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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZDRO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00104

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

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/12/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on May 12, 2014. Refer to CMS form 2567B.

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 05/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/20/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/21/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245431

June 20, 2014

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

Dear Ms. Gustason:

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

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

Effective May 7, 2014 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.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

May 29, 2014

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

RE: Project Number S5431024

Dear Ms. Gustason:

On March 17, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 27, 2014. 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 March 28, 2014 a survey team representing the office of the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey of your facility. As the survey team informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found the most serious deficiencies in the facility to be an E, whereby corrections were required.

On April 9, 2014, CMS forwarded the results of the FMS to you and informed you that the following enforcement remedy was being imposed:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 27, 2014. (42 CFR 488.417 (b))

In addition, CMS notified you in their letter of April 9, 2014, in accordance with Federal law, as specified in the ACT at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 27, 2014.

On May 12, 2014, the Minnesota Department of Health and on March 31, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 27, 2014 and an FMS completed on March 28, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 7, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies pursuant to our standard survey, completed on February 27, 2014 and FMS completed March 28, 2013, effective May 7, 2014.

As a result of the revisit findings, this Department recommended to CMS Region V Office the following actions related to the remedies in their letter of April 9, 2014. CMS Concurs and has authorized this Department to notify you of these actions:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 27, 2014 be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 27, 2014 be rescinded. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 27, 2014 be rescinded.

In the CMS letter of March 1, 2012, you were advised that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 27, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 7, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Enclosed is a copy of the Post Certification Revisit (PCR) form, (CMS-2567b) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245431	A. Building B. Wing	5/12/2014

Name of Facility	Street Address, City, State, Zip Code
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 55940

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**05/07/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 3/28/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245431	A. Building B. Wing **01 - MAIN BUILDING 01**	3/31/2014

Name of Facility	Street Address, City, State, Zip Code
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 55940

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **02/26/2014**	ID Prefix	Correction Completed **03/28/2014**	ID Prefix	Correction Completed **03/06/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0038		LSC K0062		LSC K0067	
ID Prefix	Correction Completed **03/29/2014**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0147		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/25/2014	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245431	A. Building B. Wing	5/12/2014

Name of Facility	Street Address, City, State, Zip Code
FIELD CREST CARE CENTER	318 SECOND STREET NORTHEAST HAYFIELD, MN 55940

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **03/29/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/29/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/29/2014**
ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	Correction Completed **03/29/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KFD/GPN	05/29/2014	15425	05/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/27/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

May 29, 2014

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

Re: Reinspection Results - Project Number S5431024

Dear Ms. Gustason:

On May 12, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 12, 2014,with orders received by you on . At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

AH Form Approved
5/20/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00104	A. Building B. Wing	5/12/2014

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **03/29/2014**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **03/29/2014**	ID Prefix **21695** Reg. # **MN Rule 4658.1415 Subp.** LSC	Correction Completed **03/29/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 2/27/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZDRO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00104

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245431**
2.STATE VENDOR OR MEDICAID NO.
(L2) **304240500**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/27/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 03/26/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/21/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/21/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN 27-5431

At the time of the standard survey on February 27, 2014 the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7845

March 17, 2014

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

RE: Project Number S5431024

Dear Ms. Gustason:

On February 27, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast, Rochester, Minnesota 55904
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 May 6, 2014, 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 May 6, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 27, 2014 (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 27, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the

specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205 Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Enclosure

cc: Licensing and Certification File

MAR 21 2014
MN Dept of Health
Rochester

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	02/27/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 6 of 35 resident rooms (18, 19, 20, 21, 22, 23) with identifiable odors. Findings include: Observations including the sense of smell during the survey on 2/24/14, at 3:30 p.m., 5:30 p.m., 7:30 p.m., 2/25/14, at 8:10 a.m., 2/26/14, at 7:05 a.m., and 2/27/14, at 9:25 a.m., strong foul odor was observed on the middle hallway located between rooms 18 and 19 across hall from each other; rooms 20 and 21 across hall from each other; and rooms 22 and 23 across hall from each other.	F 253	Attachment 1 03/24/14 GPN	3/29/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheryl A. Gustafson — TITLE: Administrator — (X6) DATE: 3/21/2014

A 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.

