Electronically Submitted
October 15, 2020

Administrator
Field Crest Care Center
318 Second Street Northeast
Hayfield, MN 55940

RE: CCN: 245431
Cycle Start Date: September 24, 2020

Dear Administrator:

On September 24, 2020, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On September 24, 2020, the situation of immediate jeopardy to potential health and safety cited at F0600 was removed. However, continued non-compliance remains at a lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 30, 2020.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 30, 2020 (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 30, 2020, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Field Crest Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 24, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of

correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Phone: 651-201-3784

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your

verification.

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.

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

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 March 24, 2021 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.

Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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 _____	C 09/24/2020

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 On 9/22/20-9/24/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5431034C, H5431035C. Deficiency issued F600. The survey resulted in an immediate jeopardy began on 9/2/20, when the facility failed to prevent R1's recurrent physical aggression towards other residents. The facility had not implemented an effective system of supervision for R1 to remove the risk of continued aggression toward other residents. The administrator and director of nursing (DON) were notified of the IJ on 9/23/20, at 7:27 p.m. In addition, an extended survey was completed on 9/24/20, related to the substandard quality of care findings. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with	F 000		

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

Electronically Signed | 10/23/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	C 09/24/2020

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	Continued From page 1 your verification.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess, evaluate and monitor for the reoccurrences of resident-to-resident abuse for 1 of 2 residents (R1) who had a history of physical aggression. R1 had recurrent aggressions towards R2 and R3 resulting in an Immediate Jeopardy (IJ). The immediate jeopardy began on 9/2/20, when the facility failed to prevent R1's recurrent physical aggression towards other residents. The facility had not implemented an effective system of supervision for R1 to remove the risk of continued aggression toward other residents. The administrator and director of nursing (DON) were notified of the IJ on 9/23/20, at 7:27 p.m. The IJ was removed on 9/24/20 at 5:18 p.m., when it	F 600	Field Crest Care Center policy reflects the residents right to be free from abuse, neglect, misappropriation of property, and financial exploitation. The goal of the staff is to provide a safe environment that protects residents from abuse. To the best ability possible, the facility ensures the safety and well-being of each resident and ensures that all staff are trained and knowledgeable in how to react and respond appropriately to negative resident behavior including resident-to-resident altercations. At the time of admission, the Social Service Director completes an	11/3/20

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 _____	C 09/24/2020

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 600	Continued From page 2 could be verified the facility had developed and implemented interventions to minimize risks of resident-to-resident abuse. However, non-compliance remained at the lower scope and severity of D, isolated, no actual harm, with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's Admission Record face sheet printed 9/23/20, included diagnoses of Alzheimer's disease and dementia with behavioral disturbance. R1's quarterly Minimum Data Set (MDS) assessment dated 8/7/20, indicated the resident had moderate cognitive impairment, exhibited physical behavior towards others and rejection of care 1-3 days during the assessment period, and utilized a wheelchair (w/c) for mobility. R1's care plan last revised 9/10/20, indicated the resident has had episodes of aggressive behavior and has threatened staff as well as other residents. Resident has made inappropriate sexual comments and needs some guidance to maintain optimal social relationships. Interventions included to remove residents whom may be targeted in times of resident's aggression, and 1:1 (one to one) with validation of feelings when resident is frustrated, agitated. The care plan also indicated the resident has had instances of false accusations of others (someone jumped up and down on him, beat him up, etc.) Family have reported that resident makes false statements about staff persons. Interventions included: If resident making untrue accusation, attempt to identify trigger. Remove	F 600	assessment of the resident□s vulnerability to abuse and the risk of the resident abusing others. Based on the assessment, a resident-centered comprehensive plan of care is developed which includes interventions to manage behaviors which may have a negative impact on others including physical, sexual and/or verbal aggression. The care plan is reviewed at least quarterly and with significant changes in condition; the effectiveness of interventions is evaluated and the care plan is revised as necessary. According to facility policy, the staff are instructed to immediately intervene as necessary to ensure the safety of residents including protection from abuse and neglect. Staff are observant for resident behaviors that may negatively impact others such as verbal/physical/sexual abuse or aggressiveness, wandering into other resident□s rooms/spaces, infringing on personal space as well as taking, touching, or rummaging through the property of others. Staff immediately report all suspected resident abuse/neglect to their supervisor. The Administrator and Director of Nurses are notified immediately of all allegations of abuse and neglect. The interdisciplinary care team (IDT) routinely investigates incidences of alleged abuse/neglect including resident-to-resident physical and verbal abuse with the goal to understand causal factors and implement interventions to	

