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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: N533

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 **1/7/2019** (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 :
Maria King, Assistant Program Manager 02/02/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/02/2019 (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

CMS Certification Number (CCN): 245431

January 7, 2019

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 December 24, 2018 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
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 7, 2019

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

RE: Project Number S5431031

Dear Administrator:

On December 4, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on November 15, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 7, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 26, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 15, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 24, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 15, 2018, effective December 24, 2018 and therefore remedies outlined in our letter to you dated December 4, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
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**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: N533

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00104

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(L1) **245431**
2.STATE VENDOR OR MEDICAID NO.
(L2) **304240500**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/15/2018** (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)

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 01/02/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/07/2019 (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:

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

December 4, 2018

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

RE: Project Number S5431030

Dear Administrator:

On November 15, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) as evidenced by the electronically attached CMS-2567 whereby corrections are required.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is December 25, 2018.

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.

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Maria King, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Mankato Place
12 Civic Center Plaza, Suite 2105
Mankato, Minnesota 56001-7789
Email: maria.king@state.mn.us
Phone: (507) 344-2716
Fax: (507) 344-2723

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 15, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 15, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
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 _____	11/15/2018

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 for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted November 13, 14 & 15, 2018, during a recertification survey. The facility is not in compliance with Appendix Z, Emergency Preparedness Requirements. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	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	E 041		12/6/18

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

Electronically Signed | 12/10/2018

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 _____	11/15/2018

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 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 [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	E 041		

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 _____	11/15/2018

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 2 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. (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 and interview the facility failed to ensure the emergency generator had a remote or externally mounted E-stop (emergency stop) button. This deficient practice could affect	E 041	Field Crest Care Center has established and will maintain an emergency preparedness program that describes the facility's comprehensive approach to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. BUILDING _____ B. WING _____	11/15/2018

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 3 the safety of all 44 residents, staff and visitors within the facility. Findings Include: During a facility tour between 9:00 a.m. and 1:00 p.m. on 11/15/18, observations and staff interview revealed the facility's emergency generator did not have a remote or externally mounted E-stop button. During the tour, the facility's maintenance director confirmed this deficient practice. Refer to LSC tag K-918.	E 041	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. To assure safe operation of the emergency generator, on December 6, 2018, Kestneer Electric Company installed an emergency stop button with a weather proof cover on the outside of the emergency generator building. The maintenance director/designee will be responsible for monitoring compliance with regulations addressing safety features, maintenance, and testing of the emergency generator system. Compliance with emergency preparedness requirements will be routinely reviewed during the monthly Safety and Quality Assurance and Performance Improvement (QAPI) Committee meetings and also during the January quarterly QAPI Committee meeting. In accordance with Life Safety Code.	
F 000	INITIAL COMMENTS On 11/13/18 through 11/15/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve	F 000		

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 _____	11/15/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 4 as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		12/24/18

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F 584	Continued From page 5 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the air temperature was comfortable for 7 of 7 residents (R5, R7, R15, R18, R29, R30 & R34) reviewed for environmental concerns. This had the potential to affect all 44 residents in the facility. The findings include: On 11/13/18 at 1:11 p.m., R34 was observed sitting in resident room wearing a winter coat. R34 stated, " It feels like it is too cold in here and the thermostat is set full bore." The thermostat in the resident's room was observed to be set at 88 degrees Fahrenheit. On 11/13/18 at 6:39 p.m., R5 was in observed in bed covered with blankets. R5 stated, "My room is cold and the hall is even colder." During a random observation on 11/14/18 at 9:50	F 584	Field Crest Care Center provides a homelike environment for residents with comfortable and safe temperature levels. The goal is to maintain an ambient temperature within a range (71 - 81 degrees Fahrenheit) that minimizes the risk of hypothermia or hyperthermia, and is comfortable for the residents. The facility respects and is responsive to the resident's preferences regarding room temperature. In response to the residents' concerns regarding cool temperatures, on November 21, 2018 Harty Mechanical Company reestablished boiler set points to increase the temperature of circulating water. This adjustment allows the option of higher temperature settings in the resident care and common areas.	