Attachment 1

Regulation 483.15(h)(5) Tag F253
Housekeeping and Maintenance Services

Field Crest Care Center provides housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable environment for the residents. Residents are provided with a pleasant, home-like, and safe environment that promotes their highest practicable level of well-being.

The frequency and procedures for cleaning resident rooms, bathrooms, and halls have been reviewed and found appropriate. The administrative and housekeeping supervisory staff have been routinely checking for odors in the hallways with a focus on the middle hallway adjacent to rooms 18, 19, 20, 21, 22 and 23. Only transient odors related to residents' bowel/bladder function have been noted. No unpleasant pervasive odors were detected. Two new products are now being used for odor control–an odor digester/ deodorizer which will be applied to the floor before mopping and a deodorizing mist for transient odors.

Use of the new products and the room/bathroom cleaning policy and procedures have been reviewed with the housekeeping staff. All staff members will be instructed 1) to be alert for unpleasant odors 2) the availability of the deodorizing mist to control transient odors that may negatively impact resident dignity and quality of life 3) the need to remove soiled incontinence products from the room after completion of cares and 4) to report odors to their supervisors that are not transient with an identifiable cause.

Compliance will be monitored by the Housekeeping Director or designee by routine monitoring for unpleasant odors in resident care areas three times weekly for four weeks; random checks for unpleasant odors will be ongoing. If pervasive unpleasant odors are noted, additional staff training and monitoring will be done and the appropriateness of the cleaning schedules and products will be further investigated. Compliance will be reviewed at the April and July Quality Assurance Committee meetings.

Completion date: March 29, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____ MN Dept of Health Rochester	02/27/2014

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

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F 253	Continued From page 1 During environment tour on 2/24/14, at 11:40 a.m., housekeeper-A (hskp-A) verified foul odors on middle hallway and stated the odors had been present for a while. Hskp-A stated possibly odor from room 19. Observations at that time revealed maintenance manager checked room 19 vent which was working and verified middle hallway vent switch was on and working. During interview on 2/27/14, at 9:45 a.m., housekeeping/laundry director stated room 20 had large amounts of paper and gloves in wastebasket and possibly that was source of foul odor. During interview on 2/27/14, at 1:30 p.m., nursing assistant (NA)-A verified foul odors on middle hallway had been present this week. Review of facility policy Housekeeping Operations dated 6/1997, identified Cleaning Tasks included: Step 2. b. "Spot clean any stains on the walls." c. "Clean mirror, sink, and plumbing areas." Deep Room Clean 4. "Moving in a clockwise rotation from the bathroom door, clean, polish, scrub, scrape, dust, disinfect, sweep, wipe, and mop everything in the room including:" a." Walls-Spot scrub all walls." c. "Sink-Using scouring cream or cleanser, clean all porcelain on sink both top and bottom. Scrub all fixtures and drains. Be sure to scrub wall under sink." h. "Mirror-Clean edges of mirror and shelf."	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	Attachment 2	3/29/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____ MAR 21 2014 MN Dept of Health Section	02/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop care plan interventions related to pain for 1 of 5 residents (R38) reviewed for unnecessary medications. Findings include: R38's care plan dated 7/12/13, revealed no identification of chronic pain, risk factors, goals, or non-pharmacological interventions to treat pain. R38's Resident Care Area Assessment (CAA) Resource Report dated 11/3/13, revealed indicators of pain included gastroesophageal	F 279		

Attachment 2

Regulation 483.20(d,k) Tag F279
Comprehensive Care Plans

Field Crest Care Center uses the results of the comprehensive assessment to develop, review and revise the resident's comprehensive plan of care. The individualized care plan 1) includes measurable objectives and timetables to meet the resident's needs as identified in the comprehensive assessment 2) describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and 3) recognizes the residents' right to refuse cares/services.

The care plan related policies/procedures and the staff responsibilities for development and revision of the comprehensive plans of care were reviewed and found appropriate. At the time of admission, a temporary care plan is implemented; the interdisciplinary care plan is developed within seven days after completion of the comprehensive assessment.

During the mandatory training meetings, the nursing staff will be 1) reminded of the facility policies for care plan implementation/reviews/updates 2) reminded that the residents' care plans must be current at all times and 3) instructed that care plans must address symptoms, conditions, and strengths that impact the resident's functional status/well-being including pain.

The pain management plan for resident number ~~28~~ 38 APN was reviewed and found to be effective. The care plan has been updated to address pain management and will be revised with changes in care/services.