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 _____	C 09/24/2020

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 600	Continued From page 3 trigger if able. Male staff being present have triggered this in the past. Report all accusation to nurse in charge immediately. Increase monitoring and provide support and reassurance as needed if resident exhibiting accusations of others, agitation and seeking out others that he is threatening to harm. Monitor for anxiety, distress and / or fear. Remove others from environment if possible. Redirect and offer calm, quiet environment. Investigate any accusations of abuse or harm from resident. If unable to rule out or explain immediately, follow protocol for filing VA (vulnerable adult) incident report to OHFC (Office of Health Facility Complaints-designated state agency) until full investigation can be completed. R1's Visual/Bedside Kardex Report utilized by the nursing assistants (NAs) included: 1:1 with validation of feelings when resident is frustrated, agitated. If resident is agitated, remove peers from area. Allow resident to wander freely in common areas. Limit number of staff for intervention if possible. Staff to monitor resident while in public areas and if appears to be propelling to room, they will follow and assist with any needs he may have, ensuring when they leave that the call light is within reach and needs met. On 9/22/20, at 12:43 p.m. R1 was observed propelling self out of the dining room and down wing 1 in w/c, holding onto the railing and pulling to assist with movement. No other residents or staff were in the hallway on wing 1 at that time. R1 stopped in front a resident room looking in. There was a female resident in the room lying in bed. R1 remained in the doorway to the room looking in for approximately 2 minutes until a	F 600	protect residents from harm. Resident care plans and nursing assistant care guides are revised as necessary to reflect related safety interventions. The facility s Resident Protection Program policies and procedures were reviewed. The policies and procedures will be revised to include more detailed guidance for staff response to resident-to-resident altercations/abuse. During small group meetings, the staff will be instructed on the new policy. Vulnerable adult regulations and related facility polices are reviewed with the staff on an annual basis and all new employees are informed of the residents right to be free from abuse, neglect, mistreatment, and financial exploitation. Resident Number One was admitted to the facility April 23, 2018 with the diagnosis of major neurocognitive disorder. Due to behavior symptoms negatively impacting the safety of others, there was frequent audio/visual communication with the nurse practitioner during the past two months addressing behavior management options. The resident□s psychotropic medications were reviewed with multiple adjustments in an attempt to decrease the resident□s agitation and improve his quality of life. On September 23, 2020, every thirty minute checks were initiated for Resident Number One. All oncoming staff were instructed to provide one-on-one	

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 _____	C 09/24/2020

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 600	Continued From page 4 nursing assistant (NA) observed R1 in front of the door and redirected R1 back into the dining room. R1's progress notes dated 9/2/20 included: - 18:32 (6:32 p.m.) Behavior Note Note Text: Resident w/ (with) confrontation seeking, accusing people of stealing money from him. Behaviors began at about 1730 (5:30 p.m.). He was given a PRN (as needed) Seroquel (an antipsychotic medication) at the onset of behavior. Resident was served his evening meal and ate 100% of his meal in the dining room. Behaviors began to escalate after he finished eating. Resident wheeling himself up and down the hallway swinging out and grabbing at anyone who walks by him, staff and residents included. Resident wheeling out to dining room for confrontation. Other residents removed to place of safety and staff to give resident space to de-escalate. Will continue to monitor resident from a distance to ensure safety. - 19:07 (7:07 p.m.) Behavior Note Text: Resident continuing to be confrontation seeking, Kicked another resident (medical record number/R3) who had walked out to dining room. [R3] was in the process of being escorted out of the dining room by NAR (nursing assistant registered). [R3] sustained no injuries and was escorted to safety. Will continue to monitor per nursing measures. R1's physician progress note dated 9/3/20, included the following: He is noted to start having escalation of behaviors typically around noon. He unfortunately kicked another resident yesterday. This was a female resident, typically in the past his physical aggression has been directed towards males...Assessment/Plan: Unfortunately had escalation of physical interaction with another	F 600	supervision if the resident displayed any symptoms that indicated he may harm himself or other residents. The staff were instructed to move other residents from the proximity of Resident Number One when his behavior posed a risk of harm/injury to others. On September 24, 2020, during a meeting with management staff from the dietary, therapy, activity, nursing, maintenance, environmental and finance departments, the recent behaviors of Resident Number One and his behavior management plan were discussed. The managers were instructed to inform their department staff to be observant of the location of resident number one and his interaction with other residents and to report any concerning behaviors to the charge nurse. After changes in his medications, the resident□s behavior improved, especially during the day shift. The resident is no longer exhibiting aggressive behaviors toward staff or other residents. Effective October 19, 2020, the 30-minute checks during the day were discontinued. Since the resident needs assistance transferring from bed, during the October 26, 2020 IDT meeting, the possibility of discontinuing the every 30-minute checks while the resident is in bed will be evaluated. The resident□s behaviors will continue to be reviewed during the weekly IDT meetings and quarterly care conferences and more often if necessary. Behavior	

