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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DYM4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00104

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **2/20/2019** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)
13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: A (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, Unit Supervisor 2/25/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 2/25/2020 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 25, 2020

CMS Certification Number (CCN): 245431

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

Dear Administrator:

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

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

Effective January 21, 2020 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered

February 25, 2020

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

RE: CCN: 245431
Cycle Start Date: December 12, 2019

Dear Administrator:

On January 29, 2020 the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Discretionary denial of payment for new Medicare and Medicaid admission. (42 CFR 488.417(b))

- Federal Civil Money Penalty

On February 20, 2020 the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 21, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions did not go into effect. (42 CFR 488.417 (b))

- Federal Civil Money Penalty

However, as we notified you in our letter of , in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 12, 2019. This does not apply to or affect any previously imposed NATCEP loss.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

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(L5) **HAYFIELD, MN** (L6) **55940**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/12/2019** (L34)

8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 01/24/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/27/2020 (L20)

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

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

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23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted
December 31, 2019

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

RE: CCN: 245431
Cycle Start Date: December 12, 2019

Dear Administrator:

On December 12, 2019, a 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. 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 past non-complaince, immediate jeopardy (Level J). The Statement of Deficiencies (CMS-2567) is being electronically delivered. Past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On October 24, 2019, the situation of immediate jeopardy to potential health and safety cited at F695 was removed.

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 March 1, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 1, 2020, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 1, 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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 12, 2019. This prohibition is not subject to appeal. 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.

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. <u>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.</u>

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 December 12, 2019. 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), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731

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 June 12, 2020 (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.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 12/12/2019

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
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements was conducted 12/9-12/11/19 , during a recertification survey. The facility was found not to be in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The	E 041		1/21/20

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

Electronically Signed | 01/09/2020

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 12/12/2019

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
E 041	Continued From page 1 [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.	E 041		

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	245431	A. BUILDING _____ B. WING _____	C 12/12/2019

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E 041	Continued From page 2 (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to engage the recommended change-out schedule for the generator battery in accordance with the Life Safety Code NFPA 101 - 2012 edition (6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70). This deficient practice could affect 37 residents. Findings Include: During a facility tour with the fire marshall between 08:00 AM and 12:00 PM on 12/11/2019, observations and staff interview revealed the following:	E 041	Field Crest Care Center has established and will maintain an emergency preparedness program that describes the facility's comprehensive approach to meeting the health, safety, and security needs of their staff and residents during an emergency or disaster situation, including the use of an emergency generator in the event of a power outage. The Maintenance Director has changed out the generator battery. The task of changing out the battery at the required interval will be included in the generator testing/maintenance contract that is being	

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E 041	Continued From page 3 Observed during the walk-through inspection of the facility - the generator battery was dated 2015 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. A review of the facility Emergency Preparedness Plan indicated the facility would require a working generator in the case of power failure to the facility.	E 041	negotiated with Zeigler Power Systems. The Maintenance Director will be responsible for monitoring future compliance with timely generator battery change outs through an audit of the tasks completed by the Zeigler Power Company. Checking battery function/maintenance is included on the routine maintenance task list for the generator. Compliance with emergency preparedness requirements will be reviewed during the April 2020 quarterly Quality Assurance and Performance Improvement Committee meeting and ongoing.	
F 000	INITIAL COMMENTS On 12/9/19 through 12/12/19, a standard survey was conducted at your facility. Complaint investigations were also conducted. In addition, an extended survey was completed on 12/12/19, related to the substandard quality of care findings. Your facility was found not to be in compliance with the federal requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. Complaint H5431030C was substantiated with a deficiency at past non-compliance Immediate Jeopardy (IJ) identified at F695. The past non-compliance IJ began on 10/23/19. The IJ was removed and the deficient practice was corrected by 10/24/19, when the facility had developed and implemented a plan to prevent recurrence including a system to check for equipment and supplies needed before residents leave the facility.	F 000		

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F 000	Continued From page 4 The following complaints were found to be substantiated with a corresponding deficiency H5431024C at F761 The following complaints were found to be substantiated with no citations. H5431033C, H5431023C, H5431026C and H5431025C The following complaints were found to be unsubstantiated: H5431032C, H5431031C, H5431029C, H5431027C and H5431028C The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to assess a resident or obtain physician orders for self-administration of	F 554	Field Crest Care Center staff respect the residents□ right to self-administer drugs after the interdisciplinary team has	1/21/20

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F 554	Continued From page 5 medications for 1 of 10 residents (R25) observed during medication administration. Findings include: R25's Admission Sheet indicated diagnosis related to a fractured femur Parkinson's Disease (a neurological disorder that results in problems with movement and may cause dementia), and had a recent diagnosis of pneumonia. On 12/10/19 at 11:30 a.m. a trained medication aide (TMA-A) was observed to inform R25 that he was due for his nebulizer treatment and would give it to him as soon as he finished his meal. TMA-A then went to the medication cart and removed a package and placed it in her pocket. Shortly after, R25 finished his meal and TMA-A assisted him to his room. She removed the package from her pocket. The label of the package indicated the contents to be Ipratrobium-Albuterol Solution 0.5-2.5 MG/3Ml. TMA-A placed the nebulizer machine on R25's bed and stated he was able to turn it off when he was done if staff left the machine close enough to him. TMA-A filled the medication cup attached to a face mask with the medication solution and applied the mask to R25's face. TMA-A started the machine and said she would be back in about ten minutes and R25 told the TMA-A to make sure she didn't come back too soon. TMA-A stated R25 watched the clock "like a hawk" and wanted the treatment to run for exactly ten minutes. TMA-A then left R25's room, went to another resident's room and administered medications to that resident from items she had in her pocket and returned to her medication cart. At the medication cart, TMA-A stated it was her	F 554	determined that this practice is safe. The policy for self-administration of medications was reviewed and found appropriate. Residents who prefer to take medications independently will be allowed to do so after 1) an assessment has been completed indicating the resident is capable of safely self-administering medications and 2) the physician has written an order for self-administration. The care plan will reflect who will be responsible for storage, documentation, and the location of drug administration. The appropriateness of a resident self-administrating drugs will be reviewed at least quarterly and more often as necessary. During the staff meeting January 17, 2020, the resident□s right to self-administer medications and the existence of policies and procedures addressing this issue will be reviewed. The licensed nurses and trained medication assistants will be reinstructed on 1) the regulatory requirement for a physician□s order and interdisciplinary assessment of capability before a resident is permitted to self-administer medications and 2) that the care plan must reflect who will be responsible for storage of the medication and documentation of administration. Resident number 25 was assessed and found capable of being left alone during	

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F 554	Continued From page 6 understanding that a person was allowed to self-medicate a nebulized solution if they were able to turn their machine off. She stated she did not think there was an assessment that needed to be done but thought there would be a spot in the medication administration record (MAR) where it would indicate if a person was able to self-administer medications. TMA-A was unable to locate any direction in the MAR indicating R25 was able to self-administer any medications. TMA-A then stated the physician orders would state if he was unable to self-administer his nebulizer solution. A registered nurse (RN-A) overheard TMA-A's statement and said, "No, the order will say if someone CAN self-administer." RN-A instructed TMA-A that residents were not to self-administer medications until they had a physician's order to do so. A review of R25's physician orders failed to indicate an order for self-administration of medications. A review of R25's care plan was done and self-administration of medications was not found. No record of an assessment for competence in self-administration of medications was found in R25's facility chart. During an interview on 12/12/19, at 9:33 a.m. the director of nursing (DON) stated residents were not to be left unattended with their nebulizer solution running until they had been deemed competent to do so and had a physician's order in the MAR. DON stated part of standard medication administration rights was to ensure the resident has taken their medication. A policy related to self-administration of medications was requested. Facility provided a	F 554	nebulizer treatments. The physician has written an order for self-administration of the nebulizer treatments after set up by the nursing staff. The staff will continue to be responsible for setting up the nebulizer treatments, storage of the nebulizer medication/equipment, and documentation of the medication administration. The care plan was reviewed and revised to reflect self-administration of nebulizer medication. The resident□s ability to safely self-administer nebulizers will be reviewed during the quarterly interdisciplinary care conferences and with changes in condition. The Director of Nursing/designee will monitor compliance with self-administration of medication requirements through observation and record review. The records of all residents who self-administer medications will be audited to ensure appropriate assessments, care planning and physician orders with a focus on residents who have orders for nebulizer treatments. For the next three months, residents who move in with nebulizer treatments and those with new orders for self-administration of nebulizer treatments or other medications will be monitored to ensure that there are related assessments, orders and care plans consistent with regulatory guidelines and facility policy. If noncompliance is noted, additional audits and staff education will be done. Compliance will be addressed at	

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F 554	Continued From page 7 policy titled Self Medication Administration Policy dated 11/2008. The policy indicated that persons who express a desire to self-administer "will have their "cognitive, physical and visual ability to carry out this responsibility" assessed. The policy also indicated an order would be obtained from the physician for self-administration of mediations. In addition, the policy indicated the information would appear on the resident's care plan and a quarterly review of the process would occur during care conference meetings.	F 554	the April 2020 quarterly Quality Assurance and Performance Improvement Committee meeting.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that staff followed professional standards of practice of medication administration for 2 of 10 residents (R1 and R25) observed during a noon medication pass. Findings include: R1's Admission Sheet indicated R1was admitted to the facility with a principle diagnosis of Parkinson's Disease (a neurological disorder that results in problems with movement and may cause dementia). R25's Admission Sheet indicated R25 was admitted to the facility with a principle diagnosis related to a fracture's femur and R25 also had	F 658	Field Crest Care Center arranges and/or provides care as outlined by the residents comprehensive care plan that meets professional standards of quality. Resident care and services are provided based on an ongoing comprehensive assessment of the resident with adherence to accepted and recommended practices which follow research founded practice standards. The facility s policy and procedures for medication administration were reviewed and found appropriate. Competency training was provided to the licensed staff and trained medication aides in November 2019 with return	1/21/20

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F 658	Continued From page 8 Parkinson's Disease, and had a recent diagnosis of pneumonia. On 12/10/19 11:30 a.m. a trained medication aide (TMA-A) was observed to inform R25 that he was due for his nebulizer treatment and would give it to him as soon as he finished his meal. TMA-A then went to the medication cart and opened the medication drawers. A computer was available on top of the medication cart to refer to resident Medication Administration Records (MAR) during medication set up; however, the screen for the MAR was observed to be in locked mode so the MAR was not open for viewing or documentation. TMA-A placed several paper medication cups on top of the cart and removed several cards from the drawer. TMA-A looked at the cards and punched several small yellow pills into one of the yellow cups; took another medication card and punched out a small white pill into the paper medication cup. TMA-A then placed one paper cup on top of the medications that had been removed from the cards and placed the cups, with medications, in her right pocket. The cups were not observed to have been marked in any way to identify the contents or the name of the resident to receive them. TMA-A then removed a package of what appeared to be a solution for nebulized medication and placed it in her right pocket. Shortly after, R25 finished his meal and TMA-A assisted him to his room. She removed the cup of medications from her pocket and set them on the over bed table in R25's room and then removed the package of solution from her pocket. The label of the package indicated the contents to be Ipratrobium-Albuterol Solution 0.5-2.5 MG/3Ml. TMA-A placed the nebulizer machine on R25's bed and filled the medication	F 658	demonstrations. Reeducation on correct medication administration techniques was provided as needed. During the January 17, 2020 training for the licensed staff and trained medication assistants, use of the PointClickCare electronic medication record software will be reviewed. The use of the software accuracy prompt options will be discussed. The staff will be assigned to watch the manufacturer□s medication documentation training video. During the training session, the staff will be instructed to check the medication administration record (MAR) to verify medication accuracy prior to administering medication. Medication administration training will continue to be included as part of the new employee orientation and the annual staff competency training curriculum. According to facility policy and standards of practice, resident numbers 1 and 25 as well as all other residents will have their medications checked against the MAR for accuracy prior to administration. To monitor compliance with medication administration practice standards and facility policies, all licensed staff who pass medications and the trained medication assistants will be observed during a medication pass. The Clinical Nurse Managers will also conduct additional random observations of medication administration for the next three months. If noncompliance is noted, additional auditing and staff education will provided.	

