily. Treatment directed to pack the wound with aquacel AG and cover with foam dressing. Wound healing well. The summary indicated R36 required one staff assist with activities of daily living, two staff assist for transfers, and incontinent of bowel and bladder. Document review of facility Wound Tracking, revealed the right trochanter (hip) wound was assessed weekly. Review of the wound tracking revealed the following monthly assessments: 11/24/15-1.3 cm length, 1.5 cm wide, 2.1 cm	F 314	services due to advanced dementia. The pressure ulcer to her right hip was present on admission. The resident's hip ulcer is measured weekly and is currently healing. The nurse practitioner viewed the ulcer March 1, 2015 and verified healing and that the resident has no associated pain. The resident's skin-related plan of care has been reassessed by a registered nurse and revised to reflect the results of the Tissue Tolerance Test which indicates a repositioning schedule of every 1.5 to 2.0 hours. The nursing assistants have been informed of the repositioning schedule and the importance of timely repositioning. Compliance with timely repositioning for residents with mobility dependencies will be monitored by the charge nurses through observation of the direct care staff. Resident care observations will be assigned by the Director of Nurses/designee for two weeks. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the April quarterly Quality Assurance and Performance Improvement Committee meeting.	

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F 314	Continued From page 16 depth, no tunneling, 1.3 cm undermining; 12/22/15-0.5 cm length, 0.5 cm wide, 1.0 cm depth, no tunneling, 0.7 cm undermining; 1/26/16-0.5 cm length, 0.3 cm wide, 0.6 cm depth, 0.7 cm tunneling, no undermining; 2/16/16-0.3 cm length, 0.3 cm wide, 0.6 cm depth, no tunneling, 6.5 cm undermining. Skin/wound progress note dated 2/9/16 wound measurements revealed the following: right trochanter (hip) wound stage four healing, measured 0.3 length by 0.3 wide, by 0.7 depth, 100 percent granulated tissue in wound bed, with 0.7 cm undermining, no tunneling. The progress note indicated no signs or symptoms of infection, no drainage, and no odor noted. Peri wound skin intact, dry and pink to normal color scarring tissue, no pain. R36 received supplement. R36 is on 2-2.5 hour repositioning schedule, continue current treatment. R36's care plan initiated 11/7/14 and revised on 11/10/15, revealed a focus of stage four pressure ulcer on right hip. Goal was to be comfortable during dressing changes and not obtain any new pressure areas through next review date. Interventions included the following: bed as flat as possible to reduce shear, administer treatments as ordered and monitor for effectiveness, asses, record, and monitor wound healing weekly, measure length, width and depth where possible, assess and document status of wound perimeter, wound bed and healing progress, report improvements and declines to the physician, do not position on right side,	F 314		

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F 314	Continued From page 17 monitor nutritional status, serve protein supplements as ordered, notify hospice if foul odor or worsening signs and symptoms of infection, fever, confusion or pain, needs assistance to turn and reposition every 1 to 1.5 hours more often as needed or requested, keep off right hip, rotate from back to left side, use pillows to reposition, requires an overlay air mattress and a cushion in wheelchair to aid in off loading . The care plan directed staff R36 turning and repositioning program: turn and reposition every 1 to 1.5 hours, keep off right hip, use pillows to position, R36 can participate with turning and repositioning with bilateral assist bars. 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. Document review of facility Skin Integrity policy dated 12/2011, revealed procedure #3. a. "Residents whom are unable to reposition themselves, have a repositioning schedule implemented based upon the Tissue Tolerance assessment."	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		3/29/16

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F 329	Continued From page 18 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to evaluate the use of as needed (PRN) medications for 2 of 2 residents (R16 and R35), who had received the PRN medication on a scheduled basis. Findings include: 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 as needed (PRN) for dry eyes. On 2/16/16, at 4:48 p.m., registered nurse (RN)-B was observed to administer artificial tears two drops into both eyes of R16. R16's medication administration records (MAR's) dated 1/16 and 2/16, identified tears natural drops, one drop to both eyes every four hours	F 329	483.25(l) Tag F329 – Unnecessary Drugs Field Crest Care Center staff ensure that each resident's drug regime is free from unnecessary drugs. The resident's drug regime is reviewed by the staff, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued. The goal is to simplify medication regimens and identify the lowest effective dose of medications. The medication related policies and procedures were reviewed and revised to address as needed (PRN) medications.	

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F 329	Continued From page 19 while awake PRN and the times of a.m. and p.m. had been handwritten on the MAR's. R16's PRN 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 medicaiton 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 causing back discomfort and interventions of pain is aggravated by: movement, monitor and record pain characteristics and as needed, quality (e.g. sharp, burning), severity on a scale of 1 to 10, anatomical location, onset, duration, aggravating factors, relieving factors, monitor/document for side effects of pain medication and offer non pharmacological pain interventions such as ice,	F 329	Medications are reviewed by the consultant pharmacist every month, by the attending physician/nurse practitioner during the routine 30/60 day visits and during the resident's quarterly interdisciplinary care conferences. During the March 23, 2016 mandatory meetings, the nurses and trained medication assistants will be 1) reeducated on the need to document the indications, effectiveness and nonpharmacological interventions (when appropriate) for PRN topical medications and 2) instructed not to add specific administration times to the treatment administration records for PRN treatments. Plans are to implement electronic medication and treatment records in the next six months. The electronic system will prompt the staff to record indications and effectiveness of PRN medications and will not accommodate handwritten entries on the administration records. Resident number 16 – After a registered nurse reassessed the resident's use of artificial tears, the order was changed to "artificial tears 2 gtts (drops) to each eye every AM." The resident will continue to be assessed for symptoms of dry, irritated eyes and the physician will be notified of ongoing eye-related symptoms. Resident number 35 – The resident is no longer receiving Biofreeze routinely. The resident will receive Biofreeze on an as needed basis to treat pain symptoms. The	