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 _____	C 09/24/2020

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 600	Continued From page 5 resident, kicking them yesterday. Staff note that his behavior seem to be escalating on daily basis and looking at his prn Seroquel use it has been more frequent as the month of August progress and daily here so far in September. Consider dose increase in Seroquel verses addition of another psychotropic medications such as valproic acid (a mood stabilizer), but I do not think that dose would be appropriate directions to go given his level behaviors at this time. Therefore, decision was made to transition to olanzapine (an antipsychotic medication). Olanzapine 5 mg (milligrams) is equivalent to roughly 100 mg of Seroquel. Initial dose will be set plants (sic) pain (sic) 5 mg bid with additional 2.5 mg available daily prn. All this will be less of a total daily equaling dose, hoping the olanzapine will be more effective. May need some further titration. Although the facility contacted the physician to address R1's increase in aggressive behaviors there was no evidence the facility had formally increased supervision of R1 or reported the resident-to-resident altercation between R1 and R3 to the state agency (SA). R1's progress notes dated 9/7/20 - 9/8/20 revealed the following: - 9/7/20 01:32 (1:32 a.m.) Behavior Note Note Text: Resident started grabbing peers walker while it was not in use and attempted to throw it around the dinning (sic) area. Resident is taking dinning (sic) room chairs and attempting to throw them and knock them over. Staff attempted to redirect resident by offering a snack. Resident began to swing at staff, hit staff, and kick staff. Resident had gotten ahold a wooden block from activities and was swinging it at staff. staff (sic) redirected resident to other objects such as socks	F 600	symptoms/patterns, the effectiveness of current interventions, need for increased supervision, vulnerability to abuse, and the risk of abusing others will continue to be reassessed. To determine the effectiveness of the antipsychotic medications, the resident□s target behaviors justifying antipsychotic use will continue to be identified and quantified. The resident□s attending physician/nurse practitioner will be updated as necessary regarding the resident□s behavior and the effectiveness of pharmacological and nonpharmacological interventions. All staff are aware of the need to closely observe Resident Number One for behavior symptoms that may indicate an increase in the resident□s anxiety level which increases the risk for aggressive behaviors. Staff will report any symptoms of increased anxiety such as resistence to cares, verbalizing paranoid thoughts, accusatory or negative statements toward staff or other residents, moving quickly in the halls or dining room, rearranging furniture, or talking about going home to the charge nurse who will assess the resident and initiate increased supervision and interventions to manage/de-escalate behaviors. If the resident exhibits behaviors that pose a high risk of injury/abuse or actual physical/verbal aggression toward another resident, there will be immediate separation of the residents with implementation of	

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 _____	C 09/24/2020

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 600	Continued From page 6 and removed wooden object from residents reach. Staff attempted to stand back and monitor resident to allow him to calm down. Resident continues to wheel around the dinning (sic) area knocking over chairs and moving tables. Resident entered the nurses station cornering nurse he grabbed the cord for the walkie talkie and yanked it out of nurses ear. he (sic) then grabbed basket of items off of the nurses station counter and then threw it on the floor. Staff continued to attempt to safely redirect resident with conversation about his work before retirement. resident (sic) would respond appropriately and maintain a partial conversation while attempting to hit staff. Staff continues to remain a safe distance from resident to allow him to calm down as well as observe resident so that he does not hurt himself or others. staff (sic) will continue to observe. - 9/7/20 02:14 (2:14 a.m.) Behavior Note Note Text: Resident with insomnia- restlessness and multiple behaviors- was pleasant and talkative with staff at beginning of shift- then one of NAR's called for assistance with him d/t (due to) his behavior- became combative-aggressive towards the NAR and then another NAR that responded to try and assist - when this nurse approached his demeanor was totally different than prior- unsure was (sic) escalated the mood change- the NAR stated she was trying redirect and he became agitated and hasn't stopped being combative and agitated towards all staff - this nurse told all staff to stay down their halls and let him be and I would watch over him- educated that the more people that intervene the worse it becomes- he did take his anger out at all that tried to intervene such as another nurse on in training tried to distract him so this nurse could remove the wooden gadget he took out from the activity shelf and was	F 600	additional interventions and monitoring to ensure the safety of all involved. Approaches for managing/de-escalating behaviors have been added to the care plan for Resident Number One including escorting the resident to quiet area with minimal stimulation and providing one-to-one observation until the resident exhibits less anxiety/aggression. Since the resident does not respond well to stimuli, the resident will be observed from a distance to decrease interaction with staff and others. Previously, the direct care staff observed that the resident exhibited increasing agitation after weekly visits by the family. The staff closely observed the resident after family visits and attempted distraction techniques and/or stimulation reduction to reduce the risk of negative behaviors. The resident is no longer exhibiting negative behaviors after family visits; therefore, the one-to-one observation that was provided for two hours after family visits has been discontinued. The staff will continue to observe for increased behavior symptoms after family visits and if indicated, additional supervision will be provided. The resident□s care plan is routinely reviewed and interventions to manage aggressive/abusive behaviors are revised as necessary. During the morning meetings held Monday through Friday which are attended by the Social Service Director,	

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 _____	C 09/24/2020

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 600	Continued From page 7 swinging at everything- she did get hit on hand - he pushed dining room chairs into this nurse shins- swinging out-punching out- running into chair and table- tipping chairs over-banging on chairs- hitting with a rolled up newspaper as in swatting flies -- but hard--- no way to offer the prn Zyprexa (olanzapine) to calm him- I tried ice cream- he smashed the container all over the table and and floor -this nurse asked if a new face- younger NAR would try to distract him- at first he was being nice towards the new face then she reported he punched her in the left eye - stated "he did it so quick when trying to block his hands"-- this nurse will interact 1:1 (one-to-one) the rest of noc shift as to no other staff getting hurt - 2 incident's report filled out so far with his combativeness- has had new med change which is not effective to manage this behaviors this far- --has tried to rip the phone off the wall- throwing and shredding boxes- making threatening comments such as "I get ahold of you I will punch your eyes out"- "call the cops- see where that gets ya"--will stay at distance to monitor. - 9/7/20 03:29 (3:29 a.m.) Behavior Note Note Text: Resident started with heavy eyes and wearing himself out from non-stop all noc (night) so far- took majority of the oj (orange juice) in with the prn Zyprexa- was cooperative with this nurse and other nurse with transferring him into bed with EZ (mechanical device) stand- allowed incontinent cares and also allowed to face wash face and mattered eyes- 02 (oxygen) supplement on and warm blanket from the warmer for comfort- resident very difficult to manage behaviors once he starts- - 9/7/20 23:55 (11:55 p.m.) Behavior Note Note Text: combative, confrontational, active seeking	F 600	Dietary Manger, Director of Nursing and Clinical Managers, problematic resident behaviors, falls, infections and other care related issues for all residents are reported and reviewed by the attendees. Related interventions are discussed and care plans are modified as necessary. During the weekly IDT meetings, the effectiveness of interventions will continue to be routinely reassessed including interventions to lessen the risk of resident-to-resident altercations. To monitor compliance with appropriate investigation of resident-to-resident altercations and implementation of effective interventions to keep residents safe, for one month, the Director of Social Service/designee in consultation with the Director of Nursing will review altercation related documentation and interview staff as necessary. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the January 2021 Quality Assurance and Performance Improvement Committee meeting.	