To monitor compliance the Director of Nursing/designee will conduct care plans audits weekly for the next two months with a focus on pain management. If care plan omissions or inaccuracies are identified, additional care plan audits and staff training will be done. As part of the quarterly care conference process, the interdisciplinary team continues to review the care plans for completeness, accuracy, and relevancy. Compliance will be discussed at the April quarterly Quality Assurance Committee meeting.

Completion Date: March 29, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____ MAR 21 2014 MN Dept of Health Rochester	02/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 3 reflux disease and arthritis, disturbed sleep, limited day to day activities, limited independence with activities of daily living, other considerations included improper positioning. Analysis of findings included, diagnosis of degenerative joint disease, history of back pain, pelvic pain, knee pain and at risk for decline related to pain. Decision was to care plan problem of pain. R38 was identified on the quarterly Minimum Data Set, an assessment dated 1/29/14, to have occasional severe pain, received scheduled and as needed pain medication, pain interfered with sleep and activities, and received non-pharmacological interventions for pain. Document review of the facility pain assessment dated 7/1/13, identified R38 had no pain. Document review of the facility pain assessment dated 1/29/14, identified resident had pain in the right groin, knee, and thigh, which was occasional pain, rated 3-6 out of scale of 10. Pain was identified by facial grimaces, was treated with repositioning and medication. Document review of physician signed orders dated 1/29/14, revealed orders for the following pain medication: extra strength Tylenol 500 milligrams two tablets three times a day; oxycodone 2.5 milligrams every six hours as needed for pain/restlessness. Document review of the physician Limited Evaluation visit report dated 1/29/14, identified R38 had no non-verbal signs of pain and received as needed oxycodone (a medication for pain) 2-3 times a week. The physician Impression/Report/Plan included: #3--Osteoarthritis with chronic pain--Tylenol	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 4 scheduled, as needed oxycodone and biofreeze appeared to be effective. If restless, medicate first with as needed oxycodone in addition to other environmental interventions. Document review of facility Medication Administration Record (MAR) and facility as needed (PRN) Medication Documentation Record revealed the following for 12/13, 1/14, and 2/1-27/14: 12/13-received extra strength Tylenol three times a day as ordered. Received 32 doses of as needed oxycodone. 1/14- received extra strength Tylenol three times a day as ordered. Received 15 doses of as needed oxycodone. 2/1-2/27/14-received extra strength Tylenol three times a day as ordered. Received 19 doses of as needed oxycodone. During interview on 2/27/14, at 10:05 a.m., director of nursing verified although R38 had occasional pain and received scheduled and as needed pain medication and R38's care plan did not address pain management.	F 279		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	Attachment 3	3/29/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MN Dept of Health
Rochester

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F 441	Continued From page 5 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control (IC) program to include surveillance and investigation of infections that occur in the facility in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. This had the potential to affect all 36	F 441		

Attachment 3

Regulation 483.65 Tag F441
Infection Control

Field Crest Care Center has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development of disease and infection. The facility has an infection control program that 1) investigates, controls, and prevents infections in the facility 2) determines the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control.

The facility's quarterly infection control log currently tracks thirteen data points and the data are routinely analyzed to track trends. The log will be modified to improve clarity. When a culture is ordered, the causative organism will be documented on the log. The symptoms and resolution of resident infections will continue to be documented in the nursing progress notes.

During the mandatory training meeting, 1) the direct care staff will be reminded to alert the charge nurse of any observed symptoms could be related to an infection and 2) the licensed nurses will be reminded to document the symptoms and resolution of infections.

The Administrator will monitor compliance by auditing the completeness and content of the infection control tracking log monthly for three months. If noncompliance is noted, additional auditing and staff training will be done. Adequacy of infection surveillance will be reviewed with the Medical Director at the April quarterly Quality Assurance Committee meeting.