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F 329	Continued From page 20 heat or repositioning. R35's physician orders, dated 1/13/16, identified an order for Biofreeze (pain medication), apply topically four times daily (QID) PRN for pain. R35's medication administration records (MAR's) dated 12/15, 1/16 and 2/16, Biofreeze apply topically QID PRN and the time HS (bedtime) had been handwritten on the MAR's. R35's PRN medication records, dated from 12/15, 1/16 and 2/16, failed to include documentation for the reason the medication was being administered, pain level, non-pharmalogical measures offered and effectiveness of the medication. On 2/17/16, at 3:14 p.m., the director of nursing (DON) stated she would expect R35's Biofreeze to be administered as written per physician orders or evaluate if R35 would benefit from something else for pain. The facility policy Medication Administration, dated 11/12/10, indicated Objective: 2. To provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administrating of all drugs and biologicals to meet the needs of each resident. Procedure: 1. Pharmacy services: C. The licensed nurse is responsible for ensuring that residents receive all medications as ordered during his/her work period. A policy for PRN medications was requested, but not provided.	F 329	indications for use, effectiveness of the medication, and nonpharmacological interventions will be documented. The physician will be notified if the resident's 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 to assure that PRN eye drops and topical medications are given on as needed basis and that related documentation is completed according to facility policy. The consultant pharmacist will also review the administration patterns/documentation of PRN eye drops and topical medications. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the April Quality Assurance and Performance Improvement Committee meeting.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		3/29/16

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F 356	Continued From page 21 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the required posting of the daily census on the daily nurse staff posting was current. This had the potential to affect 32 of 32 residents residing in the facility, staff, and visitors.	F 356	Regulation 483.30 Tag F356 – Nurse Staffing Information As required Field Crest Care Center posts the following information in a clear and readable format in a prominent location:	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 22 Findings include: During the initial tour of the facility on 2/16/16, at 12:04 p.m., the facility staff posting dated 2/16/16, was posted near the main dining room. The document displayed the facility name, staff type and number of staff, shift time, total number of staff on duty, scheduled hours and actual hours worked. However, the facility census for the current day, 2/16/16, read 35 and the actual census was 32 upon entrance to the facility. On 2/16/16, at 12:55 p.m., the director of nursing (DON) stated the staffing coordinator was responsible for posting of the census. The DON stated the staffing coordinator fills out the daily nurse staff posting sheets ahead of time. The Don stated the staffing coordinator was on vacation and licensed practical nurse (LPN)-A was overseeing the posting of the daily nurse staff posting sheet. On 2/16/16, at 1:30 p.m., the DON stated the census was 33 this a.m., but one resident had discharged this a.m. The DON confirmed at the time the surveyors entered the building the census was 32. The DON confirmed the daily nurse staff posting dated 2/16/16, read census of 35. On 02/16/16, at 2:08 p.m., LPN-A stated she had posted the daily nurse staff posting sheet for 2/16/16 yesterday (2/15/16). LPN-A stated I put the next day's sheet behind the current day's sheet posted and the overnight shift pulls out the old sheet. LPN-A verified the 2/16/16, census	F 356	(i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the registered nurses, licensed practical nurses, and certified nursing assistants directly responsible for resident care per shift. (iv) Resident census. 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 policy for timely posting of accurate staffing and census information. The Administrative Assistant will monitor compliance by randomly checking the date and census listed on the staffing report for two weeks. If problems are noted, additional monitoring and staff training will be done. Compliance will be reviewed during the April quarterly Quality Assurance and Performance Improvement Committee meeting.	

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	245431	A. BUILDING _____ B. WING _____	02/18/2016

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F 356	Continued From page 23 posting of 35 was inaccurate and updating the census just got missed. The facility policy, Daily Staffing Report, dated 4/14, indicated as required Field Crest Care Center posts the following in a prominent location in a clear readable format. Procedure: 1. d. Resident census. 2. The staff member responsible for posting the staffing information was reminded to update the posting with changes in census/staffing in a timely manner.	F 356		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the consultant pharmacist identified the ongoing use of as needed (PRN) medications for 2 of 2 residents (R16 and R35), who had received the PRN medication without reason for giving and if effective or not. Findings include:	F 428	Regulation 483.60(c) Tag F428 – Drug Regimen Review The goal of Field Crest Care Center is to maintain the resident's highest practicable level of functioning and prevent or minimize adverse consequences related to medication therapy. The drug regimen	3/29/16

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F 428	Continued From page 24 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 as needed (PRN) for dry eyes. On 2/16/16, at 4:48 p.m., registered nurse (RN)-B was observed to administer artificial tears two drops into both eyes of R16. R16's medication administration records (MAR's) dated 1/16 and 2/16, identified tears natural drops, one drop to both eyes every four hours while awake PRN and the times of a.m. and p.m. had been handwritten on the MAR's. R16's PRN medication administration records, dated 1/16 and 2/16, failed to include the reason the eye drops were administered and effectiveness of the medication. 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. 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. Also no documentation of reason for giving or if effective or not. R35's physician orders, dated 1/13/16, identified an order for Biofreeze (pain medication), apply topically four times daily (QID) PRN for pain. R35's medication administration records (MAR's) dated 12/15, 1/16 and 2/16, Biofreeze apply topically QID PRN. R35's PRN medication	F 428	of each resident is reviewed at least once a month by a licensed pharmacist. The pharmacist reports irregularities to the attending physician and the director of nursing, and these reports are acted upon. The Director of Nursing and Consultant Pharmacist discussed the policies and procedures for documenting and tracking as needed eye drops and topical medications during the February 19, 2016 telephone discussion. The Consultant Pharmacist and Director of Nurses meet monthly and the administration/documentation procedures for PRN topical medications will be reviewed at the March meeting and ongoing as necessary. Topical medications will continue to be listed on the treatment administration record until the implementation of the electronic medication administration records at which time this practice will be reevaluated. The Consultant Pharmacist has agreed to review the treatment administration records during the routine monthly reviews of the medication administration records. The documentation of administration times, indications for use, effectiveness of PRN topical medications, nonpharmacological interventions and pain level for analgesics will be audited by the pharmacist. During the March 23, 2016 mandatory meetings, the nurses and trained medication assistants will be 1) reeducated on the need to document the	