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 _____	C 09/24/2020

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 600	Continued From page 8	F 600		

harm towards staff, disruptive yelling out, unable to redirect r/t (related to) behaviors, confusion. verbal and physical threats w/ agitation. striking out, threats to kill everyone. disruptive to facility staff routine of caring for others as Res (resident) will enter others rooms w/ harmful confrontation seeking.

- 9/8/20 00:37 (12:37 a.m.) Behavior Note Note Text: staff heard Res [medical record number (MRN)/R3] yelling out help. Res found physically attacking this Res [MRN/R3] while she was sitting in recliner in MDR (main dining room) watching TV. Res striking her, grabbing on RUE (right upper extremity) twisting it attempting to harm. required staff direct intervention for separation of Res r/t behavior w/ disregard to safety of others, confrontation seeking to injure others. accusative (sic) w/ paranoia of others. Res remains disruptive to facility w/ behaviors, calling out, throwing items around MDR and at staff. unable (sic) to deescalate behaviors r/t seeking harmful confrontational behaviors. kicking at, threatening staff

In a facility report to the SA dated 9/8/20, at 8:55 a.m. indicated: [R3] was sitting in dining room watching television. Staff heard her calling out for help. Approached and observed [R1] grabbing her right arm and twisting it with the apparent attempt to injure her. Staff intervened immediately and separated residents. [R3] has no injury following incident. [R1] has not sought out resident further since this incident.

In the facility's investigative report submitted to SA dated 9/9/20, at 9:10 a.m. indicated R1's care plan was updated to remove others from area if resident expressing physical, threatening

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 _____	C 09/24/2020

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 600	Continued From page 9	F 600		

behavior and provide 1:1 or close observation as needed to ensure resident and others' safety. The investigation also addressed R1's medication change from Seroquel to Zyprexa on 9/3/20, and the residents increase in physical and threatening behavior after the medication was changed. R1's Zyprexa was discontinued and Seroquel was resumed as that was more effective in managing the residents behavior. Staff were educated on removing other residents from area if a resident is a risk to harming others. Although the investigative report indicated staff would provide 1:1 or close observation as needed should R1 express physical, threatening behavior, there were no formal parameters in place on when or how this increase in supervision would occur.

R1's progress note dated 9/16/2020, at 21:52 (9:52 p.m.) indicated: Incident Note Note Text: Resident became restless, and aggressive with staff and peers. nurse (sic) found resident in dining room with peer [R2] and was using his shirt to attempt to choke him from behind. staff (sic) intervened and separated residents. scheduled (sic) seroquel given med was ineffective. PRN seroquel administered. Resident continues to have aggressive behaviors and wandering the hallways. staff (sic) will continue to observe.

An investigative report submitted to the SA on 9/17/20, at 14:06 (2:06 p.m.) included: Staff heard [R2] yelling out in the dining room at approximated 7:17 p.m. and responded immediately. Nurse was the first person to respond and witnessed [R1] in his wheelchair behind [R2] in his wheelchair in the main dining room. [R1] was holding [R2] by the shirt and shaking him yelling at [R2] to "shut up". The shirt was tight across [R2's] neck but staff stated [R2]

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 _____	C 09/24/2020

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 600	Continued From page 10	F 600		

was breathing and yelling out. Nurse and CNA (certified nursing assistant) intervened and [R1] released [R2's] shirt. [R2] was examined no injuries noted. Prior to incident no trigger was able to be identified and resident appeared calm with staff interactions. [R1] Seroquel order resumed to 100 mg TID (three times a day) & (and) 100 mg PRN on 9/8/20. This medication has been successful in reducing his target behaviors of paranoia and aggression. During investigation staff reported having the dose earlier than at HS (hour of sleep/8:00 p.m.) would be more effective in preventing these behaviors. [Physician name] was updated and time for one of the doses was changed from HS to 6:00 pm. IDT (interdisciplinary team) will continue to monitor [R1] for effectiveness of Seroquel and update provider as needed. Though the facility contacted R1's physician for time change of the HS Seroquel, no formal plan to increase supervision of R1 to protect other residents was implemented.

When interviewed on 9/22/20, at 12:03 p.m. NA-A confirmed R1 could be physically aggressive towards staff and residents. NA-A stated R1 had a med (medication) change not that long ago and it seemed like the aggressive behaviors started to escalate with the med change. NA-A confirmed R1 was now back on his original medication (did not name the med) and he seemed better as had not exhibited any aggressive behavior in the past 4 days that she'd been working. NA-A stated if R1exhibited escalating behaviors or was going after other residents the staff would separate the residents and keep an eye on R1 to assure safety for other residents. NA-A further stated when R1 was in the dining room they usually would remove the other residents if his behavior was escalating

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 _____	C 09/24/2020

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 600	Continued From page 11	F 600		

as that seemed to work better than trying to remove R1. Staff also had shut the fire doors to the wing entrances until R1 calmed down to prevent him from trying to enter other resident rooms. NA-A confirmed staff try to keep eyes on R1, especially if he started to exhibit aggressive behavior, though confirmed no formal plan for supervision was in place.