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F 658	Continued From page 9 cup, attached this to a face mask and applied this to R25's face. TMA-A started the machine and said she would be back in about ten minutes. TMA-A picked up the paper cup of pills, left R25's room, and went to R1's room. She poured the pills onto the bedside table, two and a half small yellow pills and a small white pill and told R1 she had his Sinemet pills for Parkinson's and his Lasix. R1 then picked up the pills, ingested them with water. TMA-A then returned to the medication cart where she unlocked the computer screen. TMA-A proceeded to document that she had administered R25's nebulized solution and R1's Sinemet and Lasix tablets. She stated they were not supposed to document anything on the MAR until they were sure the resident had taken the medication. TMA-A stated this was how she had been trained. TMA-A did remove R1's medication cards from the cart for review and the label for the yellow tablets indicated the pills were Sinemet tablets 25-100mg give 2.5 tablets by mouth three times daily for Parkinson's disease and the label for the white tablet indicated the card held Lasix tablets 40mg give one tablet once a day for heart failure and localized edema. The medications administered did match physician orders. According to an interview 12/12/19, 9:33 a.m. the director of nursing (DON) stated it was her expectation for nurses and TMAs to follow standard medication administration rights: checking the medication cards against the MAR to determine the right medication, the right dose, the right time and the right resident before giving the medications. DON stated she expected the medications to be checked against the MAR	F 658	The consultant pharmacist also randomly observes medication administration techniques and reports noncompliance to the administrative staff. Compliance will be reviewed during the April 2020 Quality Assurance and Performance Improvement Committee meeting.	

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F 658	Continued From page 10 before being placed in the medication cup and again before returning the medications to storage. DON confirmed that simply reading a label without checking it against the MAR was not adequate to ensure a resident was receiving the correct medications and could result in a medication error. DON also confirmed placing unmarked medications in a pocket was against facility standards of medication administration. DON said the facility had recognized a problem with medication errors in the facility and had done audits and training with nurses and TMAs in response to that problem; however, DON stated she was unsure if they had standardized the use of their facility software for documentation in the MAR. DON confirmed that different staff may be using the software in different ways and they did not have any competency training specifically related to the Medication Administration software. The facility used PointClickCare's electronic medication administration software. A training video by the manufacturer, available to users in the facility, indicated the person administering medication should mark "Y" from the choice of "Y/N" (yes-administer or no-do not administer) for each medication being prepared for administration. After the medications had been compared to the MAR, the video indicated the person giving the medications should "click on the yellow lock icon" to hide the screen. After administration, the nurse or TMA would return to the computer program, re-open the screen to see the MAR and review the medications previously marked to ensure they were given. If they were not given the software allowed the user to change the "Y" to "N" but if no changes, the training indicated the user was simply to click on	F 658		

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F 658	Continued From page 11 the "save" icon to document administration was complete. A policy on medication administration was requested and the facility provided a document titled Medication Administration dated 1/13/18. The policy indicated an objective of "administer medication in an effective and safe manner, in accordance with physician's orders and standards of practice." The procedure indicated the process was to check the name on the MAR matched the name on the medication label as well as the name of the medication, the dose, the route and the times to be given; in addition, this information was to be checked against the physician order in the resident's MAR. The procedure stated the identity of the resident should be confirmed and resident's should be observed while taking the medication. Following medication administration the nurse or TMA should immediately document in the MAR. The current facility policy does not include any instruction on use of the facility software.	F 658		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition	F 692		1/21/20

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F 692	Continued From page 12 demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview, observations and record review, the facility failed to reassess nutritional needs for 1 of 1 resident's (R185) who was reviewed for unplanned weight loss. Findings include: R185's admission Sheet and diagnosis sheet, R185 was admitted to the facility with a primary diagnoses of a diffuse traumatic brain injury with a gastrostomy (feeding tube), dysphagia (difficulty swallowing) and anxiety among other diagnoses. R185's care plan dated, 8/19/19 and revised 11/01/19 indicated, The resident has nutritional problem or potential nutritional problem r/t (related to) weaning from tube feedings & altered diet: general, mechanical soft textures. Thin liquids, house supplement 4 oz. TID (three times daily), 1.5 liter fluid restriction. The listed interventions included: "Monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of dysphagia ... refusing to eat," "provide and serve supplements as ordered: House Supplement, 8 oz. TID," "Provide, serve diet as ordered: general,	F 692	Field Crest Care Center ensures that based on a resident's comprehensive assessment, the facility assists the resident in maintaining an acceptable parameter of nutritional status, such as usual or desirable body weight range and electrolyte balance, unless the resident□s clinical condition demonstrates that this is not possible or the resident preferences indicate otherwise. The facility 1) provides nutritional and hydration care and services to each resident, consistent with the resident□s comprehensive assessment 2) recognizes, evaluates, and addresses the dietary needs of every resident, including residents at risk or already experiencing impaired nutrition and hydration and 3) when there is a nutritional indication, provides a therapeutic diet that takes into account the resident□s clinical condition and preferences. A comprehensive nutritional assessment is completed on any resident identified as being at risk for unplanned weight	

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F 692	Continued From page 13 mechanical soft textures, thin liquids, 2500 fluid restriction, 1500 minimum ..." R185's list of weights: 8/15/19 was 192.4 pounds (lbs) 9/10/19 was 206.4 lbs 9/19/19 was 199.1 lbs 10/11/19 was 189.7 lbs 10/19/19 was 188.7 lbs 11/6/19 was 182.7 lbs 11/20/19 was 180.8 lbs 12/11/19 was 177.5 lbs R185's Nutrition assessment dated 11/27/19 read "no weight loss" and did not indicate the 12.8 lbs loss since admission. During an observation on 12/10/19 at 11:42 a.m. R185 was brought to the dining area for the noon meal. His meal was delivered eight minutes later; however, R185 was observed to have only eaten a few bites and after ten minutes later suddenly stood up and left the room. He was observed shortly afterwards shouting in a charting room that he was able to care for himself and he did not understand why he was in the facility. During an observation on 12/11/19 at 8:18 a.m. R185 was in the dining room and received his meal. Staff were not observed to interact with him. R185 remained in the dining area for approximately 15 minutes and left the table after drinking a small glass of juice and taking a few bites of fruit sauce. His cereal and coffee cake were both untouched. R185's dietary intake for the last 2 weeks was reviewed, indicated R185's had 42 meals offered	F 692	changes and/or compromised nutritional status. The assessment identifies factors that place the resident at risk for inadequate nutrition/hydration and takes into account the resident□s appearance, height, weight and medical diagnoses. Through the comprehensive nutritional assessment process, the interdisciplinary team considers the resident□s overall condition and clarifies nutritional issues and needs. The resident and family are encouraged to share food preferences, lifelong dietary practices and goals of care. A nutrition plan of care is drafted and communicated to the staff. During the January 17, 2020 staff training, the facility□s policies and procedures addressing weight loss will be reviewed. The staff will be reminded of the importance of monitoring the resident□s intake, taking accurate weights, providing assistance with eating to maximize intake, being aware of the resident□s food preferences as well as respecting the resident□s care goals. Resident number 185 - The resident was admitted to the facility August 14, 2019 with an enteral feeding tube due to swallowing difficulties related to the diagnosis of diffuse traumatic brain injury. Hospice care was discussed. The resident□s condition improved and the tube feedings were discontinued 11/21/2019 with tube removal 12/6/2019. The resident□s nutritional status was	

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F 692	Continued From page 14 and R185 ate less than 50% at 19 of those meals, ate 25% or less at 19 of those meals and refused to eat anything at four meals. R185's quarterly Minimum Data Set (MDS) assessment dated, 11/21/19 indicated R185 has impaired cognition, highly impaired vision and requires supervision with eating with one person assistance. During an interview on 12/11/19 at 10:05 a.m. registered nurse (RN)-A stated R185 was cognitively aware and knew how to eat and did not require assistance during meals. During an interview on 12/11/19, at 8:54 a.m. certified dietary manager (CDM) said the facility works as a team when a resident has weight loss. CDM stated she generally would check documented resident weights on a daily basis and looked for those that the system would flag as having weight loss. She stated the interdisciplinary team (IDT) would discuss reasons for weight loss so they could choose appropriate interventions. CDM indicated she was aware of R185's nutritional issues and stated he had had a feeding tube, but this had recently been removed. CDM stated he was to be seen by the dietician monthly due to weight loss and his feeding tube. CDM confirmed she had done his most recent nutritional assessment which resulted in a score indicating he was of low nutritional risk. CDM stated she did not give such a score and the score was simply generated by the system. CDM confirmed that R185 continued to lose weight since admission and said the dietician should have written notes documenting her assessment and plan for him. CDM was	F 692	reassessed; weight loss was discussed with the physician. To improve food acceptance and intake, the resident□s diet was changed from mechanical soft to regular texture and the fluid restriction was discontinued. The resident was started on Remeron (appetite stimulant) 12/26/19; the physician ordered a house supplement three times per day and high calorie snacks four times per day. The resident is currently being weighed daily. On November 17, 2019, the resident□s BMI (body mass index) was 30 which is considered overweight. (A BMI over 30 is considered obese; a BMI of 18.5 to 24.9 is considered a healthy weight.) The resident□s weight has stabilized. On 12/5/2019 the resident weighed 180.5 pounds and on 1/5/2020 the resident weighed 180.2 pounds. The resident□s food and snack preferences were identified and favorite items will be offered. Staff assistance with eating will be provided as necessary to maximize intake. The resident□s care plan has been reviewed and updated as necessary. The physician/nurse practitioner will be routinely updated on the resident□s weight and nutritional status. The consultant dietitian will reassess the resident at her next visit. Compliance will be monitored by the clinical managers and certified dietary manager who will review the residents□ weights weekly for one month. Residents	

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F 692	Continued From page 15 unable to locate any dietician notes in R185's record. CDM stated the dietician had last seen R185 on 10/24/19 without any recommendations, but CDM did not have a record of him being seen in November. CDM stated that if weight loss had not stabilized within about a week of occurrence further efforts to address the problem should be initiated. Other than an increase in the amount of dietary supplement on 10/31/19, CDM was unable to confirm other interventions taken to reduce R185's nutritional risks and his weight loss. She stated they did provide snacks, but confirmed he did not appear to care for them and she did not know if he ate them. A request was made for the dietician's progress notes. Facility provided documents titled Dietary Consult Report with handwritten notes for various residents. The notes related to R185 were as follows: "8/28/19, "enteral fdg (tube feedings)-comfort cares" 9/19/19, nothing written for R185 10/24/19- "2Lfl rest (two liter fluid restriction)-hold feeding if diet intake greater or equal to 50%. Weights look stable- admit 192.4, 9/6=205, 10/24 188.9 down 7.9% no doc of edema. Wt (weight) on lift- (blank), wt on w/c (blank) wt on stand (blank) 11/26/19- nothing written for R185" According to an interview on 12/12/19, at 9:11 a.m. nurse practitioner (NP) and R185's physician (MD) stated they were both aware of R185's weight loss. NP stated the CDM kept her updated on his condition and his weight loss was of concern to them. She had not heard from the dietician. MD stated an expectation for the	F 692	with nontherapeutic weight changes will be identified and will receive ongoing weekly reviews by the interdisciplinary team. Routine review of weights by the dietary manager will be ongoing. The clinical managers/designee will observe the dining room for six meals per week for two weeks to ensure appropriate assistance is being provided to residents with eating dependencies. If noncompliance is noted, additional auditing and staff education will be provided. Compliance will be reviewed during the April 2020 quarterly Quality Assurance and Performance Improvement Committee meeting.	