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F 428	Continued From page 25 records, dated from 12/15, 1/16 and 2/16, failed to include documentation for the reason the medication was being administered, pain level, non-pharmalogical measures offered and effectiveness of the medication. R35's consultant pharmacist medication regimen reviews monthly from 4/8/15 through 2/17/16, failed to address the PRN Biofreeze lack of documentation for the reason the medication was being administered, pain level, non-pharmalogical measures offered and effectiveness of the medication. On 2/17/16, at 3:14 p.m., the director of nursing (DON) stated she would expect the R16's eye drops and R35's Biofreeze to be administered as written per physician orders. Also to document reason for giving and if effective or not. The facility policy Consultant Pharmacist Services Provider Requirements, dated 2/15, indicated Procedures, F. Specific activities that the consultant pharmacist performs includes, but is not limited to: 2) communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well as regulatory compliance issues at least monthly.	F 428	indications, effectiveness and nonpharmacological intervention for PRN topical medications and 2) instructed not to add specific administration times to the medication and treatment administration records for PRN medications/treatments. Plans are to implement electronic medication and treatment records in the next six months. The electronic system will prompt the staff to record indications and effectiveness of PRN medications and will not accommodate handwritten entries on the administration records. Resident number 16 – After a registered nurse reassessed the resident's use of artificial tears, the order was changed to "artificial tears 2 gtts (drops) to each eye every AM." The resident will continue to be assessed for symptoms of dry, irritated eyes and the physician will be notified of ongoing eye-related symptoms. Resident number 35 – The resident is no longer receiving Biofreeze routinely. The resident will receive Biofreeze on an as needed basis to treat pain symptoms. The indications for use, effectiveness of the medication, and any nonpharmacological interventions will be documented. The physician will be notified if the resident's 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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F 428	Continued From page 26	F 428	to assure that PRN eye drops and topical medications are given on as needed basis and that related documentation is completed according to facility policy. The consultant pharmacist will also review the administration patterns/documentation of as needed eye drops and topical medications. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the April Quality Assurance and Performance Improvement Committee meeting.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		3/29/16

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F 441	Continued From page 27 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper infection control practices were implemented when sanitizing a glucometer for 1 of 1 resident (R18) observed for blood glucose monitoring. In addition the facility failed to properly clean and store nebulizer equipment to prevent infection for 3 of 4 residents reviewed (R40, R56 & R53) who received inhalation therapy. Findings include: LACK OF PROPER SANITIZING AGENT USED ON GLUCOMETER AFTER USE: R18 was observed on 2/17/16, at 11:13 a.m., when licensed practical nurse (LPN)-A completed a glucose test. LPN-A was observed to remove gloves and cleansed the entire outside of R18's glucometer with an alcohol wipe. The manufacturer Turneries instructions provided by the facility, read "Meter Care Wipe Meter with	F 441	Regulation 483.65 Tag F441 Infection Control Field Crest Care Center has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment for the residents and to prevent the development and transmission of disease and infection. The infection control program 1) investigates, controls, and prevents infections in the facility 2) determines the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control. The facility has comprehensive infection control policies and procedures consistent	

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F 441	Continued From page 28 clean, lint-free cloth dampened with mild detergent/soap or 10% household bleach and water. Never put Meter in liquids or allow any liquids to enter Test Port. Do not use alcohol to clean Meter. Cleaning the Meter with alcohol WILL cause damage." During interview on 2/17/16, at 11:28 a.m., LPN-A stated she typically cleans the glucometer with an alcohol wipe. LPN-A stated the facility also had germicidal (super Sani-cloth) wipes used for cleaning of glucometers. LPN-A stated if I do not use an alcohol wipe I use the germicidal wipe. LPN-A verified she had cleansed the glucometer with an alcohol wipe after checking R18's blood sugar. LPN-A verified she had removed gloves and then had cleansed the glucometer. LPN-A stated I should have washed my hands, applied clean gloves and then cleansed the glucometer. During interview on 2/17/16, at 3:12 p.m., the director of nursing stated staff should use the super Sani-cloth (germicidal disinfecting wipe) to sanitize the glucometer and she would expect gloves to be worn when cleaning the glucometer. The facility policy Blood Glucose Testing/Cleaning and Care dated 9/6/11, indicated Procedure: 2. Checking Blood Glucose: C. Following the finger stick place used lancet in sharps container; place used test strip in sharps container. D. Remove gloves; wash hands with soap and water or alcohol-based hand rub; apply new gloves. E. Disinfect blood glucose meter after each use by wiping with approved sanitizer per label directions and allow drying. F. Remove gloves; wash hands. 4. B. Meter Care: Cleaning the meter. Wipe Meter with approved sanitizer. Do not use alcohol to clean Meter, doing so will cause damage.	F 441	with the current state and federal infection control regulations and recommendations. The policies address the surveillance and investigation of infections and the maintenance of accurate and comprehensive records of resident/employee infections. The policies and procedures for cleaning blood glucose machines was reviewed and found appropriate; the procedure for cleaning the nebulizer machines was revised to specify cleaning after each use. During the March 23, 2016 mandatory 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 weeks. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be reviewed at the April quarterly Quality Assurance and Performance Improvement Committee meeting.	

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F 441	Continued From page 29 LACK OF STORING NEBULIZER EQUIPMENT TO PREVENT INFECTION/S FROM DEVELOPING: R40 was observed on 2/16/16 at 2:56 p.m., in his room watching television. The nebulizer equipment on a bedside table next to the resident. The mask and medication canister were connected by tubing to the machine. The medication canister was observed to contain a small amount of liquid in the canister. R40 stated that the nursing staff would usually leave the equipment in place like that. 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. R56's physician orders, dated 2/1/16, indicated that the resident had been prescribed Duoneb; ipratropium-albuterol; 1 vial dose four times a day as needed for shortness of breath. On 2/16/16 at 12:06 p.m., during the initial tour of the facility R56's room was observed to have a	F 441		

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F 441	Continued From page 30	F 441		

nebulizer machine at the bedside table. A mask and medication canister was connected to the machine. They were both intact. There was observed to be condensation on the inner walls of the medication canister.

R53's room was checked on 2/16/16 at 12:06 p.m., during the initial tour of the facility, to have nebulizer equipment near the bed. The nebulizer mask and canister were connected by the tubing to the machine. There was visible condensation on the inner walls of the canister.

R53's physician orders, dated 1/13/16, indicated 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.