Completion Date: March 29, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 6 residents (this includes R40 and R23) who resided in the facility. Findings include: A review of the facilities Quarterly Infection Logs from June 2013 through February 26, 2014 indicated the following urinary tract infections (UTIs) in the facility: 1st quarter log with dates from January 1, 2014 to February 26, 2014, indicated 8 UTIs with 7 infections not revealing the causative organism and all 8 (R40 was included in the eight) with no accompanying symptoms. 4th quarterly log with dates from October 2013 to December 2013, indicated 15 UTI's with one having no symptoms, one having no symptoms, causative organism, and onset and 13 (R23 included in the 13) having no symptoms and no causative organism identified. 3rd quarterly log with dates of July 2013 to September 2013, indicated 5 UTIs, with two infections with no accompanying symptoms, one with no identifying causative organism nor symptoms, one with no duration, resolution, symptoms or causative organism, and one with no onset, duration, symptoms or resolution. During an interview with the Director of Nursing (DON) on 2/26/14 at 11:14 a.m., DON indicated that the facility was receiving the urinary cultures but that she did not have a process in place to track the organisms on the quarterly infection control log. DON also indicated that she did not have a process in place for monitoring the symptoms of the infection. The Nurse Practitioner had resigned at the end of November 2013 and since then the monitoring hadn't been always done as far as the causative organism. The policy dated 2/2010 titled Infection Control Documentation objective statement indicates that	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 7 infection control documentation is designed to help prevent the development and transmission of disease and infection by tracing incidents of infection. Outcome surveillance is designed to identify and report evidence of an infection. The process consists of collecting/documenting data on individual cases and comparing the collected data to detect clusters and trends.	F 441		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 3 kitchen freezers was in good working order. This freezer stored foods that were consumed by most residents who ate foods prepared and had been stored in this freezer. Findings include: During observations on the initial kitchen tour on 2/24/14, at 2:15 p.m., one freezers had three shelves with ice accumulation on food packages and a large area of thick ice located on the floor of the freezer. The freezer temperature at that time was minus six degrees Fahrenheit. The ice accumulation was verified by cook-A. During tour of the kitchen on 2/26/14, at 10:00 a.m., dietary manager verified he had cleaned out the thick ice on the floor of the freezer, he had not	F 456	Attachment 4	3/29/14

Attachment 4

483. 70(h) Tag F456
Safe, Sanitary, Comfortable Environment

Field Crest Care Center staff strive to 1) maintain all essential mechanical, electrical, and patient care equipment in safe operating condition and 2) provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

The ice build up in the freezer has been removed. The SCR company was contracted to assess the freezer water leak. Their recommendation was to replace the freezer and bids for a new freezer have been received from four companies. After Board review, the replacement of the freezer will commence in a timely manner. In the interim, a water collection tray will be used to prevent ice build up inside the freezer.

All kitchen staff have been informed of the need to report any ice build up to his/her supervisor.

Until the freezer is replaced, the dietary manager/designee will monitor compliance through daily direct observation of the placement of water collection tray and ice build up. Any ice build up will be promptly removed.

Completion Date: March 29, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 8 cleaned the ice accumulated on three shelves of food packages. Dietary manager stated it was an old freezer and the condenser located on the freezer ceiling dripped water which formed the ice. Dietary manager stated he placed a pan beneath the condenser to catch the drips although the pan had been pushed aside. He stated he cleaned the ice from the freezer every Thursday. Observations during the kitchen tour revealed the freezer temperature was minus eight degrees Fahrenheit. Document review of the facility Safety Program Enhancements Facility Safety Inspections dated 3/20/13, read, "Purpose: To inspect, on a scheduled basis, the different departments within the facility to identify unsafe working conditions and make corrections as necessary to provide safe and healthy working environment for employees and residents." The monthly safety inspections included dietary department and identified #4. "Equipment free of water leaks?" During interview on 2/27/14, at 8:00 a.m., clerical (CL)-A stated the safety inspections for the facility were most recently completed on 12/31/13, which included the dietary department.	F 456		

STATEMENT OF COMPLIANCE

Field Crest Care Center has been providing nursing home services to the community for past 44 years. Its policies and procedures have been developed in accordance with the law and the community standard of practice.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/25/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Fieldcrest Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok JB 3-26-14 RECEIVED MAR 24 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 5-6-14

EXIT: 3-27-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cheryl A. Shaha	Administrator	3/21/2014

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

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Fieldcrest Care Center is a 1-story building. The original building was constructed in 1969 and was determined to be of Type II (111) construction, with a partial basement. In 1972, an addition was constructed and was determined to be of Type II (111) construction, with a full basement. In 1995, an addition was constructed and was determined to be of Type II (111) construction, with no basement. The facility is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 37 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