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dietician to be following R185's case as he had been on a tube feeding, had weight loss and they were reluctant to try pharmaceuticals to stimulate his appetite as it would increase his fall risk.
.
According to an interview on 12/12/19, at 9:22 a.m. director of nursing (DON) stated that R185 was offered snacks between meals, but she was aware he was not a snack eater. DON stated an expectation for staff to encourage R185 at meals and to offer alternative foods if not eating. DON stated they had discussed concerns about R185's weight loss at IDT meetings and confirmed his weight loss was significant. DON did not know if his situation indicated a need to be seen by a dietician. DON was unable to state any other interventions the facility had taken to encourage R185's intake or reduce his nutritional risks and weight loss.

A call was placed to the facility consulting registered dietician 12/11/19, 9:46 a.m. with a message left to return a call; however, dietician did not return the call.

A policy related to significant weight loss and/or dietician visits was requested. A policy titled Immediate Temporary Interventions for Unintended Significant Weight loss with a copyright date of 2017 was provided. The policy indicated "the registered dietician (RDN) or designee will review all significant/severe weight losses monthly or more often as needed and assess nutritional status ... the RDN or designee will determine a monitoring system to evaluate the success of the interventions initiated. The facility provided a policy titled Transitioning from Enteral Feedings to Oral feedings with a

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F 692	Continued From page 17 copyright date of 2017. The policy indicated the RDN would work closely with the speech language pathologist (SPL), the nursing supervisor and physician to accomplish the transition. The policy further indicated "the facility staff will intervene as appropriate for poor food/fluid intake, weight loss, or other negative reactions to the discontinuation of the enteral feeding, and refer to the RND, SLP and physician as needed ...the nursing staff and physician will work closely with the RDN and the SLP to assure the best quality of care for the individual involved."	F 692		
F 695 SS=J	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure oxygen was supplied as prescribed by the physician for 1 of 1 resident (R240) reviewed for oxygen usage. This resulted in an immediate jeopardy (IJ) finding when R240's oxygen saturations (O2 SAT's) level dropped causing R240 to experience difficulty in breathing. The facility had developed and implemented interventions prior to survey so the finding is being cited at past non-compliance.	F 695	Past noncompliance: no plan of correction required.	1/8/20

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The past non-compliance IJ began on 10/23/19. The IJ was removed and the deficient practice was corrected by 10/24/19, when the facility had developed and implemented a plan to prevent recurrence including a system to check for equipment and supplies needed before residents leave the facility. The administrator and director of nursing were notified of the past non-compliance IJ at 3:20 p.m. on 12/11/19.

Findings include:

R240's Admission Record dated 12/12/19, included diagnoses of chronic congestive heart failure (CHF), pleural effusion, chronic right heart failure, hypertensive heart, chronic kidney disease, type two diabetes and hypoxemia (low oxygen in the blood).

In a report to the State Agency 10/23/19, it was identified R240 had arrived at [name of hospital] interventional radiology department via private transport company for a planned procedure from the nursing home. The report indicated family member (FM)-E arrived separately and met the resident in the waiting room. R240 and FM-E were brought into the radiology pre-procedure area for evaluation where staff immediately assisted R240 to transfer from the cart to the bed. The report indicated following transfer to the bed, FM-E had alerted staff that in the waiting room R240 was complaining of breathing difficulty. At that time, FM-E reported to the hospital staff that R240 was oxygen dependent at the nursing facility requiring oxygen via NC [nasal cannula] at all times. The report further indicated hospital staff immediately obtained a pulse oximetry level for R240 and his oxygen level was

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F 695	Continued From page 19 70% on room air. The report described R240 as hypoxic, ashen and not responding to verbal or physical stimuli. At that point, hospital staff placed R240 on a simple mask at eight liters for a slow increase in his oxygen levels to 94%. Hospital staff then contacted the skilled nursing facility to report the patient had been transferred to the hospital in Rochester from Hayfield, Minnesota, a 45 minute drive, without his prescribed oxygen. R240's quarterly Minimum Data Set (MDS) assessment dated 6/21/19, indicated R240 was cognitively intact and required the use of oxygen for respiratory treatment. R240's physicians orders dated 9/23/19, included orders for oxygen (O2) via NC at 2 liters per minute every shift related to hypoxemia and chronic heart failure. R240's care plan initiated 10/10/19, indicated the resident required oxygen therapy for hypoxemia, secondary to chronic CHF, cough and deep breath while awake. The care plan also included, "May use Oldness incentive spirometer" (a device that measures how deeply a person can inhale) to assist with deep breathing; Give medications as ordered by physician; Observe and document side effects and effectiveness; O2 via nasal cannula; Position resident to facilitate ventilation/perfusion; and to use upright, high Fowlers position (a semi-sitting position 45-60 degrees) whenever possible to allow for optimal diaphragm. R240's Progress Notes, included the following:	F 695		

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10/22/19, spoke with (FM-G) about chest x-ray results from today. Large left pleural effusion (is the build-up of excess fluid between the layers of the pleura outside the lungs) with associated compressive atelectasis (the reduction in lung volume is greater than its normal relaxed state)/consolidation. Trace right pleural effusion. Physician assistant consulted with medical doctor and agree to move forward with PleurX (a drainage catheter and drainage bottles that collect fluid) as ordered tomorrow (10/23/19).

10/23/19, resident left to doctor appointment via stretcher at 8:45 a.m. Family to meet at appointment.

Review of a Registration and Disposition of Complaints form dated 10/23/19, indicated on 10/23/19 the resident had been "sent to Rochester for appointment via quality stretcher without ordered oxygen and in respiratory failure (stating at 64%)."

During an interview on 12/11/19, at 12:11 p.m. FM-E confirmed R240 had been brought by stretcher in a transportation van for a procedure at the Rochester hospital. FM-E stated he had met R240 at the hospital and did not notice right away that R240 had no oxygen on. FM-E stated, "He was always on oxygen." FM-E stated when moving R240 from the stretcher to the bed, R240 sat up on the bed and stated, "I can't breathe". FM-E stated R240 had asked the van driver where the oxygen was and the van driver had said he didn't know. FM-E said it had been determined R240 hadn't been sent with his oxygen. FM-E the stated he'd told the hospital nurse R240 required on two liters of oxygen, and

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when the nurse checked R240's levels and he was at 63% and was hypoxic. FM-E stated the nurse immediately put a face mask on R240 and turned up the oxygen to eight liters. FM-E stated he could see R240 was struggling to get air but stated after the O2 was applied, R240 settled down after taking a couple of deep breaths.

During interview on 12/11/19, at 12:41 p.m. trained medication aide (TMA)-B stated she was working the day R240 was sent to his appointment. TMA-B stated nursing assistant (NA)-A and licensed practical nurse (LPN)-A had prepared R240 for his appointment. R240 had to be transferred onto a stretcher with a lift. TMA-B stated there was a call later from the hospital informing the staff R240 had not had oxygen sent with him to his appointment and had become hypoxic. TMA-B stated R240 "was suppose to have oxygen continuously."

During interview on 12/11/19, at 12:51 p.m., NA-A verified she had helped to transfer R240 from the wheelchair to the stretcher. NA-A stated she was not sure whether R240 needed oxygen or not, and stated LPN-A had come in. NA-A said she'd asked LPN-A whether R240 needed oxygen or not, and her [LPN-A] response was she was going to finish up doing the paper work and would take care of the rest of it. NA-A said she'd left R240's room and had assumed LPN-A was going to take care of the oxygen when she finished up with the transportation service. NA-A said she should have gone back to check with LPN-A to ensure oxygen was going with R240 but hadn't. She stated later that day, one of the charge nurses had asked her if she'd sent oxygen with R240, and she'd said, "No". NA-A

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stated she'd heard R240 went all the way into his appointment without any oxygen.

During interview on 12/11/19, at 12:59 p.m. LPN-A stated, "It was hectic that day [date of appointment, 10/23/19]". LPN-A stated she'd helped transfer R240 onto the stretcher using a Hoyer (full body mechanical lift). She stated, "The stretcher would not go down after [R240] was placed on it and I was worried [R240] was going to fall." LPN-A said the staff placed the stretcher straps on R240, and had applied a blanket because R240 had said he was cold, then they sent him [R240] on his way. LPN-A stated she had later been updated R240 was sent without oxygen to his appointment. LPN-A stated the director of nursing (DON) had informed her R240 had gone into respiratory distress due to not having oxygen sent with him for his appointment. LPN-A verified R240 required oxygen continuously and confirmed she had not sent oxygen with R240 to his appointment.

During interview on 12/11/19, at 1:06 p.m., the DON stated before R240 left the facility for his appointment, the staff had removed his [R240's] oxygen in order to transfer him onto the gurney. The DON stated, "Just when the nurse thought about putting [R240's] oxygen back on him he had asked for a blanket, [LPN-A] went to get the blanket and [R240] was on his way out the door. She [LPN-A] forgot to send his oxygen with him." The DON stated she understood R240's medical condition and verified R240 had experienced respiratory distress when he'd arrived at the hospital for his appointment. The DON also verified R240 was to have continuous oxygen in

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place.

During interview on 12/11/19, at 1:23 p.m. the facility's social worker (SW)-A, stated she'd first become aware of R240 not having oxygen available when he'd gone to his appointment when she received a phone call from FM-G. SW-A stated she'd documented the concern on a facility complaint form. Further, SW-A stated FM-G had informed her R240's oxygen saturation level had dropped very low, and FM-G was understandably upset.

During interview on 12/11/19, at 1:30 p.m. registered nurse (RN)-C stated the hospital had called and informed them R240 had been transferred to his appointment without his oxygen. RN-C stated she'd talked with the hospital nurse and had coordinated to ensure R240 would have oxygen for his transport back to the facility.

During interview on 12/11/19, at 1:39 p.m. RN-D stated someone from the hospital had called to inform them R240 had arrived at his appointment without oxygen and was in acute distress. RN-D stated, "If I remember right his oxygen saturation was only at 60 to 70 percent."