R53's medication administration record (MAR), dated 2/1/16 through 2/16/16, indicated that the resident had been receiving the Duoneb medication.

When interviewed on 2/17/16 at 3:01 p.m., Registered Nurse (RN)-A stated that if the nebulizer equipment was not cleaned after each use there was always the potential to introduce infection.

When interviewed on 2/17/16 at 3:37 p.m., the Director of Nursing (DON) stated that she would have expected the nebulizer equipment to be cleaned after each use. She stated that there could be the potential for infection if not.

Review of the document titled, Policy and Procedure for Cleaning Nebulizer Equipment (no date), stated rinse all equipment with tepid tap

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F 441	Continued From page 31 water; invert the cup and place equipment on paper towel to air dry; change all tubing once a week. Review of the facility policy titled, Storage of Medications (February 2015), it stated that medications were to be stored safely, securely and properly following the manufacturer's recommendations or those of the supplier.	F 441		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain dietary environment in a state of cleanliness to prevent fires when using the cook stove. This had the potential to affect dietary staff especially the person using the cook stove to make meals. Also for all residents residing in the facility. Findings include: Observations of the initial kitchen tour on 2/16/16, at 12:06 p.m., with dietary manager (DM-A), revealed thick dust on the sprinklers and sprinkler pipes located above the stove burners, thick dust on the stove hood screens located under the stove hood, and stove gas pipe located along side of the stove was coated with dust and debris. During interview at that time, DM-A verified the	F 465	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	3/29/16

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F 465	Continued From page 32 areas of thick dust and debris. DM-A stated the sprinklers were cleaned once a month. During interview on 2/17/16, at 11:37 a.m., DM-A stated she expected the stove hood screens to be cleaned every two weeks. Document review of facility dietary cleaning schedule revealed oven vent (screens) to be cleaned monthly. Documentation indicated the vents were cleaned on 2/2/16, 2/9/16, and 2/16/16. Document review of facility Procedure for Cleaning Hood Filters Over Stove policy undated read, remove screens, run through dishwasher cycle, remove screens and let air dry. Wipe off hood with degreaser, wash with hot soapy water, rinse well, wipe or spray with sanitizer, air dry and replace screens. Frequency of cleaning-monthly.	F 465	interior/exterior surfaces. Annually the hood area including the flue is deep cleaned by a professional hood cleaning service company. The dietary manager will monitor compliance through routine observation of the cleanliness of the hood area and by review of the cleaning schedule check lists. Compliance will be reviewed during the April quarterly Quality Assurance and Performance Improvement Committee meeting.	

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division on Feb 17,2016. At the time of this survey, Fieldcrest Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/11/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/17/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Fieldcrest Care Center is a 1-story building. The original building was constructed in 1969 and was determined to be of Type II (111) construction, with a partial basement. In 1972, an addition was constructed and was determined to be of Type II (111) construction, with a full basement. In 1995, an addition was constructed and was determined to be of Type II (111) construction, with no basement. The facility is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 33 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011	NFPA 101 LIFE SAFETY CODE STANDARD	K 011		3/7/16

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	245431	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/17/2016**

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K 011 SS=F	Continued From page 2 If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to properly construct and maintain a required 2-hour fire separation, in accordance with NFPA 101 (2000), Chapter 19, Sections 19.1.1.4 and 19.1.2.1. In a fire emergency, this deficient practice could adversely affect the safety of 33 residents. FINDINGS INCLUDE: During the facility tour between the hours of 9:00 AM and 12:30 PM on 2/17/2016, it was observed that the 2 hour fire separation wall between the Nursing facility and the Assisted Living has penetrations above the lay-in ceiling around wires that were not sealed with a fire rated caulking. This finding was confirmed with the Maintenance Supervisor at the time of discovery.	K 011	K011 The open penetration around the conduit in the fire separation wall above the drop ceiling between the nursing home and the Assisted Living Unit were sealed with intumescent fire barrier caulk and fire wool on March 7, 2016. The Maintenance Director is responsible for monitoring compliance.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by	K 025		3/7/16

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FIELD CREST CARE CENTER	**318 SECOND STREET NORTHEAST HAYFIELD, MN 55940**

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K 025	Continued From page 3 fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.7, 19.3.7.3, 8.3, 8.3.2 and 8.3.6. This deficient practice could affect all 33 residents within the smoke compartments. Findings include: On facility tour between 09:00 AM and 12:30 PM on 02/17/2016, it was observed that all wings had penetrations that the smoke barrier doors above ceiling tiles around wires, conducts and ducts in the following locations: A. Wing I smoke barrier B. Wing II smoke barrier C. Wing III smoke barrier This deficiency was verified by Maintenance Superior at the time of discovery.	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 March 7, 2016 with intumescent fire barrier caulk and fire wool. The Maintenance Director is responsible for monitoring compliance.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and review of available documentation, the facility has not been conducting sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient practice could affect all 33 residents.	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 to the maintenance schedule.	3/4/16

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K 054	Continued From page 4 Findings include: On facility tour between 9:00 AM and 12:30 PM on 2/17/2016, a review of the facility's available fire alarm test documentation revealed that the facility failed to conducted the required sensitivity test of each smoke detector. This deficient practice was verified by the Maintenance Supervisor.	K 054	The Maintenance Director will monitor for compliance.	

MDH
Minnesota
Department
of Health

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 only a suggestion 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.

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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00104	A. BUILDING: _____ B. WING _____	02/18/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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	2 000	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.	