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F 584	Continued From page 6 a.m., the surveyor was passing by R15's resident room. A staff member was overheard to state to R15, "Well, I hope you warm up." A few moments later, R15 was observed to be sleeping in bed with numerous blankets piled on which were tucked around the resident's head with only a small portion of R15's showing. On 11/14/18 at 10:21 a.m., the speech language pathologist (SLP)-A was observed to bring R5 a second blanket from the blanket warmer due to her complaints of being cold in her room. SLP-A stated during interview on 11/15/18 at 12:09 p.m., "[R5] consistently complains about being cold, in her room." SLP-A added, "[R18] also complains of the cold and requests warm blankets all the time too." On 11/14/18 at 10:24 a.m., R34 was observed again to be wearing a winter jacket in his room. R34 stated, he wears "it (the jacket) every day due to how cold it is." R34's wife was present and confirmed the room felt chilly. On 11/15/18 at 11:32 a.m., R7 was observed covered with blankets in bed and R30 was up in room wearing a sweat suit. Both R7 and R30 said their room was too cold and that they had complained of it to staff several times but nothing had been done. During an interview 11/15/18 at 12:21 p.m., activity assistant (AA)-A stated, "We do have to get warm blankets for people, there's no specific time or place, but it seems there are always people who are cold." On 11/15/18 at 12:22 p.m., R29 was observed in	F 584	During the December 17, 2018 mandatory meeting, all staff will be instructed to inform their supervisor or the maintenance staff if a resident expresses concern about the temperature of their room or the adjacent common areas. The staff will be instructed on the procedure for completing a work request for maintenance services. Resident number 34 – The resident was discharged home November 15, 2018. Resident number 5 - The temperature in the resident's room was increased according to her preference. During the December 7, 2018 conversation with the Director of Social Services, the resident stated that her room temperature has been comfortable. The resident plans to return to her apartment next week. If the resident remains at the facility, she will be asked about her satisfaction with the room temperature during subsequent visits by the social service staff and during the quarterly care conference. Resident number 18 - The resident moved to an assisted living facility November 20, 2018. Resident number 15 - The temperature in the resident's room was increased according to her preference. During a visit by the Director of Social Services on December 7, 2018, the resident stated that her room temperature has been comfortable and she denied being cold. She was reminded to notify staff anytime	

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F 584	Continued From page 7 the dining room with warm blankets provided by AA-A. R29 was also covered with a lap blanket and wore long sleeves. R29 stated she felt "cold every day." During interview with nursing assistant (NA)-E on 11/15/18 at 12:26 p.m., nursing assistant (NA)-E verified residents complain of the cold and added, "we go through a lot of warm blankets!" NA-D, also present at that time, confirmed residents complain of the cold. When asked what was done about the cold NA-D stated, "We grab them a warm blanket." When asked whether maintenance could take any action about the temperature, NA-D said, "Oh, yeah, we can call him, he has his own line on the walkies." NA-D also explained there was a paper work order form staff could complete to notify maintenance of problems that occur after hours, and said if there was an emergency staff could reach the maintenance department via phone. On 11/15/18 at 11:32 a.m., the maintenance director (M)-A was asked about temperature readings in some of the resident rooms. M-A took temperature readings with the following results in Fahrenheit: RM #18A- 70.6 middle of room, and 72.5 by heat register RM #16A- 69.3 by heat register and 69 near the bed. M-A stated, "The register is giving out heat but not much." RM #24B- 72.7 by register, 69.8 in middle of room and 71.3 by bed RM #8A- 67.8 near register, M-A confirmed by touch the register was not giving off much heat. The resident was observed in bed and the temperature near the bed was 68. Just outside RM#8 in the hallway, the temperature was 70.3.	F 584	the room temperature was uncomfortable. The resident will be asked about her satisfaction with the room temperature during subsequent visits by the social service staff and during the quarterly care conference. Resident number 7 - The temperature in the resident's room was increased according to her preference. The resident moved home on November 23, 2018. Resident number 30 - The temperature in the resident's room was increased according to her preference. The resident moved home November 30, 2018. Resident number 29 - The temperature in the resident's room was increased according to her preference. During a December 7, 2018 conversation with the Director of Social Service, the resident stated she was comfortable and denied feeling cold. She was reminded to notify the staff if the room temperature was uncomfortable. The resident will be asked about her satisfaction with the room temperature during subsequent visits by the social service staff and during the quarterly care conference. To monitor compliance, temperatures in various resident rooms and common areas will be monitored at least three times per week by the maintenance staff until January 1, 2019. Temperature adjustments will be made if residents complain of being cold or if the air temperature is not between 71 and 81	