During interview on 12/12/19, at 9:11 a.m. the hospital's RN-F stated, "[R240] was scheduled to have a procedure as an outpatient and had been transferred here from the facility via a transport service. His family met [R240] in the lobby and relayed [R240] was short of breath. We immediately came out to get the patient. He was very somnolent (sleepy/drowsy)." RN-F stated she'd asked the family whether R240 required

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	245431	A. BUILDING _____ B. WING _____	C 12/12/2019

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

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F 695	Continued From page 24	F 695		

oxygen at the facility and FM-E had responded, "Yes, he is on 2-3 liters all the time." RN-F stated she'd asked if FM-E whether any oxygen had been sent with R240 to the appointment. RN-F stated, "The transportation company had stated they had not been told [R240] needed to be transported with oxygen." RN-F said she'd immediately hooked R240 to a pulse oximeter and applied oxygen. RN-F confirmed R240's oxygen saturation was in the 70's, but slowly returned to the low 90's with the oxygen on. RN-F said R240's color was gray and FM-E was visibly concerned and had reported, "They never even take his oxygen off when he is transferred from the bed to chair, he has oxygen on all the time." RN-F stated she'd then called the facility and asked how this could happen, and they'd said they didn't know how it could happen, but would look into it. RN-F stated, "[R240] had a lack of oxygen for at least the 45 minute drive from the facility to the hospital."

The facility's 9/17/13 revised policy Storage, Maintenance, Handling and Use of Oxygen included: To ensure oxygen and oxygen equipment are safely stored, readily available, and appropriately administered to residents with respiratory difficulties. Procedure for use of oxygen: Administer according to physician's order, only properly trained staff can adjust flow.

The past noncompliance IJ began on 10/23/19. The IJ was removed and the deficient practice corrected by 10/24/19 when the facility implemented a corrective action. Verification of the corrective action implementation was confirmed by observation, interview and document review. The facility initiated placement

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F 695	Continued From page 25 of a resident sign out book in the medication room which included a check list of items, including oxygen, that may need to be sent with residents before leaving the facility. In addition, a sign was observed to have been placed on the front door of the facility to "Check with a nurse before leaving the building," to ensure families and transportation providers would check to make sure they had all required equipment before leaving the building. During interview with licensed and unlicensed nursing staff, it was determined they understood the importance of using the check list, and had received education on the protocol. In addition, licensed staff were aware of the facility's portable oxygen available for use.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs	F 761		1/21/20

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F 761	Continued From page 26 listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure a response when temperatures for refrigerated medications fell below safe storage ranges, and facility failed to remove a bottle of expired Aplisol (TB testing solution) from the medication storage refrigerator. The expired Aplisol had the potential to affect any new admits or new staff after the date of 11/24/19 and the stored immunizations had the potential to impact any resident whom might have received a dose after the temperature dropped below safe storage levels. During an observation of the facility medication storage area on 12/10/19, 2:10 p.m. a document titled Daily Refrigerator/Freezer temperature year: 2019 was posted on the facility refrigerator for storing medication. The document covered the months of October, November and December up unto the date observed, 12/10/19. A trained medication aide (TMA)-A stated the night nurses were responsible to record the temperatures each night shift. The temperature log was reviewed and found that the recorded refrigerator temperatures fell below a posted 35 degrees F for safe storage of medications as follows: December: 12/10/19- 32 degrees 12/9/19- 30 degrees 12/7/19- 30 degrees	F 761	Field Crest Care Center provides pharmaceutical services to meet the needs of each resident. The drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. The medication administration policies and procedures were reviewed and found appropriate. Facility policies and procedures require that outdated and expired drugs and biologicals be discarded according to accepted practice standards and that medication/biological storage containers be dated when opened. During the January 17, 2020 meeting, the licensed nursing staff and trained medication assistants will be reinstructed on the need to check expiration dates before administering medications/biologicals. Instruction will also address the procedures to ensure proper refrigerator temperatures for medication storage. The safe temperature range is posted on the refrigerator for	

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F 761	Continued From page 27 12/6/19- 32 degrees 12/5/19- 32 degrees 12/4/19- 30 degrees 12/2/19- 32 degrees 12/1/19- 32 degrees. November: 11/28/19- 30 degrees 11/27/19- 34 degrees 11/26/19- 30 degrees 11/25/19- 30 degrees 11/24/19-30 degrees 11/23/19- 32 degrees 11/18/19- 34 degrees 11/13/19- 30 degrees 11/10/19- 32 degrees 11/6/19- 32 degrees 11/2/19- 30 degrees October: 10/31/19- 32 degrees 10/30/19- 32 degrees 10/29/19- 34 degrees 11/27/19- 34 degrees 11/26/19- 32 degrees 11/25/19- 32 degrees 11/24/19- 34 degrees 11/22/19- 32 degrees 11/21/19- 34 degrees 11/12/19- 32 degrees 11/10/19- 34 degrees 11/4/19- 32 degrees 11/1/19- 32 degrees At the time of the observation a registered nurse (RN)-A confirmed the temperatures were out of range for safe storage of medications and stated a response to the temperature would depend how long the refrigerator had remained at the posted temperature. The refrigerator was	F 761	staff reference. The night shift will continue to check and record the refrigerator temperature on the designated log. Temperature adjustments will be made if temperatures outside the specified parameters are identified. A refrigerator thermometer that alarms to alert staff when temperatures are outside of the safe range has been installed. All medication storage areas have been checked for expired medications and biologicals. The assigned staff will continue monthly monitoring of medication storage areas for expired medications and biologicals. To further monitor compliance, the medication storage areas will be checked by the clinical managers/designee for expired medications and biologicals every two weeks for four weeks. The Consultant Pharmacist will continue to conduct random observations of medication storage areas. To monitor compliance with acceptable refrigerator temperatures for medication storage, the clinical managers will monitor the refrigerator temperature and temperature monitoring logs three times weekly for two weeks. If noncompliance is found regarding expired medications/biologicals or unacceptable refrigerator temperatures, additional auditing and staff education will be done. Compliance will be reviewed during the April 2020 quarterly Quality Assurance and Performance Improvement Committee meeting.	

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F 761	Continued From page 28	F 761		

observed to have a thermometer that was sitting near the back of the refrigerator at that time which read approximately 43 degrees and RN-A confirmed the temperature at that time fell into the "green" range marked on the thermometer as appropriate for storage. RN-A stated it was unknown how long the refrigerator had remained below the safe storage temperature on the posted document and said they would need to contact the pharmacy to see what should be done with the stored medications. The medications observed to be in the refrigerator at that time were:

Five unopened insulin pens containing Lantus insulin delivered that afternoon, 12/10/19 belonging to resident (R16).

Four unopened vials of stock Engerix B (hepatitis B immunization solution) not opened, delivery date unknown.

Three boxes with 22 doses remaining of Fluzone (influenza immunization) with eight doses missing. The box indicated the solution should have been stored at a temperature of no less than 35-36 degrees. It could not be determined who would have received the 8 missing doses or when they were administered.

One box of nine Flucelvax doses with one missing. The box indicated the vaccine was to be stored between the temperatures of 36 and 46 degrees and "do not freeze." It could not be determined who would have received the missing dose.

According to an interview on 12/10/19, at 2:12

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F 761	Continued From page 29 p.m. the director of nursing (DON) confirmed the refrigerator temperatures often fell below the safe storage temperature. DON was unable to confirm the medications were still safe to use. At that time, a container of Aplisol serum (to test for tuberculosis) was found in the refrigerator, opened but marked as "do not use after 11/24/19." DON confirmed that the solution would be considered expired, but she was unable to confirm if the solution was used after 11/24/19. Unknown if anyone received a test dose with possible frozen serum. DON stated she was going to call the pharmacy about what should be done. On 12/10/19, at 3:52 p.m. DON reported the pharmacy told her to destroy all of the medications except the insulin as they were no longer any good. At 3:57 p.m. DON reported the consulting pharmacist referred her to the Medical Director but did not feel there should be any ill effects from the medications if they had been given after having been frozen. At 4:11 p.m. the DON reported the Medical Director told her there should not be any problems and recommended against re-vaccinating any residents in the facility. A policy related to safe storage of medications was requested. A document titled Medication Storage dated 2/15/18 was provided and addressed medication storage. The policy indicated "medication with storage requirements for temperature, light or humidity controls must be stored to meet specifications for the medication" and "medications will be monitored by the Nursing Staff to assure that they are not expired, contaminated, or unusable." Policy failed	F 761		

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F 761	Continued From page 30 to indicate actions to take if a problem with medication storage should occur, such as low temperature readings for refrigerated medications. According to the Centers for Disease Control (CDC) influenza vaccines are "cold sensitive and damaged rapidly by freezing temperatures." Additionally, the CDC indicated, "The desired average refrigerator vaccine storage temperature is 40°F (5°C). Exposure to temperatures outside these ranges may result in reduced vaccine potency and increased risk of vaccine-preventable diseases."	F 761		
F 843 SS=C	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the	F 843		1/7/20

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F 843	Continued From page 31 hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and/or have evidence of an in-effect transfer agreement with a local Medicare participating hospital entity. This had potential to affect all 37 residents in the facility who could require hospitalization on an emergent basis. Findings include: During the extended survey on 12/12/19, documention was requested from the administrator to demonstrate the facility had a transfer agreement in place with a local Medicare/Medicaid participating hospital entity. During interview on 12/12/19, at 1:27 p.m. the social services designee stated the facility did not have a transfer agreement with a hospital in place.	F 843	Field Crest Care Center has successfully transferred residents to local hospitals for care and services throughout the time the facility has been in operation. The facility has formalized a written transfer agreement with a local hospital which is approved for participation under the Medicare and Medicaid programs which provides that: 1. Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with State law; and 2. Medical and other information needed for care and treatment of the resident will be provided to the receiving facility. Information will also be provided as necessary to assist in determining the most appropriate treatment setting for the resident.	

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F 843	Continued From page 32	F 843	Compliance with hospital transfer agreement requirements will be monitored by the administrator during the annual review of the facility□s policies and procedures. Transfer agreements will also be reviewed/updated in the event of changes in local hospital providers. The hospital agreement will be discussed during the April 2020 quarterly Quality Assurance and Performance Improvement Committee meeting.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		1/21/20

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F 880	Continued From page 33 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 34 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an on-going infection prevention program including comprehensive analysis and interpretation of data to identify and respond to possible patterns of infection. This had the potential to effect all 37 residents in the facility. Findings include: On 12/11/2019, at 9:15 a.m. the director of nursing (DON) was interviewed on the facility infection control program. The DON shared the facility infection preventionist was currently on maternity leave. The DON stated for QAPI the facility presented on infection control and documented the analysis of infections. Copies of the data analysis was requested and surveyor was provided with the data analysis completed for the July 11, 2019 QAPI meeting. The DON stated that was the only documentation of the data analysis for antibiotic use and infections in the last year. The DON stated she was aware the data analysis was not being done for infections and antibiotic usage as she attended the QAPI meetings. The Infection Prevention and Control Surveillance Policy dated 7-31-19 included, "Data Analysis: The Infection Preventionist with the assistance from the IDT will utilize the information collected from the surveillance in order to identify	F 880	Field Crest Care Center has established and maintains an infection prevention and control program (IPCP) designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of communicable diseases and infections. The infection control program includes 1) identifying, reporting, investigating, controlling, and preventing infections in the facility 2) determining the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintaining a record of incidences of infections and tracking any corrective actions taken. Using a data collection log provided by the Centers for Medicare and Medicaid Services (CMS), the facility tracks the resident name, room number, onset of infection, site of infection, laboratory tests, culture results, microbe, whether antibiotic was appropriate, last day of antibiotic, infection resolution date, whether infection was acquired in the hospital or at the facility as well as other pertinent data. The CMS software program accommodates graphing of the collected data to facilitate data analysis and interpretation. Collected data and	

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F 880	Continued From page 35 opportunities for improved care and process and identify an action plan for follow up and corrective action reporting. Plan: Based on the analysis of data, develop and implement an action plan that includes corrective actions and staff education."	F 880	graphed information will be interpreted and analyzed by the Director of Nursing/Infection Preventionist to identify trends and clustering which will be investigated. The results will be reviewed weekly with the interdisciplinary team, addressed during the monthly Quality Assurance and Performance Improvement (QAPI) Committee meeting and summarized for presentation at the quarterly QAPI Committee meeting. After analysis, the Director of Nurses will review significant infection incidences, trends, and clustering with the Medical Director. During the January 17, 2020 educational meetings, the direct care staff will be informed of the importance of being alert to symptoms of infections and notifying the licensed nurses of any symptoms that could be indicative of an infection. The licensed nurses will be reminded of the importance of completing the infection control symptom/treatment tracking form. The Director of Nursing will monitor compliance with regulatory requirements and facility policies for resident care infection control analysis/surveillance/reporting for the next three months through interviews with the Infection Preventionist and a review of the infection control tracking data for appropriate analysis and interpretation. If noncompliance is noted, additional training and auditing will be done. Compliance will be reviewed during the	

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F 880	Continued From page 36	F 880	April 2020 quarterly QAPI Committee meeting and ongoing.	

