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



Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245431

April 12, 2016

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

Dear Ms. Gustason:

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

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

Effective March 29, 2016 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Sincerely,

Kumala Fiske Downing

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 5, 2016

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

RE: Project Number S5431027

Dear Ms. Gustason:

On March 2, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 18, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kumalu Fiske Downing

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

## **POST-CERTIFICATION REVISIT REPORT**

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

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

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

# **POST-CERTIFICATION REVISIT REPORT**

| IDENTIFICATION NUMBER                       | MULTIPLE CONSTRUCTION<br>A. Building 01 - MAIN BUILDING 01<br>B. Wing | Y2   | DATE OF REVIS<br>3/28/2016 | SIT<br>Y3 |
|---|---|--|----------------------------|-----------|
| NAME OF FACILITY<br>FIELD CREST CARE CENTER |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>318 SECOND STREET NORTHEAST |                            |           |
|   |   | HAYFIELD. MN 55940   |                            |           |

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

| DATE                                  |
|---------------------------------------|
| Y5                                    |
| Correction<br>Completed<br>03/07/2016 |
| Correction<br>Completed               |
| Correction<br>Completed               |
| Correction<br>Completed               |
| Correction<br>Completed               |
| 2016<br>3                             |
| 20                                    |

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



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered March 2, 2016

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

RE: Project Number S5431027

Dear Ms. Gustason:

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

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

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

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

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

#### attached deficiencies.

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

#### DEPARTMENT CONTACT

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

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

## **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 29, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 29, 2016 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

## **ELECTRONIC PLAN OF CORRECTION (ePoC)**

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its

effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

#### **Original deficiencies not corrected**

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the

level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

## Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

## Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

# FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 18, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 18, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

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

|                          |   | AND HUMAN SERVICES  |                     | FOF   | MAPPROVED                  |
|--------------------------|---|---|---------------------|---|----------------------------|
| CENTEF                   | RS FOR MEDICARE   | & MEDICAID SERVICES   | 1                   | OMB N   | <u>O. 0938-0391</u>        |
|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 |   | ATE SURVEY<br>OMPLETED     |
|                          |   | 245431  | B. WING _           | 0   | 2/18/2016                  |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |                            |
| FIELD CF                 | REST CARE CENTER  |   |                     | 318 SECOND STREET NORTHEAST<br>HAYFIELD, MN 55940   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>YMUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | (X5)<br>COMPLETION<br>DATE |
| F 000                    | INITIAL COMMENT   | S   | F 00                | 00  |                            |
|                          | as your allegation o<br>Department's accept<br>enrolled in ePOC, y<br>at the bottom of the  | f correction (POC) will serve<br>f compliance upon the<br>otance. Because you are<br>our signature is not required<br>first page of the CMS-2567<br>ic submission of the POC will<br>ion of compliance. |                     |   |                            |
| F 176<br>SS=D            | on-site revisit of you<br>validate that substa<br>regulations has bee<br>your verification.   | acceptable electronic POC, an<br>ur facility may be conducted to<br>ntial compliance with the<br>en attained in accordance with<br>NT SELF-ADMINISTER<br>D SAFE   | F 17                | 76  | 3/29/16                    |
|                          | the interdisciplinary   | nt may self-administer drugs if<br>team, as defined by<br>as determined that this   |                     |   |                            |
|                          | by:<br>Based on observat<br>review, the facility fa<br>assessment to dete<br>capable of safely se<br>for 1 of 1 resident (<br>have medications in<br>Findings include:<br>R40's Admission Re<br>indicated that the re<br>cognitive impairment | rmine whether a resident was<br>elf-administering medications<br>R40) who was observed to   |                     | <ul> <li>483.10(n) Tag F176 Self-administration of Drugs</li> <li>Field Crest Care Center respects the residents right to self-administer drugs after the interdisciplinary team has determined that this practice is safe.</li> <li>The policy for self-administration of medications was reviewed and found appropriate. Residents who prefer to tak medications independently will be allower to do so after 1) an assessment has been appropriated to do so after 1.</li> </ul> | e<br>d                     |
| LABORATORY               | DIRECTOR'S OR PROVID  | ER/SUPPLIER REPRESENTATIVE'S SIGN   | NATURE              | TITLE   | (X6) DATE                  |