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K 038 SS=D	Continued From page 2 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2 and 7.1.10.1. The deficient practice could affect all 12 out 37 residents. Findings include: On facility tour between 10:00 AM and 1:00 PM on 02/25/2014, observation revealed, hallway #3, required exit discharge to the public way has ice and snow build up on path This deficient practice was confirmed by the Facility Maintenance Director (KB) at the time of discovery.	K 038	K038 The ice and snow build up near the exit door in hallway #3 was removed immediately. The exit discharge to the public walkway will be closely monitored for ice and snow build during the winter months. The Maintenance Director will be responsible for monitoring compliance. Completion date: Feb 26, 2014	2/26/14
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062	K062 All sprinkler heads in the facility were checked for paint deposits. The Olympic Fire Protection Company plans to replace the three affected sprinkler heads by March 28, 2014. Sprinkler heads will be protected from paint spatters during future maintenance/remodeling projects.	3/28/14

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K 062	Continued From page 3 Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-2.1.1, 2-2.2 and 2-4.1.4. This deficient practice could affect all 12 out of 37 residents. Findings include: On facility tour between 10:00 AM and 1:00 PM on 02/25/2014, observation revealed that the following was found: 1. Basement - Activity storage sprinkler head has paint on it. (NOTE: Check the entire facility for this deficiency) 2. 1st floor - Wing 1 several pendant sprinkler heads have dropped down creating a gap around sprinkler piping 3. Basement - Laundry room duct work is supported by the sprinkler line 4. Spare sprinkler head box does not contain 2 of each type of sprinkler head in the facility These deficient practices were confirmed by the Facility Maintenance Director (KB) at the time of discovery.	K 062	The Olympic Fire Protection Corporation plans to secure the sprinkler heads on first floor wing one in the proper position by March 28, 2014. On March 3, 2014, the basement laundry room duct work was secured to the ceiling and is no longer supported by the sprinkler line. On March 28, 2014, the Olympic Fire Protection Corporation will provide two spare sprinkler heads for each type of head installed at the facility. The Maintenance Director will be responsible for monitoring compliance. Completion date: March 28, 2014	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	K067 The fire dampers were checked by Harty's Mechanical March 6, 2014. Routine testing of the dampers has been added to the maintenance task log.	3/16/14

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K 067	Continued From page 4 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, that the facility's general ventilating and air conditioning system (HVAC) was not maintained in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 3-4.7. A noncompliant HVAC system could affect all 37 residents. Findings include: On facility tour between 10:00 AM and 1:00 PM on 02/25/2014, documentation review of the fire damper testing log for the past 4 years revealed, all of the fire/smoke dampers have not been tested with-in the last 4 years. This deficient practice was confirmed by the Facility Maintenance Director (KB) at the time of discovery.	K 067	The Maintenance Director will be responsible for monitoring compliance. Completion date: March 6, 2014	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical supply in accordance with the requirements of 2000 NFPA 101 - 19.5.1, 9.1.2, 1999 NFPA 70, 110-26. The deficient practice could affect 12 out of 37 residents. Findings include:	K 147	K 0147 The laundry carts in front of the circuit breaker panels were immediately moved. All staff will be/have been instructed on the panel clearance requirements. OSHA approved signs informing staff of the required 36 inch front clearance were applied to the breaker panels. The Maintenance Director will monitor for compliance. Completion date: March 29, 2014	3/29/14

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K 147	Continued From page 5 On facility tour between 10:00 AM and 1:00 PM on 02/25/2014, observation revealed, that the following circuit breaker panels were block: 1. 1st floor by room # 47 2. 1st floor - wing # 1, by flush room NOTE: Check the entire facility for this deficiency These deficient practices were confirmed by the Facility Maintenance Director (KB) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 147		

Minnesota Department of Health

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	00104	A. BUILDING: _____ B. WING _____ MAR 21 2014 MN Dept of Health Rochester	02/27/2014

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On February 24, 25, 26, 27, 2014, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature."	2 000	03/24/14 GPN Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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

Cheryl A. Stasson — Administrator — 3/21/2014

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2 000	Continued From page 1 Make a copy of these orders for your records and return the original to the address below: Minnesota Department of Health 18 Wood Lake Drive SE, Rochester, MN 55904 c/o Gary Nederhoff, Unit Supervisor 507-206-2731 Office	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).	2 560		