When interviewed on 9/22/20, at 4:40 p.m. NA-B confirmed having worked the evening of 9/16/20, though did not witness the altercation between R1 and R2. NA-B stated R1 was kind of "iffy" that night as to whether he needed a PRN Seroquel or not with the behaviors he was exhibiting. NA-B stated R2 and R3 were in the dining room with R1 just prior to the incident. NA-B had left the dining room area and the altercation happened shortly after that. NA-B confirmed licensed practical nurse (LPN)-A was also working that evening and thought she was the one that came upon the incident first between R1 and R2. NA-B stated staff try to keep visual on R1 and if they don't see him around will walkie each other to see who has eyes on him. NA-B confirmed there were no staff present in the dining room when the incident occurred between R1 and R2. When asked if R1 ever targeted any other residents she confirmed R1 had kicked R3 and also goes after R7 at times or depending upon his mood ,could turn on anyone. NA-B confirmed R1's physical behaviors included hitting, kicking, ramming chair into people or throwing things when agitated. NA-B denied any formal documented increased supervision for R1.

When interviewed on 9/22/20, at 4:50 p.m. licensed practical nurse (LPN)-A confirmed having worked the evening shift on 9/16/20, and

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 _____	C 09/24/2020

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 600	Continued From page 12	F 600		

coming upon the altercation between R1 and R2. LPN-A stated not being sure what triggered the event; she was down wing 3 and heard R2 yelling. "I turned and I looked and could see that [R1] had ahold of [R2's] shirt from behind and was trying to choke him with it." LPN-A stated she and NA-A separated R1 and R2 then brought R2 back to his room. LPN-A confirmed R1 remained in the dining room as there was no getting him back to his room. LPN-A further confirmed there were no staff or other residents in the dining room at the time of the altercation. LPN-A stated the staff all kind of took turns monitoring R1 after the incident with the walkie talkies and kept an eye on him at all times. LPN-A stated she had never seen R1 become physically aggressive with another resident though had with staff. LPN-A confirmed prior to the incident on 9/16/20 there was not extra supervision for R1. LPN-A stated at this time if staff start to see R1 get agitated they keep a closer eye on him, and further stated the night of 9/16/20, there wasn't the signs like he wanted to leave or stating someone was after him- that night there wasn't any trigger to make them think he needed increased supervision. LPN-A confirmed there was no formal documented increased supervision in place for R1.

During an interview on 9/23/20, at 11:03 a.m. with LPN-B and registered nurse (RN) -A, LPN-B confirmed having worked the evening of 9/2/20 when R1 kicked R3. LPN-B confirmed R1 was agitated that day and the staff had moved all the residents out of the dining room. R3 had walked into the dining room independently so one of the NA's went into the dining room to redirect R3 back to her room. LPN-B stated when the NA started walking with R3 back to her room R1 went

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 _____	C 09/24/2020

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 600	Continued From page 13	F 600		

after R3 and kicked her. LPN-B confirmed she had not witnessed the altercation but was told this by the NA who did. LPN-B stated she would check in with other staff to see how R 1 was doing and what his mood was throughout the shift. If R1 was wandering up and down the halls they try to keep eyes on him and communicate his whereabouts. RN-A stated if it's a busy time such as at mealtime when the NA's are assisting residents with eating, they involve activity staff with keeping an eye on R1 so he wouldn't go into another resident's room. RN-A further stated R1 had never done that but they want to make sure it wouldn't happen. LPN-B stated if R1 was agitated at times they would shut the fire doors from the dining room into the wings to protect the other residents; if R1 was already in a hallway they would keep eyes on him. LPN-B stated sometimes R1's mood could change very quickly-could be smiling and happy one minute and then can get angry the next. When the resident was agitated is best to watch him from a distance as he doesn't want staff's one to one attention and also would strike out at staff when agitated. RN-A and LPN-B confirmed since R1's antipsychotic medication was changed back to Seroquel and with the dosing time changes his mood had been better though was still doing a lot of wandering but not as aggressive.

When interviewed on 9/23/20, at 12:44 p.m. case manager registered nurse (RN)-B stated R1 typically targeted aggression towards certain residents, and staff could usually tell when R1 was ramping up. Staff would then get the other residents out of R1's area which was usually the dining room. RN-B confirmed R1 would target R3 and R7, though R1 had never been physically abusive with R7, more verbal. RN-B confirmed

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 _____	C 09/24/2020

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 600	Continued From page 14	F 600		