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

Electronically Signed | 03/11/16

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 2/16/16, 2/17/16 and 2/18/16 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).	2 560		3/29/16

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2 560	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan that included a list of possible side affects from the use of an anticoagulation medication for 1 of 5 residents (R26) reviewed for unnecessary medications. Findings include: R26's physician orders dated 12/28/15, identified an order for Lovenox 120 mg (milligrams) per 0.8 ml (milliliters), give 120 mg subcutaneously (SQ) daily for history of deep vein thrombosis (DVT) and pulmonary embolism (PE). The medication administration record, dated 2/16, showed the medication was given daily per the physician orders. R26's current care plan failed to identify the use of the medication and the diagnoses of DVT and PE. On 2/17/16, at 3:18 p.m., the director of nursing (DON) confirmed R26's care plan failed to identify the use of the medication and diagnoses of DVT and PE. The DON stated she would expect the risk for bleeding to be identified on R26's care plan. The facility policy Care Planning, dated 4/12, identified Comprehensive Care Plan: Procedure: This is a personalized plan of daily care based on the nature of the illness, treatment prescribed, long and short range goals which include: the physicians orders for medication, treatments, diet and other therapy; the types of care and consultation services needed; how they can best be accomplished; how the plan meets the needs	2 560	See corresponding F tag	

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2 560	Continued From page 3 and interests of the patient; what methods are most successful; and the modification necessary to ensure best results. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the facility develop care plans to address to address resident specific concerns. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provided services and treatments as assessed to promote healing of pressure ulcers and prevent new pressure ulcers from developing for 1 of 3 residents (R36) reviewed in the sample with current pressure ulcers.	2 565	See corresponding F tag	3/29/16

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2 565	Continued From page 4 Findings include: R36 was observed (continuous) to sit in wheel chair without repositioning from 8:17 a.m. to 12:52 p.m. or a total of 4 hours and 35 minutes even though R36 was assessed to be repositioned very 1 to 1 1/2 hours as care plan directed due to stage IV pressure ulcer located on right hip. R36 was admitted to the facility on 10/22/14, with diagnosis that included vascular dementia according to facility Admission Record dated 2/17/16. The Admission Record identified other diagnosis of pressure ulcer of right hip, stage four, with onset date of 9/30/15. 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, and required extensive assistance of two staff for activities of daily living including bed mobility and transfers. R36 continuous observations on 2/17/16, from 8:17 a.m., to 12:52 p.m., revealed the following: From 8:17 a.m. to 9:30 a.m. observed to be in dining room, eating independently, some assistance to eat from staff, completed eating meal at 9:30 a.m. From 9:38 a.m. activity aide (AA)-A moved R36 in her wheelchair from dining room table to cozy cove room for an activity starting at 10:00 a.m. At 9:44 a.m.-AA-A left cozy cove room, while R36 remained in the room with two other residents. From 9:56 a.m. to 11:00 a.m. R36 with five other residents attended church service. From 11:00 a.m. to 12:51 p.m. R36 was in the	2 565		

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2 565	Continued From page 5 dining room eating meal, had some assistance from staff to eat, and when R36 began to fall asleep at 12:51 p.m. staff asked if she wanted to go to bed which at this time was moved to her room. At 12:52 p.m. nursing assistant (NA)-A moved R36 to her room and then NA-A proceeded to place gait belt on R36. NA-A and NA-B transferred R36 from wheelchair to bed. NA-B removed incontinent brief, incontinent of small amount soft stool, no urine, and provided peri-rectal care. Wound dressing on right hip was clean, dry, and intact. No redness or wrinkles on buttocks. A-A and NA-B verified R36's incontinent brief was dry of urine. NA-A and NA-B positioned R36 in bed on left side with pillow to back, heel protectors on, pillow between knees, and bed flat. Observed air mattress on bed and cushion in wheelchair. During interview on 2/17/16, at 1:01 p.m., NA-A and NA-B stated R36 was to be repositioned every 1 to 2 hours. R36's care plan initiated 11/7/14 and revised on 11/10/15, noted a stage four pressure ulcer on right hip. Goal was to be comfortable during dressing changes and not obtain any new pressure areas through next review date. Interventions included the following: bed as flat as possible to reduce shear, administer treatments as ordered and monitor for effectiveness, asses, record, and monitor wound healing weekly, measure length, width and depth where possible, assess and document status of wound perimeter, wound bed and healing progress, report improvements and declines to the physician, do not position on right side, monitor nutritional status, serve protein	2 565		

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2 565	Continued From page 6 supplements as ordered, notify hospice if foul odor or worsening signs and symptoms of infection, fever, confusion or pain, needs assistance to turn and reposition every 1 to 1.5 hours more often as needed or requested, keep off right hip, rotate from back to left side, use pillows to reposition, requires an overlay air mattress and a cushion in wheelchair to aid in off loading . The care plan directed staff R36 turning and repositioning program: turn and reposition every 1 to 1.5 hours, keep off right hip, use pillows to position, R36 can participate with turning and repositioning with bilateral assist bars. 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. Document review of facility Skin Integrity policy dated 12/2011, revealed procedure #3. a. "Residents whom are unable to reposition themselves, have a repositioning schedule implemented based upon the Tissue Tolerance assessment." SUGGESTED METHOD OF CORRECTION: The director of nursing could develop, review, and/or revise policies and procedures to ensure the facility followed care plan interventions according to the resident's individualized needs. The director of nursing could educate all appropriate staff on the policies and procedures to follow care plan interventions. The director of nursing could monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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2 570	Continued From page 7	2 570		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to revise the care plan to include a fall intervention for 1 of 2 residents (R35) reviewed for accidents. In addition, the facility failed to include identified targeted mood symptoms for 1 of 5 residents (R26) reviewed for unnecessary medications. Finding include: R35's care plan, dated revision 9/28/15, identified the resident has had multiple falls related to poor balance and poor safety awareness with interventions of allow resident to have door partially shut when hallway is noisy, assess noise level when leaving room, keep door cracked, do not shut all of the way due to safety concerns, bed height should be at knee level, Dycem (non-slip pad) to wheelchair to reduce/prevent sliding down in chair, keep bathroom door shut	2 570	See corresponding F tag	3/29/16

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2 570	Continued From page 8 when resident is not in the bathroom, perimeter mattress to bed, auto locking brakes on wheelchair, offer toileting every two hours while awake, first and second rounds and as needed (PRN) to prevent the need for self-transferring, soft touch call light attached to call cord, keep soft touch near edge of bed when leaving room when resident is in bed and wheelchair within reach at bedside when resident in bed. R35's Fall Scene Investigation Report and Progress Notes, dated 2/4/16 and 2/5/16, identified R35 was found on knees with upper body half way on bed. Falls team reviewed and intervention implemented was resident is not to be left in room alone when in wheelchair during an agitation episode. R35's care plan failed to include the intervention of resident is not to be left in room alone when in wheelchair during an agitation episode. In addition, the nursing assistant resident kardex, dated 2/17/16, failed to include the intervention. R35's fall risk assessment dated 12/15/15, identified a score of 10, a high risk for falls. On 2/17/16, at 3:24 p.m., the director of nursing (DON) verified R35's care plan failed to include the intervention of the resident is not to be left in room alone when in wheelchair during an agitation episode and she would expect the care plan to be updated. The DON stated R35's care plan would need to be updated by the nurse to include the intervention in order for the intervention to be on the nursing assistant kardex. The facility policy Fall Risk, dated 1/28/10, indicated Procedure: 3. Residents at risk will be identified on the care plan with specific interventions to minimize the risk. 5. The	2 570		