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2 560	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop care plan interventions related to pain for 1 of 5 residents (R38) reviewed for unnecessary medications. Findings include: R38's care plan dated 7/12/13, revealed no identification of chronic pain, risk factors, goals, or non-pharmacological interventions to treat pain. R38's Resident Care Area Assessment (CAA) Resource Report dated 11/3/13, revealed indicators of pain included gastroesophageal reflux disease and arthritis, disturbed sleep, limited day to day activities, limited independence with activities of daily living, other considerations included improper positioning. Analysis of findings included, diagnosis of degenerative joint disease, history of back pain, pelvic pain, knee pain and at risk for decline related to pain. Decision was to care plan problem of pain. R38 was identified on the quarterly Minimum Data Set, an assessment dated 1/29/14, to have occasional severe pain, received scheduled and as needed pain medication, pain interfered with sleep and activities, and received non-pharmacological interventions for pain. Document review of the facility pain assessment dated 7/1/13, identified R38 had no pain. Document review of the facility pain assessment dated 1/29/14, identified resident had pain in the right groin, knee, and thigh, which was occasional pain, rated 3-6 out of scale of 10. Pain was identified by facial grimaces, was treated with	2 560		

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2 560	Continued From page 3 repositioning and medication. Document review of physician signed orders dated 1/29/14, revealed orders for the following pain medication: extra strength Tylenol 500 milligrams two tablets three times a day; oxycodone 2.5 milligrams every six hours as needed for pain/restlessness. Document review of the physician Limited Evaluation visit report dated 1/29/14, identified R38 had no non-verbal signs of pain and received as needed oxycodone (a medication for pain) 2-3 times a week. The physician Impression/Report/Plan included: #3--Osteoarthritis with chronic pain--Tylenol scheduled, as needed oxycodone and biofreeze appeared to be effective. If restless, medicate first with as needed oxycodone in addition to other environmental interventions. Document review of facility Medication Administration Record (MAR) and facility as needed (PRN) Medication Documentation Record revealed the following for 12/13, 1/14, and 2/1-27/14: 12/13-received extra strength Tylenol three times a day as ordered. Received 32 doses of as needed oxycodone. 1/14- received extra strength Tylenol three times a day as ordered. Received 15 doses of as needed oxycodone. 2/1-2/27/14-received extra strength Tylenol three times a day as ordered. Received 19 doses of as needed oxycodone. During interview on 2/27/14, at 10:05 a.m.,	2 560		

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2 560	Continued From page 4 director of nursing verified although R38 had occasional pain and received scheduled and as needed pain medication and R38's care plan did not address pain management. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the facility develop care plans to address to adrress resident specific concerns. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control (IC) program to include surveillance and investigation of infections that occur in the facility in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. This had the potential to affect all 36	21375		

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21375	Continued From page 5	21375		

residents (this includes R40 and R23) who resided in the facility.
Findings include:
A review of the facilities Quarterly Infection Logs from June 2013 through February 26, 2014 indicated the following urinary tract infections (UTIs) in the facility:
1st quarter log with dates from January 1, 2014 to February 26, 2014, indicated 8 UTIs with 7 infections not revealing the causative organism and all 8 (R40 was included in the eight) with no accompanying symptoms.
4th quarterly log with dates from October 2013 to December 2013, indicated 15 UTI's with one having no symptoms, one having no symptoms, causative organism, and onset and 13 (R23 included in the 13) having no symptoms and no causative organism identified.
3rd quarterly log with dates of July 2013 to September 2013, indicated 5 UTIs, with two infections with no accompanying symptoms, one with no identifying causative organism nor symptoms, one with no duration, resolution, symptoms or causative organism, and one with no onset, duration, symptoms or resolution.
During an interview with the Director of Nursing (DON) on 2/26/14 at 11:14 a.m., DON indicated that the facility was receiving the urinary cultures but that she did not have a process in place to track the organisms on the quarterly infection control log. DON also indicated that she did not have a process in place for monitoring the symptoms of the infection. The Nurse Practitioner had resigned at the end of November 2013 and since then the monitoring hadn't been always done as far as the causative organism.