**Electronically Signed** 

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

03/11/2016

PRINTED: 03/14/2016

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

Facility ID: 00104

If continuation sheet Page 2 of 33

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

If continuation sheet Page 3 of 33

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

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|                          | OF DEFICIENCIES  | & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA  | (X2) MILLI          | IPLE CONSTRUCTION   |   | 0938-039<br>E SURVEY       |  |  |
|--------------------------|--|---|---------------------|---|---|----------------------------|--|--|
|                          | OF DEFICIENCIES<br>OF CORRECTION   | IDENTIFICATION NUMBER:  |                     | NG  |   | PLETED                     |  |  |
|                          |  | 245431  | B. WING _           |   | 02/   | 02/18/2016                 |  |  |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP C  | DE  |                            |  |  |
| FIELD C                  | REST CARE CENTER   |   |                     | 318 SECOND STREET NORTHEAST<br>HAYFIELD, MN 55940   |   |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>( (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)   | SHOULD BE   | (X5)<br>COMPLETIOI<br>DATE |  |  |
| F 279                    | be required under § due to the resident's  | ervices that would otherwise<br>483.25 but are not provided<br>s exercise of rights under<br>he right to refuse treatment   | F 2                 | 79  |   |                            |  |  |
|                          | by:<br>Based on interview<br>facility failed to deve<br>plan that included a<br>from the use of an a<br>1 of 5 residents (R2<br>medications.<br>Findings include:<br>R26's physician ord<br>an order for Loveno<br>ml (milliliters), give<br>daily for history of d<br>and pulmonary emb<br>administration recon<br>medication was give<br>orders. | IT is not met as evidenced<br>and document review, the<br>elop a comprehensive care<br>list of possible side affects<br>anticoagulation medication for<br>(6) reviewed for unnecessary<br>ers dated 12/28/15, identified<br>x 120 mg (milligrams) per 0.8<br>120 mg subcutaneously (SQ)<br>eep vein thrombosis (DVT)<br>polism (PE). The medication<br>rd, dated 2/16, showed the<br>en daily per the physician |                     | Tag F279 – Comprehensive<br>Field Crest Care Center use<br>of the comprehensive asses<br>develop, review and revise t<br>comprehensive plan of care<br>individualized care plan 1) in<br>measurable objectives and<br>meet the resident's needs a<br>the comprehensive assess<br>describes the services that<br>furnished to attain or mainta<br>resident's highest practicabl<br>mental, and psychosocial w<br>3) recognizes the residents'<br>cares/services. | es the results<br>ssment to<br>the resident's<br>. The<br>ncludes<br>timetables to<br>.s identified in<br>nent 2)<br>are to be<br>ain the<br>le physical,<br>ell-being and<br>right to refuse |                            |  |  |
|                          | of the medication at<br>PE.<br>On 2/17/16, at 3:18<br>(DON) confirmed R<br>the use of the medic<br>and PE. The DON s   | blan failed to identify the use<br>and the diagnoses of DVT and<br>p.m., the director of nursing<br>26's care plan failed to identify<br>cation and diagnoses of DVT<br>stated she would expect the<br>be identified on R26's care  |                     | and the staff responsibilities<br>development and revision o<br>comprehensive plans of car<br>reviewed and found appropri<br>time of admission, a tempor<br>is implemented. Within seve<br>completion of the comprehe<br>assessment, an interdiscipli<br>is developed.  | f the<br>e were<br>riate. At the<br>rary care plan<br>en days of<br>ensive  |                            |  |  |