Electronically delivered
December 31, 2019

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

Re: Event ID: DYM411

Dear Administrator:

The above facility was surveyed on December 9, 2019 through December 12, 2019 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:

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 12/12/2019

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 12/9/19, 12/10/19, 12/11/19 and 12/12/19, a survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 In addition, a complaint investigation(s) was also completed at the time of the licensing survey. As a result the following was identified: The complaint was found to be substantiated: H5431030C, H5431033C, H5431023C, H5431026C and H5431025C with no corresponding citations issued The complaint was found to be substantiated: H5431024C with licensing orders issued. The following complaints were found to be unsubstantiated: H5431032C, H5431031C, H5431029C, H5431027C and H5431028C The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		1/21/20

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2 830	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure oxygen was supplied as prescribed by the physician for 1 of 1 resident (R240) reviewed for oxygen usage. This resulted in an immediate jeopardy (IJ) finding when R240's oxygen saturations (O2 SAT's) level dropped causing R240 to experience difficulty in breathing. The facility had developed and implemented interventions prior to survey so the finding is being cited at past non-compliance. The past non-compliance IJ began on 10/23/19. The IJ was removed and the deficient practice was corrected by 10/24/19, when the facility had developed and implemented a plan to prevent recurrence including a system to check for equipment and supplies needed before residents leave the facility. The administrator and director of nursing were notified of the past non-compliance IJ at 3:20 p.m. on 12/11/19. Findings include: R240's Admission Record dated 12/12/19, included diagnoses of chronic congestive heart failure (CHF), pleural effusion, chronic right heart failure, hypertensive heart, chronic kidney disease, type two diabetes and hypoxemia (low oxygen in the blood). In a report to the State Agency 10/23/19, it was identified R240 had arrived at [name of hospital] interventional radiology department via private	2 830	Acknowledged and corrected	

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2 830	Continued From page 3	2 830		

transport company for a planned procedure from the nursing home. The report indicated family member (FM)-E arrived separately and met the resident in the waiting room. R240 and FM-E were brought into the radiology pre-procedure area for evaluation where staff immediately assisted R240 to transfer from the cart to the bed. The report indicated following transfer to the bed, FM-E had alerted staff that in the waiting room R240 was complaining of breathing difficulty. At that time, FM-E reported to the hospital staff that R240 was oxygen dependent at the nursing facility requiring oxygen via NC [nasal cannula] at all times. The report further indicated hospital staff immediately obtained a pulse oximetry level for R240 and his oxygen level was 70% on room air. The report described R240 as hypoxic, ashen and not responding to verbal or physical stimuli. At that point, hospital staff placed R240 on a simple mask at eight liters for a slow increase in his oxygen levels to 94%. Hospital staff then contacted the skilled nursing facility to report the patient had been transferred to the hospital in Rochester from Hayfield, Minnesota, a 45 minute drive, without his prescribed oxygen.

R240's quarterly Minimum Data Set (MDS) assessment dated 6/21/19, indicated R240 was cognitively intact and required the use of oxygen for respiratory treatment.

R240's physicians orders dated 9/23/19, included orders for oxygen (O2) via NC at 2 liters per minute every shift related to hypoxemia and chronic heart failure.

R240's care plan initiated 10/10/19, indicated the resident required oxygen therapy for hypoxemia,

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2 830	Continued From page 4 secondary to chronic CHF, cough and deep breath while awake. The care plan also included, "May use Oldness incentive spirometer" (a device that measures how deeply a person can inhale) to assist with deep breathing; Give medications as ordered by physician; Observe and document side effects and effectiveness; O2 via nasal cannula; Position resident to facilitate ventilation/perfusion; and to use upright, high Fowlers position (a semi-sitting position 45-60 degrees) whenever possible to allow for optimal diaphragm. R240's Progress Notes, included the following: 10/22/19, spoke with (FM-G) about chest x-ray results from today. Large left pleural effusion (is the build-up of excess fluid between the layers of the pleura outside the lungs) with associated compressive atelectasis (the reduction in lung volume is greater than its normal relaxed state)/consolidation. Trace right pleural effusion. Physician assistant consulted with medical doctor and agree to move forward with PleurX (a drainage catheter and drainage bottles that collect fluid) as ordered tomorrow (10/23/19). 10/23/19, resident left to doctor appointment via stretcher at 8:45 a.m. Family to meet at appointment. Review of a Registration and Disposition of Complaints form dated 10/23/19, indicated on 10/23/19 the resident had been "sent to Rochester for appointment via quality stretcher without ordered oxygen and in respiratory failure (stating at 64%)." During an interview on 12/11/19, at 12:11 p.m.	2 830		

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2 830	Continued From page 5 FM-E confirmed R240 had been brought by stretcher in a transportation van for a procedure at the Rochester hospital. FM-E stated he had met R240 at the hospital and did not notice right away that R240 had no oxygen on. FM-E stated, "He was always on oxygen." FM-E stated when moving R240 from the stretcher to the bed, R240 sat up on the bed and stated, "I can't breathe". FM-E stated R240 had asked the van driver where the oxygen was and the van driver had said he didn't know. FM-E said it had been determined R240 hadn't been sent with his oxygen. FM-E the stated he'd told the hospital nurse R240 required on two liters of oxygen, and when the nurse checked R240's levels and he was at 63% and was hypoxic. FM-E stated the nurse immediately put a face mask on R240 and turned up the oxygen to eight liters. FM-E stated he could see R240 was struggling to get air but stated after the O2 was applied, R240 settled down after taking a couple of deep breaths. During interview on 12/11/19, at 12:41 p.m. trained medication aide (TMA)-B stated she was working the day R240 was sent to his appointment. TMA-B stated nursing assistant (NA)-A and licensed practical nurse (LPN)-A had prepared R240 for his appointment. R240 had to be transferred onto a stretcher with a lift. TMA-B stated there was a call later from the hospital informing the staff R240 had not had oxygen sent with him to his appointment and had become hypoxic. TMA-B stated R240 "was suppose to have oxygen continuously." During interview on 12/11/19, at 12:51 p.m., NA-A verified she had helped to transfer R240 from the wheelchair to the stretcher. NA-A stated she was not sure whether R240 needed oxygen or not,	2 830		

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2 830	Continued From page 6 and stated LPN-A had come in. NA-A said she'd asked LPN-A whether R240 needed oxygen or not, and her [LPN-A] response was she was going to finish up doing the paper work and would take care of the rest of it. NA-A said she'd left R240's room and had assumed LPN-A was going to take care of the oxygen when she finished up with the transportation service. NA-A said she should have gone back to check with LPN-A to ensure oxygen was going with R240 but hadn't. She stated later that day, one of the charge nurses had asked her if she'd sent oxygen with R240, and she'd said, "No". NA-A stated she'd heard R240 went all the way into his appointment without any oxygen. During interview on 12/11/19, at 12:59 p.m. LPN-A stated, "It was hectic that day [date of appointment, 10/23/19]". LPN-A stated she'd helped transfer R240 onto the stretcher using a Hoyer (full body mechanical lift). She stated, "The stretcher would not go down after [R240] was placed on it and I was worried [R240] was going to fall." LPN-A said the staff placed the stretcher straps on R240, and had applied a blanket because R240 had said he was cold, then they sent him [R240] on his way. LPN-A stated she had later been updated R240 was sent without oxygen to his appointment. LPN-A stated the director of nursing (DON) had informed her R240 had gone into respiratory distress due to not having oxygen sent with him for his appointment. LPN-A verified R240 required oxygen continuously and confirmed she had not sent oxygen with R240 to his appointment. During interview on 12/11/19, at 1:06 p.m., the DON stated before R240 left the facility for his	2 830		

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2 830	Continued From page 7 appointment, the staff had removed his [R240's] oxygen in order to transfer him onto the gurney. The DON stated, "Just when the nurse thought about putting [R240's] oxygen back on him he had asked for a blanket, [LPN-A] went to get the blanket and [R240] was on his way out the door. She [LPN-A] forgot to send his oxygen with him." The DON stated she understood R240's medical condition and verified R240 had experienced respiratory distress when he'd arrived at the hospital for his appointment. The DON also verified R240 was to have continuous oxygen in place. During interview on 12/11/19, at 1:23 p.m. the facility's social worker (SW)-A, stated she'd first become aware of R240 not having oxygen available when he'd gone to his appointment when she received a phone call from FM-G. SW-A stated she'd documented the concern on a facility complaint form. Further, SW-A stated FM-G had informed her R240's oxygen saturation level had dropped very low, and FM-G was understandably upset. During interview on 12/11/19, at 1:30 p.m. registered nurse (RN)-C stated the hospital had called and informed them R240 had been transferred to his appointment without his oxygen. RN-C stated she'd talked with the hospital nurse and had coordinated to ensure R240 would have oxygen for his transport back to the facility. During interview on 12/11/19, at 1:39 p.m. RN-D stated someone from the hospital had called to inform them R240 had arrived at his appointment without oxygen and was in acute distress. RN-D stated, "If I remember right his oxygen saturation	2 830		

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2 830	Continued From page 8 was only at 60 to 70 percent." During interview on 12/12/19, at 9:11 a.m. the hospital's RN-F stated, "[R240] was scheduled to have a procedure as an outpatient and had been transferred here from the facility via a transport service. His family met [R240] in the lobby and relayed [R240] was short of breath. We immediately came out to get the patient. He was very somnolent (sleepy/drowsy)." RN-F stated she'd asked the family whether R240 required oxygen at the facility and FM-E had responded, "Yes, he is on 2-3 liters all the time." RN-F stated she'd asked if FM-E whether any oxygen had been sent with R240 to the appointment. RN-F stated, "The transportation company had stated they had not been told [R240] needed to be transported with oxygen." RN-F said she'd immediately hooked R240 to a pulse oximeter and applied oxygen. RN-F confirmed R240's oxygen saturation was in the 70's, but slowly returned to the low 90's with the oxygen on. RN-F said R240's color was gray and FM-E was visibly concerned and had reported, "They never even take his oxygen off when he is transferred from the bed to chair, he has oxygen on all the time." RN-F stated she'd then called the facility and asked how this could happen, and they'd said they didn't know how it could happen, but would look into it. RN-F stated, "[R240] had a lack of oxygen for at least the 45 minute drive from the facility to the hospital." The facility's 9/17/13 revised policy Storage, Maintenance, Handling and Use of Oxygen included: To ensure oxygen and oxygen equipment are safely stored, readily available, and appropriately administered to residents with respiratory difficulties. Procedure for use of	2 830		