R1 kicked R3 one weekend, a couple times, mostly he thinks R3 is his wife. Related to the altercation between R1 and R2 on 9/16/20, RN-B stated, "That was an unusual situation, he usually doesn't go after [R2]." RN-B confirmed both altercations occurred in the evening and staff were monitoring R1 every 30 minutes to one hour and that should be documented. RN-B further confirmed the increased monitoring was implemented after the first time R1 kicked R3 on 9/2/20. After the incident between R1 and R2, RN-B stated to her knowledge R1's supervision continued at 30 minutes to an hour checks. RN-B and RN-A checked the electronic medical record (EMR) to verify documentation of increased supervision of R1 following the incidents with R3 and R2. RN's were unable to locate evidence of increased monitoring in the EMR. RN-A stated she would also check her office as staff may have been documenting the increase in supervision on paper. RN-A further stated on the evening of 9/16/20, following R1's altercation with R2, the director of nursing (DON) had come into the facility and provided 1:1 supervision of R1 for a period of time. When asked what staff would do to keep residents safe after a physical altercation, RN-B confirmed supervision would be increased. RN-B stated R1's aggressive behaviors typically happened on the evening shift. The evening shift knew if R1's behaviors started to increase to utilize the prn Seroquel and they were good about doing that. RN-A and RN-B were unable to find any evidence of increased monitoring of R1 by staff either on paper or in the EMR.

When interviewed on 9/23/20, at 1:39 p.m. the director of nursing (DON) stated at the time of the incident on 9/2/20 when R1 kicked R3, staff were

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 _____	C 09/24/2020

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 600	Continued From page 15	F 600		

trying to keep R3 safe by getting the resident out of the dining room where R1 was located. DON confirmed the altercation was not reported as a VA as R3 had no injury, though in hindsight should have reported it. DON stated that when R1 is ramping up staff try to get everyone out of the dining room. R3 is strong willed and sometimes doesn't want to leave. If we can see that R1's behavior is escalating sometimes would have a staff member stay in the dining room with him - sometimes it's hard to know when it's coming. DON stated at times the nurse of trained medication aide (TMA) will station the med cart in the dining room to stay in visual sight of R1 while passing medications to keep an eye on him. DON confirmed the resident would not be 1:1'd at that time but would be less then 30 minutes between visual checks. After the incident during the early morning of 9/9/20 between R1 and R3, night staff were re-educated that R3 was not to be going out to the dining room when R1 was up and out there. DON confirmed R3 was in the recliner resting when R1 came upon her. DON further confirmed R1 was exhibiting behaviors that evening and would have expected staff to remove R3 out of the dining room and did retrain them about that as well.

When interviewed on 9/23/20, at 3:20 p.m. NA-D confirmed having worked the night shift on 9/7/20 into the morning of 9/8/20. NA-D confirmed R1 had been combative that night and had punched one of the NA's in the eye. NA-D stated R3 was sleeping in the recliner in the dining room. NA-D was doing her rounds and could hear R3 screaming; by the time NA-D got to the dining room the nurse had got in between R1 and R3. NA-D thought R3 was just scared because R1 had grabbed a hold of her and wouldn't let go

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 _____	C 09/24/2020

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 600	Continued From page 16	F 600		

until the nurse snatched him away. NA-D confirmed knowledge of R3's presence in the dining room and stated, "Everyone knew she was out there because she's always there at night." NA-D stated R3 sleeps wherever she wants and lots of times will sleep in the chair by the nurses station, she never stays in her room. NA-D was not sure if the facility was doing any increased monitoring/supervision of R1 as she no longer worked at the facility.

When interviewed on 9/23/20, at 3:34 p.m. LPN-C confirmed having worked the night shift on 9/7/20 into the morning of 9/8/20. LPN-C stated R1 was very agitated all day from what he understood; this was pre-Seroquel because they had put him on Zyprexa. R1 was attacking the staff which was normal when he got like that. R1 was the only one up at the time; R3 had been up and about and then went back to her room. "Then I heard R3 hollering, "Help, help, help!". Screaming it rather than just saying it like she usually does. R1 was grabbing on R2's right arm, hunched over in his w/c. I don't' know if he hit her but he was grabbing on her arm threatening her. LPN-C confirmed separating R1 and R3 then another staff went with R3 to her room. At one point R1 went down to R3's room and staff redirected him. R1 laid down about 5:00 a.m. but was back up around 6:00 a.m. when I left for the day. LPN-C stated he had no knowledge that R3 had come back out to the dining room. "I didn't even hear her until she started screaming help. I didn't know she was out in the dining room, had I known I would have redirected her back to her room." When R1 is in one of those moods he's attacking everyone so we make sure the other residents are away from him cuz there's no way you're gonna keep him isolated. The night crew

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 _____	C 09/24/2020

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 600	Continued From page 17	F 600		

all know that if R1 is in this type of agitated mood that the other residents need to be separated from him. LPN-C confirmed R1 had gone after other residents in the past but it had been awhile and that's before he was on any psychotropic medications. LPN-C further confirmed R1 and R7 had gotten into it before. LPN-C wasn't sure if R1 was on any increased monitoring/supervision as had been on vacation for the past 2 weeks.

When interviewed on 9/23/20, at 5:53 p.m. the DON confirmed the facility had not implemented formal documented monitoring/supervision for R1 related to the incidents of resident-to resident abuse.

The facility policy titled, Resident Protection Plan revised October 2019, included: Physical abuse includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.