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2 570	Continued From page 9 residents care plan will be reviewed/revised to indicate the resident is at risk for falls and specific interventions in place. R26's physician order dated 1/7/16, identified an order for Celexa 5 mg (milligrams) daily. R26's medication administration record dated 2/16, showed R26 received the medication daily as per physician orders. R26's Psychotropic Med Review, dated 12/7/15, indicated specific targeted behaviors were isolation, tearfulness and sadness. R26's care plan, dated revision 12/15/15, identified the resident uses antidepressant medication Celexa related to Depression. At risk for depressed mood related to terminal diagnosis, with interventions of administer antidepressant medication as ordered by physician, monitor/document side effects and effectiveness, assist the resident in developing a program of activities that is meaningful and of interest (hunting, socializing with others), encourage and provide opportunities for exercise, physical activity, assist the resident, family, caregivers to identify strengths, positive coping skills and reinforce these, monitor for signs of depression, isolation, lack of appetite and loss of interest. R26's care plan failed to include the targeted behaviors of tearfulness and sadness and interventions to be implemented for the target behaviors. In addition, R26's nursing assistant kardex failed to include the targeted behaviors of isolation, tearfulness, sadness and interventions to be implemented for the targeted behaviors. On 2/17/16, at 3:18 p.m., the DON verified R26's care plan failed to include the targeted behaviors	2 570		

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2 570	Continued From page 10 of sadness, tearfulness and read under interventions monitor for isolation. The DON confirmed the R26's nursing assistant kardex failed to include the targeted behaviors of isolation, tearfulness, sadness and interventions to be implemented. The DON stated she would expect the targeted behaviors to be care planned. The DON stated the facility documents by exception if the behavior is noted. The facility policy Care Planning, dated 4/12, identified Comprehensive Care Plan: Procedure: This is a personalized plan of daily care based on the nature of the illness, treatment prescribed, long and short range goals which include: the physicians orders for medication, treatments, diet and other therapy; the types of care and consultation services needed; how they can best be accomplished; how the plan meets the needs and interests of the patient; what methods are most successful; and the modification necessary to ensure best results. Resident care plans shall be utilized by all personnel involved in the care of the resident. To assure accuracy, the comprehensive care plan will be reviewed, evaluated and updated, as needed, by the interdisciplinary team in participation with the resident's family member or legal representative at least quarterly. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance.	2 570		

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2 570	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement assessed interventions to promote healing of one stage four pressure ulcer and prevent further development of pressure ulcers for 1 of 3 residents (R36) reviewed in the sample with pressure ulcers. Findings include: R36 sat in the wheelchair form 8:17 a.m. until 12:52 p.m. a total of 4 hours and 35 minutes without repositioning even though R36 skin assessment determined she should be	2 900	See corresponding F tag	3/29/16

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2 900	Continued From page 12 repositioned every 1.5 hours to 2 hours due to a stage IV pressure ulcer located on hip. R36 was admitted to the facility on 10/22/14, with diagnosis that included vascular dementia according to facility Admission Record dated 2/17/16. The Admission Record identified other diagnosis of pressure ulcer of right hip, stage four, with onset date of 9/30/15. 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, and required extensive assistance of two staff for activities of daily living including bed mobility and transfers. R36 continuous observations on 2/17/16, from 8:17 a.m., to 12:52 p.m., revealed the following: From 8:17 a.m. to 9:30 a.m. observed to be in dining room, eating independently, some assistance to eat from staff, completed eating meal at 9:30 a.m. From 9:38 a.m. activity aide (AA)-A moved R36 in her wheelchair from dining room table to cozy cove room for an activity starting at 10:00 a.m. At 9:44 a.m.-AA-A left cozy cove room, while R36 remained in the room with two other residents. From 9:56 a.m. to 11:00 a.m. R36 with five other residents attended church service. From 11:00 a.m. to 12:51 p.m. R36 was in the dining room eating meal, had some assistance from staff to eat, and when R36 began to fall asleep at 12:51 p.m. staff asked if she wanted to go to bed which at this time was moved to her room. At 12:52 p.m. nursing assistant (NA)-A moved R36 to her room and then NA-A proceeded to	2 900		

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2 900	Continued From page 13 place gait belt on R36. NA-A and NA-B transferred R36 from wheelchair to bed. NA-B removed incontinent brief, incontinent of small amount soft stool, no urine, and provided peri-rectal care. Wound dressing on right hip was clean, dry, and intact. No redness or wrinkles on buttocks. A-A and NA-B verified R36's incontinent brief was dry of urine. NA-A and NA-B positioned R36 in bed on left side with pillow to back, heel protectors on, pillow between knees, and bed flat. Observed air mattress on bed and cushion in wheelchair. During interview on 2/17/16, at 1:01 p.m., NA-A and NA-B stated resident was to be repositioned every 1 to 2 hours. Sitting/Tissue Tolerance Evaluation, an assessment dated 10/30/15, summary indicated no redness noted related to test, due to R36 has healing stage four pressure ulcer on right trochanter and had redness to coccyx previously, will put R36 on a 1.5 to 2 hour repositioning schedule while sitting, has a pressure reducing wheelchair cushion. The quarterly Braden Scale/ Comprehensive Skin Risk Data Collection, an assessment dated 1/25/16, summary, revealed R36 was at moderate risk for development of pressure ulcer. The summary identified R36 has stage four ulcer on right trochanter (hip), measuring 0.5 centimeters (cm) by 0.3 cm by 0.4 cm. The summary identified ulcer dressing was changed daily. Treatment directed to pack the wound with aquacel AG and cover with foam dressing. Wound healing well. The summary indicated R36 required one staff assist with activities of daily living, two staff assist for transfers, and incontinent of bowel and bladder.	2 900		