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2 830	Continued From page 9 oxygen: Administer according to physician's order, only properly trained staff can adjust flow. The past noncompliance IJ began on 10/23/19. The IJ was removed and the deficient practice corrected by 10/24/19 when the facility implemented a corrective action. Verification of the corrective action implementation was confirmed by observation, interview and document review. The facility initiated placement of a resident sign out book in the medication room which included a check list of items, including oxygen, that may need to be sent with residents before leaving the facility. In addition, a sign was observed to have been placed on the front door of the facility to "Check with a nurse before leaving the building," to ensure families and transportation providers would check to make sure they had all required equipment before leaving the building. During interview with licensed and unlicensed nursing staff, it was determined they understood the importance of using the check list, and had received education on the protocol. In addition, licensed staff were aware of the facility's portable oxygen available for use. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to oxygen use to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.	2 830		

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2 830	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on interview, observations and record review, the facility failed to reassess nutritional needs for 1 of 1 resident's (R185) who was reviewed for unplanned weight loss. Findings include: R185's admission Sheet and diagnosis sheet, R185 was admitted to the facility with a primary diagnoses of a diffuse traumatic brain injury with a gastrostomy (feeding tube), dysphagia (difficulty swallowing) and anxiety among other diagnoses. R185's care plan dated, 8/19/19 and revised 11/01/19 indicated, The resident has nutritional problem or potential nutritional problem r/t (related to) weaning from tube feedings & altered diet: general, mechanical soft textures. Thin liquids, house supplement 4 oz. TID (three times	2 965	Acknowledged and corrected.	1/21/20

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2 965	Continued From page 11 daily), 1.5 liter fluid restriction. The listed interventions included: "Monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of dysphagia ... refusing to eat," "provide and serve supplements as ordered: House Supplement, 8 oz. TID," "Provide, serve diet as ordered: general, mechanical soft textures, thin liquids, 2500 fluid restriction, 1500 minimum ..." R185's list of weights: 8/15/19 was 192.4 pounds (lbs) 9/10/19 was 206.4 lbs 9/19/19 was 199.1 lbs 10/11/19 was 189.7 lbs 10/19/19 was 188.7 lbs 11/6/19 was 182.7 lbs 11/20/19 was 180.8 lbs 12/11/19 was 177.5 lbs R185's Nutrition assessment dated 11/27/19 read "no weight loss" and did not indicate the 12.8 lbs loss since admission. During an observation on 12/10/19 at 11:42 a.m. R185 was brought to the dining area for the noon meal. His meal was delivered eight minutes later; however, R185 was observed to have only eaten a few bites and after ten minutes later suddenly stood up and left the room. He was observed shortly afterwards shouting in a charting room that he was able to care for himself and he did not understand why he was in the facility. During an observation on 12/11/19 at 8:18 a.m. R185 was in the dining room and received his meal. Staff were not observed to interact with him. R185 remained in the dining area for approximately 15 minutes and left the table after	2 965		

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2 965	Continued From page 12 drinking a small glass of juice and taking a few bites of fruit sauce. His cereal and coffee cake were both untouched. R185's dietary intake for the last 2 weeks was reviewed, indicated R185's had 42 meals offered and R185 ate less than 50% at 19 of those meals, ate 25% or less at 19 of those meals and refused to eat anything at four meals. R185's quarterly Minimum Data Set (MDS) assessment dated, 11/21/19 indicated R185 has impaired cognition, highly impaired vision and requires supervision with eating with one person assistance. During an interview on 12/11/19 at 10:05 a.m. registered nurse (RN)-A stated R185 was cognitively aware and knew how to eat and did not require assistance during meals. During an interview on 12/11/19, at 8:54 a.m. certified dietary manager (CDM) said the facility works as a team when a resident has weight loss. CDM stated she generally would check documented resident weights on a daily basis and looked for those that the system would flag as having weight loss. She stated the interdisciplinary team (IDT) would discuss reasons for weight loss so they could choose appropriate interventions. CDM indicated she was aware of R185's nutritional issues and stated he had had a feeding tube, but this had recently been removed. CDM stated he was to be seen by the dietician monthly due to weight loss and his feeding tube. CDM confirmed she had done his most recent nutritional assessment which resulted in a score indicating he was of low nutritional risk. CDM stated she did not give such	2 965		

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2 965	Continued From page 13 a score and the score was simply generated by the system. CDM confirmed that R185 continued to lose weight since admission and said the dietician should have written notes documenting her assessment and plan for him. CDM was unable to locate any dietician notes in R185's record. CDM stated the dietician had last seen R185 on 10/24/19 without any recommendations, but CDM did not have a record of him being seen in November. CDM stated that if weight loss had not stabilized within about a week of occurrence further efforts to address the problem should be initiated. Other than an increase in the amount of dietary supplement on 10/31/19, CDM was unable to confirm other interventions taken to reduce R185's nutritional risks and his weight loss. She stated they did provide snacks, but confirmed he did not appear to care for them and she did not know if he ate them. A request was made for the dietician's progress notes. Facility provided documents titled Dietary Consult Report with handwritten notes for various residents. The notes related to R185 were as follows: "8/28/19, "enteral fdg (tube feedings)-comfort cares" 9/19/19, nothing written for R185 10/24/19- "2Lfl rest (two liter fluid restriction)-hold feeding if diet intake greater or equal to 50%. Weights look stable- admit 192.4, 9/6=205, 10/24 188.9 down 7.9% no doc of edema. Wt (weight) on lift- (blank), wt on w/c (blank) wt on stand (blank) 11/26/19- nothing written for R185" According to an interview on 12/12/19, at 9:11 a.m. nurse practitioner (NP) and R185's physician (MD) stated they were both aware of	2 965		

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2 965	Continued From page 14 R185's weight loss. NP stated the CDM kept her updated on his condition and his weight loss was of concern to them. She had not heard from the dietician. MD stated an expectation for the dietician to be following R185's case as he had been on a tube feeding, had weight loss and they were reluctant to try pharmaceuticals to stimulate his appetite as it would increase his fall risk. . According to an interview on 12/12/19, at 9:22 a.m. director of nursing (DON) stated that R185 was offered snacks between meals, but she was aware he was not a snack eater. DON stated an expectation for staff to encourage R185 at meals and to offer alternative foods if not eating. DON stated they had discussed concerns about R185's weight loss at IDT meetings and confirmed his weight loss was significant. DON did not know if his situation indicated a need to be seen by a dietician. DON was unable to state any other interventions the facility had taken to encourage R185's intake or reduce his nutritional risks and weight loss. A call was placed to the facility consulting registered dietician 12/11/19, 9:46 a.m. with a message left to return a call; however, dietician did not return the call. A policy related to significant weight loss and/or dietician visits was requested. A policy titled Immediate Temporary Interventions for Unintended Significant Weight loss with a copyright date of 2017 was provided. The policy indicated "the registered dietician (RDN) or designee will review all significant/severe weight losses monthly or more often as needed and assess nutritional status ... the RDN or designee will determine a monitoring system to evaluate	2 965		

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2 965	Continued From page 15 the success of the interventions initiated. The facility provided a policy titled Transitioning from Enteral Feedings to Oral feedings with a copyright date of 2017. The policy indicated the RDN would work closely with the speech language pathologist (SPL), the nursing supervisor and physician to accomplish the transition. The policy further indicated "the facility staff will intervene as appropriate for poor food/fluid intake, weight loss, or other negative reactions to the discontinuation of the enteral feeding, and refer to the RND, SLP and physician as needed ...the nursing staff and physician will work closely with the RDN and the SLP to assure the best quality of care for the individual involved." SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) and/or dietary manager could provide training to all existing staff and to new staff as they are hired in the offering and provision of dietary alternatives as appropriate within the facility for persons of nutritional concern. Audits could be done to check that persons with poor nutritional intake are offered alternatives, supplement or additional supplements to prevent adverse outcomes of nutritional deficiency. Dietary manager could ensure all residents at nutritional risk are reviewed by the dietician on a monthly or more frequent basis in order to address their unique concerns. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 965		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program	21375		1/21/20

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21375	Continued From page 16 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish an on-going infection prevention program including comprehensive analysis and interpretation of data to identify and respond to possible patterns of infection. This had the potential to effect all 37 residents in the facility. Findings include: On 12/11/2019, at 9:15 a.m. the director of nursing (DON) was interviewed on the facility infection control program. The DON shared the facility infection preventionist was currently on maternity leave. The DON stated for QAPI the facility presented on infection control and documented the analysis of infections. Copies of the data analysis was requested and surveyor was provided with the data analysis completed for the July 11, 2019 QAPI meeting. The DON stated that was the only documentation of the data analysis for antibiotic use and infections in the last year. The DON stated she was aware the data analysis was not being done for infections and antibiotic usage as she attended the QAPI meetings. The Infection Prevention and Control Surveillance Policy dated 7-31-19 included, "Data Analysis: The Infection Preventionist with the assistance from the IDT will utilize the information	21375	Acknowledged and corrected	

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21375	Continued From page 17 collected from the surveillance in order to identify opportunities for improved care and process and identify an action plan for follow up and corrective action reporting. Plan: Based on the analysis of data, develop and implement an action plan that includes corrective actions and staff education." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure the ongoing, routine collection of infection data and subsequent analysis of the data to reduce the risk of spread within the facility; then educate applicable staff and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to assess a resident or obtain physician orders for self-administration of medications for 1 of 10 residents (R25) observed during medication administration. Findings include: R25's Admission Sheet indicated diagnosis	21565	Acknowledged and corrected.	1/21/20

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21565	Continued From page 18 related to a fractured femur Parkinson's Disease (a neurological disorder that results in problems with movement and may cause dementia), and had a recent diagnosis of pneumonia. On 12/10/19 at 11:30 a.m. a trained medication aide (TMA-A) was observed to inform R25 that he was due for his nebulizer treatment and would give it to him as soon as he finished his meal. TMA-A then went to the medication cart and removed a package and placed it in her pocket. Shortly after, R25 finished his meal and TMA-A assisted him to his room. She removed the package from her pocket. The label of the package indicated the contents to be Ipratrobium-Albuterol Solution 0.5-2.5 MG/3Ml. TMA-A placed the nebulizer machine on R25's bed and stated he was able to turn it off when he was done if staff left the machine close enough to him. TMA-A filled the medication cup attached to a face mask with the medication solution and applied the mask to R25's face. TMA-A started the machine and said she would be back in about ten minutes and R25 told the TMA-A to make sure she didn't come back too soon. TMA-A stated R25 watched the clock "like a hawk" and wanted the treatment to run for exactly ten minutes. TMA-A then left R25's room, went to another resident's room and administered medications to that resident from items she had in her pocket and returned to her medication cart. At the medication cart, TMA-A stated it was her understanding that a person was allowed to self-medicate a nebulized solution if they were able to turn their machine off. She stated she did not think there was an assessment that needed to be done but thought there would be a spot in the medication administration record (MAR) where it would indicate if a person was able to	21565		

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21565	Continued From page 19	21565		

self-administer medications. TMA-A was unable to locate any direction in the MAR indicating R25 was able to self-administer any medications. TMA-A then stated the physician orders would state if he was unable to self-administer his nebulizer solution. A registered nurse (RN-A) overheard TMA-A's statement and said, "No, the order will say if someone CAN self-administer." RN-A instructed TMA-A that residents were not to self-administer medications until they had a physician's order to do so.