The immediate jeopardy that began on 9/8/20, was removed on 9/24/20 at 5:18 p.m., when the facility developed and implemented interventions to ensure residents at risk for resident-to resident abuse were safe by: Implementing 30 minute checks for R1 with documentation of any behaviors displayed. Assigning one staff each shift to be responsible for R1's 30 minute checks, 1:1 the resident should he display any symptoms that may indicate he could harm himself or other residents, and to remove all residents who may be in danger. Finally, the facility comprehensively assessed R1's cognitive status and risk factors noting symptoms associated with past aggression to include: paranoia; accusatory statements toward staff or other residents; verbal aggression; resistance with cares; moving quickly in the halls

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 _____	C 09/24/2020

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 600	Continued From page 18 or dining room; moving furniture; talking about going home.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident-to-resident abuse was reported to the State Agency (SA) in a timely	F 609	Field Crest Care Center policies and procedures require that all alleged resident mistreatment, neglect, abuse,	11/3/20

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 _____	C 09/24/2020

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 609	Continued From page 19 manner in accordance with established policies and procedures, for 1 of 3 residents (R3) who were reviewed for abuse. Findings include: R3's Admission Record printed 9/23/20, included diagnoses of Alzheimer's disease and anxiety disorder. R3's annual Minimum Data Set (MDS) assessment dated 9/15/20, indicated R3 had moderate cognitive impairment and exhibited wandering behavior 4-6 days but less than daily during the assessment period. The MDS further indicated R3 was independent with locomotion on the unit. Review of the care plan last revised 9/15/20, indicated R3 was a vulnerable adult (VA) due to physical and cognitive impairments. Interventions included to report all allegations of abuse/maltreatment toward resident immediately to the state agency (SA). Complete investigation and put interventions in place to protect residents from future instances. Review of R3's Field Crest Care Center Resident Incident Report dated 9/2/20, at 8:00 p.m. indicated the following: This resident was kicked by another resident (medical record number/R1) in the right lower leg. This resident sustained no injuries, and no bruising was noted. Denies pain r/t (related to) incident, stating that "it wasn't hard" and "didn't hurt." Altercation was witnessed by NAR (nursing assistant registered). Will continue to monitor per nursing measures. There was no evidence to indicate the altercation had been reported to the SA.	F 609	and misappropriation of resident property be 1) reported immediately to the administrator and other appropriate officials/state agencies and 2) thoroughly investigated in a timely manner with the investigative results reported to the administrative staff and Minnesota Department of Health Office of Health Facility Complaints (OHFC) as required. If the alleged violation is verified, appropriate corrective action is taken. The policies and procedures have measures to prevent further potential abuse, neglect, financial exploitation, and mistreatment while the investigation is in process. The facility□s vulnerable adult policies and procedures for identifying, reporting and internally investigating incidents were reviewed and found appropriate. The Resident Protection Program policies and procedures will be revised to include more detailed guidance for staff response to resident-to-resident altercations/abuse. During small group sessions, the staff will be reinstructed on abuse reporting requirements including reporting of resident¿to¿resident altercations. Vulnerable adult regulations and related facility polices are reviewed with the staff on an annual basis and all new employees are informed of the residents right to be free from abuse, neglect, mistreatment, and financial exploitation. The instruction includes required reporting of abuse allegations to appropriate state agencies and law enforcement.	

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 _____	C 09/24/2020

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 609	Continued From page 20 Review of a facility provided allegation report submitted to the SA on 9/8/20 at 8:55 a.m., indicated a resident to resident altercation had occurred. R3 was in the dining room watching television when staff heard the resident calling out for help. When staff went into the dining room they observed R1 grabbing R3's right arm and twisting it with the apparent attempt to injure her. Staff intervened immediately and separated the residents; R3 was not injured. The report further indicated the altercation occurred on 9/8/20 at 00:30 (12:30 a.m.), 8 hours and 25 minutes earlier. The facility failed to report the allegation to the SA immediately. When interviewed on 9/23/20, at 1:23 p.m. the social services director (SSD) confirmed the altercation between R1 and R3 on 9/2/20, had not been reported to the SA. SSD was unsure why the director of nursing (DON) chose not to report the incident to the SA. SSD further confirmed the altercation between R1 and R3 on 9/8/20, was reported late to the SA. SSD stated the morning of 9/8/20, having read the progress notes and knew immediately that the incident should have been reported within 2 hours. SSD further stated having talked with the nurse on duty present during the incident (licensed practical nurse [LPN]-C) who indicated had tried to report the incident to the SA after it occurred but had difficulty getting through. SSD confirmed LPN-C had not notified other staff the incident still needed to be reported. SSD stated having educated LPN-C to call SSD if having problems with filing VA reports timely. When interviewed on 9/23/20, at 1:39 p.m. the director of nursing (DON) confirmed the	F 609	Resident Number One was admitted to the facility April 23, 2018 with the diagnosis of major neurocognitive disorder. Due to behavior symptoms negatively impacting the safety of others, there was frequent audio/visual communication with the nurse practitioner addressing behavior management options. Multiple pharmacological and nonpharmacological interventions were initiated/implemented with a significant improvement in the resident□s abusive/aggressive behaviors. The resident is no longer exhibiting aggressive behaviors toward other residents or staff. The staff continues to closely monitor the resident to ensure the safety of others. The resident□s care plan has been revised accordingly; the resident□s family and attending physician will be routinely updated on the effectiveness of the behavior management plan of care. For Resident Number One and all other residents, any resident-to-resident altercation that meets the definition of abuse will be immediately reported to the appropriate state agency and the administrator. Compliance with abuse reporting requirements will be monitored by the administrator/designee. For three months, all reports of resident maltreatment will be reviewed by the administrator/designee to determine whether reporting to state and federal agencies was done appropriately and in accordance with regulatory time frames. If noncompliance is noted,	