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2 900	Continued From page 14 Document review of facility Wound Tracking, revealed the right trochanter (hip) wound was assessed weekly. Review of the wound tracking revealed the following monthly assessments: 11/24/15-1.3 cm length, 1.5 cm wide, 2.1 cm depth, no tunneling, 1.3 cm undermining; 12/22/15-0.5 cm length, 0.5 cm wide, 1.0 cm depth, no tunneling, 0.7 cm undermining; 1/26/16-0.5 cm length, 0.3 cm wide, 0.6 cm depth, 0.7 cm tunneling, no undermining; 2/16/16-0.3 cm length, 0.3 cm wide, 0.6 cm depth, no tunneling, 6.5 cm undermining. Skin/wound progress note dated 2/9/16 wound measurements revealed the following: right trochanter (hip) wound stage four healing, measured 0.3 length by 0.3 wide, by 0.7 depth, 100 percent granulated tissue in wound bed, with 0.7 cm undermining, no tunneling. The progress note indicated no signs or symptoms of infection, no drainage, and no odor noted. Peri wound skin intact, dry and pink to normal color scarring tissue, no pain. R36 received supplement. R36 is on 2-2.5 hour repositioning schedule, continue current treatment. R36's care plan initiated 11/7/14 and revised on 11/10/15, revealed a focus of stage four pressure ulcer on right hip. Goal was to be comfortable during dressing changes and not obtain any new pressure areas through next review date. Interventions included the following: bed as flat as possible to reduce shear, administer treatments as ordered and monitor for effectiveness, asses, record, and monitor wound healing weekly, measure length, width and depth	2 900		

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2 900	Continued From page 15 where possible, assess and document status of wound perimeter, wound bed and healing progress, report improvements and declines to the physician, do not position on right side, monitor nutritional status, serve protein supplements as ordered, notify hospice if foul odor or worsening signs and symptoms of infection, fever, confusion or pain, needs assistance to turn and reposition every 1 to 1.5 hours more often as needed or requested, keep off right hip, rotate from back to left side, use pillows to reposition, requires an overlay air mattress and a cushion in wheelchair to aid in off loading . The care plan directed staff R36 turning and repositioning program: turn and reposition every 1 to 1.5 hours, keep off right hip, use pillows to position, R36 can participate with turning and repositioning with bilateral assist bars. 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. Document review of facility Skin Integrity policy dated 12/2011, revealed procedure #3. a. "Residents whom are unable to reposition themselves, have a repositioning schedule implemented based upon the Tissue Tolerance assessment." SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure the facility provided pressure ulcer interventions according to the resident's individualized needs. The director of nursing could review all residents at risk for pressure ulcers to assure they received the necessary treatment to prevent pressure ulcers from developing and to promote healing of	2 900		

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2 900	Continued From page 16 pressure ulcers. The director of nursing could in-service all appropriate staff on appropriate pressure ulcer interventions. The director of nursing could conduct random audits of the delivery of care to ensure appropriate care and services were implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of	21390		3/29/16

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21390	Continued From page 17 current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper infection control practices were implemented when sanitizing a glucometer for 1 of 1 resident (R18) observed for blood glucose monitoring. In addition the facility failed to properly clean and store nebulizer equipment to prevent infection for 3 of 4 residents reviewed (R40, R56 & R53) who received inhalation therapy. Findings include: LACK OF PROPER SANITIZING AGENT USED ON GLUCOMETER AFTER USE: R18 was observed on 2/17/16, at 11:13 a.m., when licensed practical nurse (LPN)-A completed a glucose test. LPN-A was observed to remove gloves and cleansed the entire outside of R18's glucometer with an alcohol wipe. The manufacturer Turneries instructions provided by the facility, read "Meter Care Wipe Meter with clean, lint-free cloth dampened with mild detergent/soap or 10% household bleach and water. Never put Meter in liquids or allow any liquids to enter Test Port. Do not use alcohol to clean Meter. Cleaning the Meter with alcohol WILL cause damage." During interview on 2/17/16, at 11:28 a.m., LPN-A stated she typically cleans the glucometer with an alcohol wipe. LPN-A stated the facility also had germicidal (super Sani-cloth) wipes used for cleaning of glucometers. LPN-A stated if I do not use an alcohol wipe I use the germicidal wipe.	21390	See corresponding F tag	

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21390	Continued From page 18 LPN-A verified she had cleansed the glucometer with an alcohol wipe after checking R18's blood sugar. LPN-A verified she had removed gloves and then had cleansed the glucometer. LPN-A stated I should have washed my hands, applied clean gloves and then cleansed the glucometer. During interview on 2/17/16, at 3:12 p.m., the director of nursing stated staff should use the super Sani-cloth (germicidal disinfecting wipe) to sanitize the glucometer and she would expect gloves to be worn when cleaning the glucometer. The facility policy Blood Glucose Testing/Cleaning and Care dated 9/6/11, indicated Procedure: 2. Checking Blood Glucose: C. Following the finger stick place used lancet in sharps container; place used test strip in sharps container. D. Remove gloves; wash hands with soap and water or alcohol-based hand rub; apply new gloves. E. Disinfect blood glucose meter after each use by wiping with approved sanitizer per label directions and allow drying. F. Remove gloves; wash hands. 4. B. Meter Care: Cleaning the meter. Wipe Meter with approved sanitizer. Do not use alcohol to clean Meter, doing so will cause damage. LACK OF STORING NEBULIZER EQUIPMENT TO PREVENT INFECTION/S FROM DEVELOPING: R40 was observed on 2/16/16 at 2:56 p.m., in his room watching television. The nebulizer equipment on a bedside table next to the resident. The mask and medication canister were connected by tubing to the machine. The medication canister was observed to contain a small amount of liquid in the canister. R40 stated that the nursing staff would usually leave the equipment in place like that.	21390		

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21390	Continued From page 19 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. R56's physician orders, dated 2/1/16, indicated that the resident had been prescribed Duoneb; ipratropium-albuterol; 1 vial dose four times a day as needed for shortness of breath. On 2/16/16 at 12:06 p.m., during the initial tour of the facility R56's room was observed to have a nebulizer machine at the bedside table. A mask and medication canister was connected to the machine. They were both intact. There was observed to be condensation on the inner walls of the medication canister. R53's room was checked on 2/16/16 at 12:06 p.m., during the initial tour of the facility, to have nebulizer equipment near the bed. The nebulizer mask and canister were connected by the tubing to the machine. There was visible condensation on the inner walls of the canister. R53's physician orders, dated 1/13/16, indicated	21390		

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21390	Continued From page 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.