A review of R25's physician orders failed to indicate an order for self-administration of medications. A review of R25's care plan was done and self-administration of medications was not found. No record of an assessment for competence in self-administration of medications was found in R25's facility chart.

During an interview on 12/12/19, at 9:33 a.m. the director of nursing (DON) stated residents were not to be left unattended with their nebulizer solution running until they had been deemed competent to do so and had a physician's order in the MAR. DON stated part of standard medication administration rights was to ensure the resident has taken their medication.

A policy related to self-administration of medications was requested. Facility provided a policy titled Self Medication Administration Policy dated 11/2008. The policy indicated that persons who express a desire to self-administer "will have their "cognitive, physical and visual ability to carry out this responsibility" assessed. The policy also indicated an order would be obtained from the physician for self-administration of mediations. In addition, the policy indicated the information

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21565	Continued From page 20 would appear on the resident's care plan and a quarterly review of the process would occur during care conference meetings. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could increase the frequency and breadth of audits to assure residents are not left to self-administer nebulized or other medications if not yet evaluated as competent to self-administer medications. DON could provide updated training to all staff who administer medications within the facility. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21565		
21580	MN Rule 4658.1325 Subp. 7 Administration of Medications; Requirements Subp. 7. Administration requirements. The administration of medications must include the complete procedure of checking the resident's record, transferring individual doses of the medication from the resident's prescription container, and distributing the medication to the resident. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure that staff followed professional standards of practice of medication administration for 2 of 10 residents (R1 and R25) observed during a noon medication pass. Findings include:	21580	Acknowledged and corrected.	1/21/20

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21580	Continued From page 21 R1's Admission Sheet indicated R1was admitted to the facility with a principle diagnosis of Parkinson's Disease (a neurological disorder that results in problems with movement and may cause dementia). R25's Admission Sheet indicated R25 was admitted to the facility with a principle diagnosis related to a fracture's femur and R25 also had Parkinson's Disease, and had a recent diagnosis of pneumonia. On 12/10/19 11:30 a.m. a trained medication aide (TMA-A) was observed to inform R25 that he was due for his nebulizer treatment and would give it to him as soon as he finished his meal. TMA-A then went to the medication cart and opened the medication drawers. A computer was available on top of the medication cart to refer to resident Medication Administration Records (MAR) during medication set up; however, the screen for the MAR was observed to be in locked mode so the MAR was not open for viewing or documentation. TMA-A placed several paper medication cups on top of the cart and removed several cards from the drawer. TMA-A looked at the cards and punched several small yellow pills into one of the yellow cups; took another medication card and punched out a small white pill into the paper medication cup. TMA-A then placed one paper cup on top of the medications that had been removed from the cards and placed the cups, with medications, in her right pocket. The cups were not observed to have been marked in any way to identify the contents or the name of the resident to receive them. TMA-A then removed a package of what appeared to be a solution for nebulized medication and placed it in her right pocket. Shortly after, R25 finished his meal and	21580		

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21580	Continued From page 22 TMA-A assisted him to his room. She removed the cup of medications from her pocket and set them on the over bed table in R25's room and then removed the package of solution from her pocket. The label of the package indicated the contents to be Ipratrobium-Albuterol Solution 0.5-2.5 MG/3Ml. TMA-A placed the nebulizer machine on R25's bed and filled the medication cup, attached this to a face mask and applied this to R25's face. TMA-A started the machine and said she would be back in about ten minutes. TMA-A picked up the paper cup of pills, left R25's room, and went to R1's room. She poured the pills onto the bedside table, two and a half small yellow pills and a small white pill and told R1 she had his Sinemet pills for Parkinson's and his Lasix. R1 then picked up the pills, ingested them with water. TMA-A then returned to the medication cart where she unlocked the computer screen. TMA-A proceeded to document that she had administered R25's nebulized solution and R1's Sinemet and Lasix tablets. She stated they were not supposed to document anything on the MAR until they were sure the resident had taken the medication. TMA-A stated this was how she had been trained. TMA-A did remove R1's medication cards from the cart for review and the label for the yellow tablets indicated the pills were Sinemet tablets 25-100mg give 2.5 tablets by mouth three times daily for Parkinson's disease and the label for the white tablet indicated the card held Lasix tablets 40mg give one tablet once a day for heart failure and localized edema. The medications administered did match physician orders. According to an interview 12/12/19, 9:33 a.m. the director of nursing (DON) stated it was her	21580		

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21580	Continued From page 23 expectation for nurses and TMAs to follow standard medication administration rights: checking the medication cards against the MAR to determine the right medication, the right dose, the right time and the right resident before giving the medications. DON stated she expected the medications to be checked against the MAR before being placed in the medication cup and again before returning the medications to storage. DON confirmed that simply reading a label without checking it against the MAR was not adequate to ensure a resident was receiving the correct medications and could result in a medication error. DON also confirmed placing unmarked medications in a pocket was against facility standards of medication administration. DON said the facility had recognized a problem with medication errors in the facility and had done audits and training with nurses and TMAs in response to that problem; however, DON stated she was unsure if they had standardized the use of their facility software for documentation in the MAR. DON confirmed that different staff may be using the software in different ways and they did not have any competency training specifically related to the Medication Administration software. The facility used PointClickCare's electronic medication administration software. A training video by the manufacturer, available to users in the facility, indicated the person administering medication should mark "Y" from the choice of "Y/N" (yes-administer or no-do not administer) for each medication being prepared for administration. After the medications had been compared to the MAR, the video indicated the person giving the medications should "click on the yellow lock icon" to hide the screen. After administration, the nurse or TMA would return to	21580		

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21580	Continued From page 24 the computer program, re-open the screen to see the MAR and review the medications previously marked to ensure they were given. If they were not given the software allowed the user to change the "Y" to "N" but if no changes, the training indicated the user was simply to click on the "save" icon to document administration was complete. A policy on medication administration was requested and the facility provided a document titled Medication Administration dated 1/13/18. The policy indicated an objective of "administer medication in an effective and safe manner, in accordance with physician's orders and standards of practice." The procedure indicated the process was to check the name on the MAR matched the name on the medication label as well as the name of the medication, the dose, the route and the times to be given; in addition, this information was to be checked against the physician order in the resident's MAR. The procedure stated the identity of the resident should be confirmed and resident's should be observed while taking the medication. Following medication administration the nurse or TMA should immediately document in the MAR. The current facility policy does not include any instruction on use of the facility software. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review and update training for all nurses or medication aides to ensure that all persons who administer medications perform the task according to the same procedure. DON or designee could perform blind audits to ensure staff are following standards of practice for medication administration.	21580		

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	00104	A. BUILDING: _____ B. WING _____	C 12/12/2019

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21580	Continued From page 25 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21580		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure a response when temperatures for refrigerated medications fell below safe storage ranges, and facility failed to remove a bottle of expired Aplisol (TB testing solution) from the medication storage refrigerator. The expired Aplisol had the potential to affect any new admits or new staff after the date of 11/24/19 and the stored immunizations had the potential to impact any resident whom might have received a dose after the temperature dropped below safe storage levels. During an observation of the facility medication storage area on 12/10/19, 2:10 p.m. a document titled Daily Refrigerator/Freezer temperature year: 2019 was posted on the facility refrigerator for storing medication. The document covered the months of October, November and December up unto the date observed, 12/10/19. A trained medication aide (TMA)-A stated the night nurses were responsible to record the temperatures each night shift. The temperature log was reviewed and found that the recorded refrigerator	21610	Acknowledged and corrected.	1/21/20

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21610	Continued From page 26 temperatures fell below a posted 35 degrees F for safe storage of medications as follows: December: 12/10/19- 32 degrees 12/9/19- 30 degrees 12/7/19- 30 degrees 12/6/19- 32 degrees 12/5/19- 32 degrees 12/4/19- 30 degrees 12/2/19- 32 degrees 12/1/19- 32 degrees. November: 11/28/19- 30 degrees 11/27/19- 34 degrees 11/26/19- 30 degrees 11/25/19- 30 degrees 11/24/19-30 degrees 11/23/19- 32 degrees 11/18/19- 34 degrees 11/13/19- 30 degrees 11/10/19- 32 degrees 11/6/19- 32 degrees 11/2/19- 30 degrees October: 10/31/19- 32 degrees 10/30/19- 32 degrees 10/29/19- 34 degrees 11/27/19- 34 degrees 11/26/19- 32 degrees 11/25/19- 32 degrees 11/24/19- 34 degrees 11/22/19- 32 degrees 11/21/19- 34 degrees 11/12/19- 32 degrees 11/10/19- 34 degrees 11/4/19- 32 degrees 11/1/19- 32 degrees At the time of the observation a registered nurse	21610		

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21610	Continued From page 27 (RN)-A confirmed the temperatures were out of range for safe storage of medications and stated a response to the temperature would depend how long the refrigerator had remained at the posted temperature. The refrigerator was observed to have a thermometer that was sitting near the back of the refrigerator at that time which read approximately 43 degrees and RN-A confirmed the temperature at that time fell into the "green" range marked on the thermometer as appropriate for storage. RN-A stated it was unknown how long the refrigerator had remained below the safe storage temperature on the posted document and said they would need to contact the pharmacy to see what should be done with the stored medications. The medications observed to be in the refrigerator at that time were: Five unopened insulin pens containing Lantus insulin delivered that afternoon, 12/10/19 belonging to resident (R16). Four unopened vials of stock Engerix B (hepatitis B immunization solution) not opened, delivery date unknown. Three boxes with 22 doses remaining of Fluzone (influenza immunization) with eight doses missing. The box indicated the solution should have been stored at a temperature of no less than 35-36 degrees. It could not be determined who would have received the 8 missing doses or when they were administered. One box of nine Flucelvax doses with one missing. The box indicated the vaccine was to be stored between the temperatures of 36 and 46 degrees and "do not freeze." It could not be	21610		

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21610	Continued From page 28 determined who would have received the missing dose. According to an interview on 12/10/19, at 2:12 p.m. the director of nursing (DON) confirmed the refrigerator temperatures often fell below the safe storage temperature. DON was unable to confirm the medications were still safe to use. At that time, a container of Aplisol serum (to test for tuberculosis) was found in the refrigerator, opened but marked as "do not use after 11/24/19." DON confirmed that the solution would be considered expired, but she was unable to confirm if the solution was used after 11/24/19. Unknown if anyone received a test dose with possible frozen serum. DON stated she was going to call the pharmacy about what should be done. On 12/10/19, at 3:52 p.m. DON reported the pharmacy told her to destroy all of the medications except the insulin as they were no longer any good. At 3:57 p.m. DON reported the consulting pharmacist referred her to the Medical Director but did not feel there should be any ill effects from the medications if they had been given after having been frozen. At 4:11 p.m. the DON reported the Medical Director told her there should not be any problems and recommended against re-vaccinating any residents in the facility. A policy related to safe storage of medications was requested. A document titled Medication Storage dated 2/15/18 was provided and addressed medication storage. The policy indicated "medication with storage requirements for temperature, light or humidity controls must be stored to meet specifications for the	21610		

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21610	Continued From page 29 medication" and "medications will be monitored by the Nursing Staff to assure that they are not expired, contaminated, or unusable." Policy failed to indicate actions to take if a problem with medication storage should occur, such as low temperature readings for refrigerated medications. According to the Centers for Disease Control (CDC) influenza vaccines are "cold sensitive and damaged rapidly by freezing temperatures." Additionally, the CDC indicated, "The desired average refrigerator vaccine storage temperature is 40°F (5°C). Exposure to temperatures outside these ranges may result in reduced vaccine potency and increased risk of vaccine-preventable diseases." SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could train all staff in the importance of temperature control for insulin, immunizations and other medications requiring refrigeration according to manufacturer instructions. The DON could audit that temperatures have been checked, documented and any temperatures outside the posted safe zone have been appropriately responded to. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Field Crest Care Center) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/09/2020

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.