The policy dated 2/2010 titled Infection Control Documentation objective statement indicates that infection control documentation is designed to

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	00104	A. BUILDING: _____ B. WING _____	02/27/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 6 help prevent the development and transmission of disease and infection by tracing incidents of infection. Outcome surveillance is designed to identify and report evidence of an infection. The process consists of collecting/documenting data on individual cases and comparing the collected data to detect clusters and trends. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service employees responsible for infection control program to include tracking, evaluating, interventions to prevent the spread of infection. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21375		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 6 of 35 resident rooms (18, 19, 20, 21, 22, 23) with identifiable odors. Findings include: Observations including the sense of smell during the survey on 2/24/14, at 3:30 p.m., 5:30 p.m., 7:30 p.m., 2/25/14, at 8:10 a.m., 2/26/14, at 7:05	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00104	A. BUILDING: _____ B. WING _____	02/27/2014

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

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21695	Continued From page 7 a.m., and 2/27/14, at 9:25 a.m., strong foul odor was observed on the middle hallway located between rooms 18 and 19 across hall from each other; rooms 20 and 21 across hall from each other; and rooms 22 and 23 across hall from each other. During environment tour on 2/24/14, at 11:40 a.m., housekeeper-A (hskp-A) verified foul odors on middle hallway and stated the odors had been present for a while. Hskp-A stated possibly odor from room 19. Observations at that time revealed maintenance manager checked room 19 vent which was working and verified middle hallway vent switch was on and working. During interview on 2/27/14, at 9:45 a.m., housekeeping/laundry director stated room 20 had large amounts of paper and gloves in wastebasket and possibly that was source of foul odor. During interview on 2/27/14, at 1:30 p.m., nursing assistant (NA)-A verified foul odors on middle hallway had been present this week. Review of facility policy Housekeeping Operations dated 6/1997, identified Cleaning Tasks included: Step 2. b. "Spot clean any stains on the walls." c. "Clean mirror, sink, and plumbing areas." Deep Room Clean 4. "Moving in a clockwise rotation from the bathroom door, clean, polish, scrub, scrape, dust, disinfect, sweep, wipe, and mop everything in the room including:" a." Walls-Spot scrub all walls." c. "Sink-Using scouring cream or cleanser, clean all porcelain on sink both top and bottom. Scrub all fixtures and drains. Be sure to scrub wall under sink."	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00104	A. BUILDING: _____ B. WING _____	02/27/2014

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21695	Continued From page 8 h. "Mirror-Clean edges of mirror and shelf." Based on observation and interview, the facility failed to ensure 1 of 3 kitchen freezers was in good working order. This freezer stored foods that were consumed by most residents who ate foods prepared and had been stored in this freezer. Findings include: During observations on the initial kitchen tour on 2/24/14, at 2:15 p.m., one freezers had three shelves with ice accumulation on food packages and a large area of thick ice located on the floor of the freezer. The freezer temperature at that time was minus six degrees Fahrenheit. The ice accumulation was verified by cook-A. During tour of the kitchen on 2/26/14, at 10:00 a.m., dietary manager verified he had cleaned out the thick ice on the floor of the freezer, he had not cleaned the ice accumulated on three shelves of food packages. Dietary manager stated it was an old freezer and the condenser located on the freezer ceiling dripped water which formed the ice. Dietary manager stated he placed a pan beneath the condenser to catch the drips although the pan had been pushed aside. He stated he cleaned the ice from the freezer every Thursday. Observations during the kitchen tour revealed the freezer temperature was minus eight degrees Fahrenheit. Document review of the facility Safety Program Enhancements Facility Safety Inspections dated 3/20/13, read, "Purpose: To inspect, on a scheduled basis, the different departments within the facility to identify unsafe working conditions and make corrections as necessary to provide	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21695	Continued From page 9 safe and healthy working environment for employees and residents." The monthly safety inspections included dietary department and identified #4. "Equipment free of water leaks?" During interview on 2/27/14, at 8:00 a.m., clerical (CL)-A stated the safety inspections for the facility were most recently completed on 12/31/13, which included the dietary department. SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff on the need to report timely environmental concerns so they can be addressed timely to provide a safe and sanitary environment for the residents, staff and visitors. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21695		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7845

March 17, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5431024

Dear Ms. Gustason:

The above facility was surveyed on February 24, 2014 through February 27, 2014 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, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health:

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast, Rochester, Minnesota 55904
Telephone: (507) 206-2731 Fax: (507) 206-2711

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 immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File