Facility ID: 00104

If continuation sheet Page 5 of 33

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

Facility ID: 00104

If continuation sheet Page 6 of 33

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

Facility ID: 00104

If continuation sheet Page 7 of 33

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

Facility ID: 00104

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

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

PRINTED: 03/14/2016

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

Facility ID: 00104

If continuation sheet Page 10 of 33

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

Facility ID: 00104

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

Facility ID: 00104

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

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

Event ID:QQT111

Facility ID: 00104

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

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

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

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

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

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PRINTED: 03/14/2016

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

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

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

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| DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 09                       |   |  |                    |   |  |                             |                            |  |  |
|---|---|--|--------------------|---|--|-----------------------------|----------------------------|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |                    |   | (X3) DATE SURVEY<br>COMPLETED  |                             |                            |  |  |
|   | 245431  |  | B. WING            |   |  | 02/18/2016                  |                            |  |  |
| NAME OF I   | NAME OF PROVIDER OR SUPPLIER  |  |                    | ST  | IREET ADDRESS, CITY, STATE, ZIP CODE   |                             |                            |  |  |
| FIELD C   | FIELD CREST CARE CENTER   |  |                    | 318 SECOND STREET NORTHEAST<br>HAYFIELD, MN 55940 |  |                             |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFI<br>TAG |   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   | BE                          | (X5)<br>COMPLETION<br>DATE |  |  |
| F 356<br>F 428<br>SS=D  | census just got mis<br>The facility policy, I<br>4/14, indicated as r<br>Center posts the fo<br>in a clear readable<br>Resident census. 2<br>responsible for pos<br>was reminded to up<br>in census/staffing ir<br>483.60(c) DRUG R<br>IRREGULAR, ACT<br>The drug regimen of<br>reviewed at least of<br>pharmacist.<br>The pharmacist mut<br>the attending physic | Daily Staffing Report, dated<br>equired Field Crest Care<br>llowing in a prominent location<br>format. Procedure: 1. d.<br>The staff member<br>ting the staffing information<br>odate the posting with changes<br>in a timely manner.<br>EGIMEN REVIEW, REPORT | F 3                | 428   |  |                             | 3/29/16                    |  |  |
|   | by:<br>Based on observat<br>review the facility fa<br>pharmacist identifie<br>needed (PRN) med<br>(R16 and R35), who  | NT is not met as evidenced<br>tion, interview and record<br>ailed to ensure the consultant<br>ed the ongoing use of as<br>lications for 2 of 2 residents<br>o had received the PRN<br>reason for giving and if   |                    |   | Regulation 483.60(c) Tag F428 – Dr<br>Regimen Review<br>The goal of Field Crest Care Center<br>maintain the resident's highest pract<br>level of functioning and prevent or<br>minimize adverse consequences rela-<br>to medication therapy. The drug regi | r is to<br>ticable<br>lated |                            |  |  |

Event ID:QQT111

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

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

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

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

If continuation sheet Page 29 of 33

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

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

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

Facility ID: 00104

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

Facility ID: 00104

If continuation sheet Page 33 of 33

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

F5431024

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

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

**Electronically Signed** 

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

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

Facility ID: 00104

If continuation sheet Page 2 of 5

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

Event ID: QQT121

Facility ID: 00104

If continuation sheet Page 3 of 5

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

Event ID: QQT121

Facility ID: 00104

If continuation sheet Page 4 of 5

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

PRINTED: 03/24/2016



Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted March 2, 2016

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

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

Dear Ms. Gustason:

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

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

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

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

Electronically Signed

STATE FORM

6899

If continuation sheet 1 of 29

03/11/16

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

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

If continuation sheet 3 of 29

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

Minnesota Department of Health STATE FORM

6899

QQT111

If continuation sheet 4 of 29

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

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

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

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

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

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

If continuation sheet 10 of 29

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

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

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

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

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

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

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

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

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

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

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

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

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

Minnesota Department of Health STATE FORM

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

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

Minnesota Department of Health STATE FORM

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If continuation sheet 25 of 29

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

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

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

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