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K 000	Continued From page 1 FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Fieldcrest Care Center is a 1-story building. The original building was constructed in 1969 and was determined to be of Type II (111) construction, with a partial basement. In 1972, an addition was constructed and was determined to be of Type II (111) construction, with a full basement. In 1995, an addition was constructed and was determined to be of Type II (111) construction, with no basement. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 37 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291	Emergency Lighting	K 291		1/20/20

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K 291 SS=D	Continued From page 2 CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not have an emergency light in the generator building to provide illumination in the event of loss of power in accordance with the Life Safety Code NFPA 101 - 2012 edition (7.9, 18.2.9.1, 19.2.9.1) This deficient practice could affect 37 residents. Findings Include: On facility tour between 08:00 AM and 12:00 PM on 12/11/2019, observations and staff interview revealed the following: Observed during the walk-through inspection of the facility - generator building had no emergency lighting fixture This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 291	A new 12 volt battery powered emergency light fixture has been ordered for installation in the generator building to provide lighting in the event of power loss. When received the light will be installed in a timely manner. The Maintenance Director will monitor compliance with emergency lighting requirements in the generator building and other locations where emergency lighting is required.	
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 293		1/17/20

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K 293	Continued From page 3 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clear and unobstructed visability of exit signage in accordance with the Life Safety Code NFPA 101 - 2012 edition (19.2.10.1) This deficient practice could affect 37 residents. Findings Include: On facility tour between 08:00 AM and 12:00 PM on 12/11/2019, observations and staff interview revealed the following: Observed during the walk-through inspection of the facility - holiday decorations hung in resident corridors were obstructing visibility of exit signs at end of corridors This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 293	The Christmas decorations in the resident corridors that were obstructing the visibility of the exit signs at the end of the corridors were immediately removed. The Activity Director was informed of the required clearance adjacent to fire sprinklers. The other department Directors will be informed of fire sprinkler clearance requirements at the next weekly department meeting. Nursing staff will be educated on fire sprinkler clearance requirements during the January 17, 2020 educational meeting. The Maintenance Director will be responsible for monitoring compliance.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2	K 324		1/20/20

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K 324	Continued From page 4 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to properly maintain the range hood suppression system in accordance with the Life Safety Code NFPA 101 - 2012 edition (19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2) This deficient practice could affect 37 residents. Findings Include: On facility tour between 08:00 AM and 12:00 PM on 12/11/2019, observation and documentation reviewed revealed the following: Documentation review indicated that the Facility does not have records to confirm that the range hood suppression system had been tested six months prior to 10/21/2019 Documentation review indicated that the Facility range suppression system was past due for hydro	K 324	The Viking Automatic Sprinkler Company inspected and hydro tested the range hood suppression system January 8, 2020. The agreement with Viking includes semi-annual testing of the Ansul-R hood fire suppression system to meet Life Safety Code requirements. The maintenance director will be responsible for monitoring compliance.	

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K 324	Continued From page 5 testing. No records were provided to confirm that system has been hydro tested and passed. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 324		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interview, the facility failed to maintain proper operation and maintence of the fire sprinkler system in accordance with the Life Safety Code NFPA 101 - 2012 edition (9.7.5, 9.7.7, 9.7.8, and NFPA 25) This deficient practice could affect 37 residents.	K 353	The Christmas decorations that were hung close to the fire sprinklers were immediately removed. The cabling that was zip-tied to the sprinkler system piping in the boiler room was relocated; required tests of the sprinkler system will be completed quarterly; and the sprinkler head in room R-59 covered with paint will	1/20/20

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K 353	Continued From page 6 Findings Include: On facility tour between 08:00 AM and 12:00 PM on 12/11/2019, observations, documentation review, and staff interview revealed the following: Observed during the walk-through inspection of the facility - holiday decorations hung from the ceiling in resident corridors and dining room were placed to close to sprinkler heads Observed during the walk-through inspection of the facility - cabling was zip-tied to the sprinkler system piping in the Boiler Rm of the facility Documentation review indicated that the Facility did not conduct quarterly tests of the sprinkler system for Q1, Q2, and Q4 Observed during the walk-through inspection of the facility - sprinkler head located in RM R-59 was covered with paint This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353	be replaced. The staff have been/will be instructed on the clearance requirements adjacent to the fire sprinkler heads. The maintenance director is aware that sprinkler system pipes are not to be used as supports for wires, cables, etc. To ensure that sprinkler system tests are completed quarterly as required, the tests will be added to a task calendar. The Viking Automatic Sprinkler Company will be replacing the sprinkler head in room R-59. The Maintenance Director will be responsible for monitoring compliance with fire sprinkler head clearance and sprinkler system pipe requirements. The Maintenance Director will also monitor compliance with quarterly sprinkler head testing and replacement of the sprinkler head in room R-59.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 355	All fire extinguishers were inspected	1/7/20

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K 355	Continued From page 7 facility failed to conduct monthly inspection of the fire extinguisher in the Elevator Rm in accordance with the Life Safety Code NFPA 101 - 2012 edition (19.3.5.12, NFPA 10) This deficient practice could affect 37 residents. Findings Include: On facility tour between 08:00 AM and 12:00 PM on 12/11/2019, observations and staff interview revealed the following: Observed during the walk-through inspection of the facility - the fire extinguisher located in the Elevator Rm had no monthly signature and date of inspection since 02/2019 when annual was completed by external vendor This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 355	January 7, 2020 by the Viking Automatic Sprinkler Company. The facility has an agreement with Viking Automatic Sprinkler Company for annual inspection of all fire extinguishers including the fire extinguisher in the elevator control room. The Maintenance Director will conduct monthly inspections of fire all extinguishers. The Maintenance Director will monitor compliance with monthly and annual fire extinguisher inspections.	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by:	K 511		1/20/20

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K 511	Continued From page 8 Based on observation and staff interview, the facility failed to properly secure electrical panels in the resident corridor in accordance with the Life Safety Code NFPA 101 - 2012 edition (NFPA 70, 19.5.1.1, 9.1.1, 9.1.2) This deficient practice could affect 37 residents. Findings Include: On facility tour between 08:00 AM and 12:00 PM on 12/11/2019, observations and staff interview revealed the following: Observed during the walk-through inspection of the facility - unsecured electrical panel in the resident corridors adjacent to the Nurses Station in the Dining Rm This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 511	The electrical panel door which had been left unlocked by an electrician after completing repairs was immediately secured. The security of the wall panels will be checked on a monthly basis. The security checks will be added to the monthly maintenance task list. The Maintenance Director will monitor compliance through observation and review of the task logs.	
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:	K 712		1/20/20

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K 712	Continued From page 9 Based on document review and staff interview, the facility failed to conduct fire drills in accordance with the Life Safety Code NFPA 101 - 2012 edition (19.7.1.4 through 19.7.1.7) This deficient practice could affect 37 residents. Findings Include: On facility tour between 08:00 AM and 12:00 PM on 12/11/2019, observation and documentation reviewed revealed the following: Documentation review indicated that the Facility does not have records confirming that 3rd shift conducted fire drills were conducted in 1st or 4th quarter. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 712	A spreadsheet is being used to monitor the date and time of fire drills. The recently hired Maintenance Director is aware of the requirement for quarterly fire drills on each shift. Fire drills will be conducted as required with compliance monitored by the administrator for the next two quarters. If noncompliance is noted, additional monitoring and staff training will be done.	
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80)	K 761		1/7/20

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K 761	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper operation for fire door hardware in accordance with the Life Safety Code NFPA 101 - 2012 edition (19.7.6, 8.3.3.1 (LSC), 5.2, 5.2.3 (2010 NFPA 80)) This deficient practice could affect 37 residents. Findings Include: On facility tour between 08:00 AM and 12:00 PM on 12/11/2019, observations and staff interview revealed the following: Observed during the walk-through inspection of the facility - the fire door assembly hardware did not latch properly operate properly upon testing (Door #18). This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 761	The closure fire door number 18 has been readjusted such that it automatically latches upon closing. All fire doors will be checked annually for proper latching when closing. The maintenance director will be responsible for monitoring compliance.	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised	K 918		1/20/20

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K 918	Continued From page 11 under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to engage the recommended change-out schedule for the generator battery in accordance with the Life Safety Code NFPA 101 - 2012 edition (6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)) This deficient practice could affect 37 residents. Findings Include: On facility tour between 08:00 AM and 12:00 PM on 12/11/2019, observations and staff interview revealed the following: Observed during the walk-through inspection of	K 918	The Maintenance Director has changed out the generator battery. The task of changing out the battery at the required interval will be included in the generator testing/maintenance contract that is being negotiated with Zeigler Power Systems. The Maintenance Director will be responsible for monitoring future compliance with timely generator battery change outs through an audit of the tasks completed by the Zeigler Power Company. Checking battery function/maintenance is included on the routine maintenance task list for the	

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K 918	Continued From page 12 the facility - the generator battery was dated 2015 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 918	generator.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain use of electrical equipment in accordance with the Life Safety Code NFPA 101 - 2012 edition (10.2.4.,10.2.3.6	K 920	All unapproved power strips and extension cords were removed. A notice will be posted in the facility newsletter reminding residents and families about	1/17/20

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K 920	Continued From page 13 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5) This deficient practice could affect 37 residents. Findings Include: On facility tour between 08:00 AM and 12:00 PM on 12/11/2019, observations and staff interview revealed the following: Observed during the walk-through inspection of the facility - extension cords in use in the following location: 1) Entrance of facility connected to holiday decorations; 2) Dining Rm behind piano connected to decorations; 3) Business Supply Rm connected to video monitoring system for the facility Observed during the walk-through inspection of the facility - power strip in used in the Employee Break Rm to power and appliance This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920	the use of extension cords and power strips in resident care areas. The staff will be informed of the approved use of extension cords and power strips during the January 17, 2020 staff meeting. The Maintenance Director will monitor compliance with safe use of electrical cords and power strips.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or	K 923		1/17/20

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K 923	Continued From page 14 limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper management of the Med Gas (O2) storage room in accordance with the Life Safety Code NFPA 101 - 2012 edition (11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)) This deficient practice could affect 37 residents.	K 923	Empty and full oxygen cylinders are stored separately. Use of two labeled, color-coded storage racks is in place to assist the staff in identifying appropriate placement of empty and full oxygen cylinders. The licensed staff have been informed that partially full tanks are to be stored with the empty tanks and only tanks that have not had the seal broken	

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K 923	Continued From page 15 Findings Include: On facility tour between 08:00 AM and 12:00 PM on 12/11/2019, observations and staff interview revealed the following: Observed during the walk-through inspection of the facility - oxygen cylinders are mixed with full and empty in the O2 storage room. Observed during the walk-through inspection of the facility - O2 storage room had incorrect signage to identify empty / full storage location of cylinders. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923	are to be stored as full tanks. Procedures for safe oxygen cylinder storage will be addressed during the January 17, 2020 staff meeting. The Maintenance Director will be responsible for monitoring compliance through random observation of oxygen storage areas.	