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 _____	C 09/24/2020

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 609	Continued From page 21 altercation between R1 and R3 on 9/2/20, had not been reported to the SA. DON stated they weren't sure how much contact there was with R1 kicking R3 as there was no injury or redness on R3's right lower leg, though in hindsite the incident should have been reported. The facility policy titled, Resident Protection Program-Investigation, last revised October 2019, included: 1. An incident or suspected incident of mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of property must be immediately reported to the administrator. The administrator will be notified in person or by phone. 2. An initial report will be completed and submitted to the state agency via Office of Health and Facility Complaints. (Refer to the Reporting a Vulnerable Adult Incident). a. If the allegation involve abuse or result in serious bodily injury the report must be made no later than 2 hours after the allegation is made.	F 609	additional auditing and staff education will be done. Compliance will be reviewed during the January 2021 quarterly Quality Assurance and Performance Improvement Committee meeting and ongoing.	

Electronically delivered
October 15, 2020

Administrator
Field Crest Care Center
318 Second Street Northeast
Hayfield, MN 55940

Re: State Nursing Home Licensing Orders
Event ID: DSWI11

Dear Administrator:

The above facility was surveyed on September 22, 2020 through September 24, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the

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

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

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

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Phone: 651-201-3784

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.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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 _____	C 09/24/2020

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
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 9/22-9/24/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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 _____	C 09/24/2020

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
2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H#5431034C, H#5431035C with a licensing order issued at MN State Statute S626.557 Subd. 4. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident-to-resident abuse was reported to the State Agency (SA) in a timely manner in accordance with established policies	21990	Acknowledged and Corrected. See F609	11/3/20

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 _____	C 09/24/2020

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
21990	Continued From page 2 and procedures, for 1 of 3 residents (R3) who were reviewed for abuse. Findings include: R3's Admission Record printed 9/23/20, included diagnoses of Alzheimer's disease and anxiety disorder. R3's annual Minimum Data Set (MDS) assessment dated 9/15/20, indicated R3 had moderate cognitive impairment and exhibited wandering behavior 4-6 days but less than daily during the assessment period. The MDS further indicated R3 was independent with locomotion on the unit. Review of the care plan last revised 9/15/20, indicated R3 was a vulnerable adult (VA) due to physical and cognitive impairments. Interventions included to report all allegations of abuse/maltreatment toward resident immediately to the state agency (SA). Complete investigation and put interventions in place to protect residents from future instances. Review of R3's Field Crest Care Center Resident Incident Report dated 9/2/20, at 8:00 p.m. indicated the following: This resident was kicked by another resident (medical record number/R1) in the right lower leg. This resident sustained no injuries, and no bruising was noted. Denies pain r/t (related to) incident, stating that "it wasn't hard" and "didn't hurt." Altercation was witnessed by NAR (nursing assistant registered). Will continue to monitor per nursing measures. There was no evidence to indicate the altercation had been reported to the SA. Review of a facility provided allegation report	21990		

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 _____	C 09/24/2020

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
21990	Continued From page 3	21990		

submitted to the SA on 9/8/20 at 8:55 a.m., indicated a resident to resident altercation had occurred. R3 was in the dining room watching television when staff heard the resident calling out for help. When staff went into the dining room they observed R1 grabbing R3's right arm and twisting it with the apparent attempt to injure her. Staff intervened immediately and separated the residents; R3 was not injured. The report further indicated the altercation occurred on 9/8/20 at 00:30 (12:30 a.m.), 8 hours and 25 minutes earlier. The facility failed to report the allegation to the SA immediately.

When interviewed on 9/23/20, at 1:23 p.m. the social services director (SSD) confirmed the altercation between R1 and R3 on 9/2/20, had not been reported to the SA. SSD was unsure why the director of nursing (DON) chose not to report the incident to the SA. SSD further confirmed the altercation between R1 and R3 on 9/8/20, was reported late to the SA. SSD stated the morning of 9/8/20, having read the progress notes and knew immediately that the incident should have been reported within 2 hours. SSD further stated having talked with the nurse on duty present during the incident (licensed practical nurse [LPN]-C) who indicated had tried to report the incident to the SA after it occurred but had difficulty getting through. SSD confirmed LPN-C had not notified other staff the incident still needed to be reported. SSD stated having educated LPN-C to call SSD if having problems with filing VA reports timely.

When interviewed on 9/23/20, at 1:39 p.m. the director of nursing (DON) confirmed the altercation between R1 and R3 on 9/2/20, had not been reported to the SA. DON stated they weren't sure how much contact there was with R1

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 _____	C 09/24/2020

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
21990	Continued From page 4 kicking R3 as there was no injury or redness on R3's right lower leg, though in hindsite the incident should have been reported. The facility policy titled, Resident Protection Program-Investigation, last revised October 2019, included: 1. An incident or suspected incident of mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of property must be immediately reported to the administrator. The administrator will be notified in person or by phone. 2. An initial report will be completed and submitted to the state agency via Office of Health and Facility Complaints. (Refer to the Reporting a Vulnerable Adult Incident). a. If the allegation involve abuse or result in serious bodily injury the report must be made no later than 2 hours after the allegation is made. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures for vulnerable adult reporting, educate staff on these policies and audit to ensure competency and understanding periodically. The results of these audits Could be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen days (14) days.	21990		