R53's medication administration record (MAR), dated 2/1/16 through 2/16/16, indicated that the resident had been receiving the Duoneb medication.

When interviewed on 2/17/16 at 3:01 p.m., Registered Nurse (RN)-A stated that if the nebulizer equipment was not cleaned after each use there was always the potential to introduce infection.

When interviewed on 2/17/16 at 3:37 p.m., the Director of Nursing (DON) stated that she would have expected the nebulizer equipment to be cleaned after each use. She stated that there could be the potential for infection if not.

Review of the document titled, Policy and Procedure for Cleaning Nebulizer Equipment (no date), stated rinse all equipment with tepid tap water; invert the cup and place equipment on paper towel to air dry; change all tubing once a week.

Review of the facility policy titled, Storage of Medications (February 2015), it stated that medications were to be stored safely, securely and properly following the manufacturer's recommendations or those of the supplier.

Suggested Method of Correction: The administrator or designee could review policies and procedures to ensure proper infection control techniques regarding blood glucose monitoring and cleaning of nebulizer equipment

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	00104	A. BUILDING: _____ B. WING _____	02/18/2016

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

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21390	Continued From page 21 are followed. Facility staff could be reeducated and an auditing system developed to ensure compliance. Time Period for Correction: Twenty one (21) days.	21390		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate	21530		3/29/16

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21530	Continued From page 22 justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the consultant pharmacist identified the ongoing use of as needed (PRN) medications for 2 of 2 residents (R16 and R35), who had received the PRN medication without reason for giving and if effective or not. Findings include: 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 as needed (PRN) for dry eyes. On 2/16/16, at 4:48 p.m., registered nurse (RN)-B was observed to administer artificial tears two drops into both eyes of R16. R16's medication administration records (MAR's) dated 1/16 and 2/16, identified tears natural drops, one drop to both eyes every four hours while awake PRN and the times of a.m. and p.m. had been handwritten on the MAR's. R16's PRN medication administration records, dated 1/16 and 2/16, failed to include the reason the eye drops were administered and effectiveness of the medication.	21530	See corresponding F tag	

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21530	Continued From page 23 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. 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. Also no documentation of reason for giving or if effective or not. R35's physician orders, dated 1/13/16, identified an order for Biofreeze (pain medication), apply topically four times daily (QID) PRN for pain. R35's medication administration records (MAR's) dated 12/15, 1/16 and 2/16, Biofreeze apply topically QID PRN. R35's PRN medication records, dated from 12/15, 1/16 and 2/16, failed to include documentation for the reason the medication was being administered, pain level, non-pharmalogical measures offered and effectiveness of the medication. R35's consultant pharmacist medication regimen reviews monthly from 4/8/15 through 2/17/16, failed to address the PRN Biofreeze lack of documentation for the reason the medication was being administered, pain level, non-pharmalogical measures offered and effectiveness of the medication. On 2/17/16, at 3:14 p.m., the director of nursing (DON) stated she would expect the R16's eye drops and R35's Biofreeze to be administered as written per physician orders. Also to document reason for giving and if effective or not.	21530		

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21530	Continued From page 24 The facility policy Consultant Pharmacist Services Provider Requirements, dated 2/15, indicated Procedures, F. Specific activities that the consultant pharmacist performs includes, but is not limited to: 2) communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well as regulatory compliance issues at least monthly. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or	21535		3/29/16

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21535	Continued From page 25 discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to evaluate the use of as needed (PRN) medications for 2 of 2 residents (R16 and R35), who had received the PRN medication on a scheduled basis. Findings include: 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 as needed (PRN) for dry eyes. On 2/16/16, at 4:48 p.m., registered nurse (RN)-B was observed to administer artificial tears two drops into both eyes of R16. R16's medication administration records (MAR's) dated 1/16 and 2/16, identified tears natural drops, one drop to both eyes every four hours while awake PRN and the times of a.m. and p.m. had been handwritten on the MAR's. R16's PRN	21535	See corresponding F tag	

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21535	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 medicaiton 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 causing back discomfort and interventions of pain is aggravated by: movement, monitor and record pain characteristics and as needed, quality (e.g. sharp, burning), severity on a scale of 1 to 10, anatomical location, onset, duration, aggravating factors, relieving factors, monitor/document for side effects of pain medication and offer non pharmacological pain interventions such as ice, heat or repositioning.

R35's physician orders, dated 1/13/16, identified

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21535	Continued From page 27 an order for Biofreeze (pain medication), apply topically four times daily (QID) PRN for pain. R35's medication administration records (MAR's) dated 12/15, 1/16 and 2/16, Biofreeze apply topically QID PRN and the time HS (bedtime) had been handwritten on the MAR's. R35's PRN medication records, dated from 12/15, 1/16 and 2/16, failed to include documentation for the reason the medication was being administered, pain level, non-pharmalogical measures offered and effectiveness of the medication. On 2/17/16, at 3:14 p.m., the director of nursing (DON) stated she would expect R35's Biofreeze to be administered as written per physician orders or evaluate if R35 would benefit from something else for pain. The facility policy Medication Administration, dated 11/12/10, indicated Objective: 2. To provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administrating of all drugs and biologicals to meet the needs of each resident. Procedure: 1. Pharmacy services: C. The licensed nurse is responsible for ensuring that residents receive all medications as ordered during his/her work period. A policy for PRN medications was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or pharmacist could in-service staff responsible for giving as needed medication to include reason for giving the medication and if the as needed medication is effective or not. TIME PERIOD FOR CORRECTION: Twenty-one	21535		

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21535	Continued From page 28 (21) days.	21535		