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F 584	Continued From page 8 M-A said it was his goal to keep the facility temperature about 70-72 degrees. When asked about a process for knowing about heat issues, MA-A stated he would expect staff to provide a report that residents were uncomfortable. MA-A said, "I don't know to fix it if they don't tell me." M-A verified he had not received any written requests to adjust the facility temperature. A copy of air temperature audits was requested but none were provided.	F 584	degrees Fahrenheit. Compliance will be reviewed during the next three monthly Quality Assurance and Performance Improvement Committee (QAPI) meetings and during the January quarterly QAPI Committee meeting.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely repositioning/offloading in order to prevent and/or reduce the risk for pressure ulcer development for 1 of 3 residents (R20) reviewed for pressure ulcers.	F 686	Based on the resident's comprehensive assessment, Field Crest Care Center staff provide skin care and treatment consistent with professional standards of practice that reflect resident preferences. The facility has policies and procedures for skin care that are consistent with	12/24/18

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F 686	Continued From page 9 The findings include: R20's Diagnosis Report dated 11/15/18, included diagnoses of dementia with behavioral disturbance and heart failure. R20's quarterly Minimum Data Set (MDS) assessment dated 10/9/18, indicated the resident had severe cognitive impairment. The MDS also indicated R20 required extensive assistance of two staff members for transfers, and extensive assistance of one staff member for bed mobility and personal hygiene. The MDS further indicated R20 was frequently incontinent of bladder and bowel and was at risk for pressure ulcers. The MDS indicated R20 had a stage 2 pressure ulcer that had developed since the previous assessment and included the following interventions: pressure reducing device for chair and bed, pressure ulcer care, and applications of ointments/medications. The MDS did not indicate whether R20 had a turning or repositioning program. R20's pressure ulcer Care Area Assessment (CAA) dated 7/9/18, indicated R20 required help with mobility, was incontinent of bowel and bladder, had experienced cognitive and physical decline, and was able to move herself in bed but needed reminders to do so. The CAA indicated R20's other risk factors for pressure ulcers included: depression, severe pulmonary disease, terminal illness, and antidepressant medications. The CAA also indicated R20 required a special mattress or seat cushion to reduce or relieve pressure, and included: Will proceed to care plan to promote good skin care and avoid complications of decreased mobility and incontinence of bowel and bladder.	F 686	professional standards of practice and that address the prevention of pressure ulcers/injuries and promote healing of existing pressure wounds. To prevent unavoidable pressure ulcers, the facility's procedures include 1) identifying whether the resident is at risk for developing a pressure ulcer/injury 2) assessing any pressure ulcers/injuries which are present upon admission 3) evaluating the resident's specific risk factors and changes in the resident's condition that may impact the development and/or healing of a pressure ulcer/injury 4) implementing, monitoring and modifying interventions in an attempt to stabilize, reduce or remove underlying risk factors and 5) providing treatment to heal existing pressure wounds and prevent the development of additional pressure ulcers/injuries. Considering the resident's choices/preferences, clinical condition, and physician input, a care plan is developed that includes goals and approaches to maintain/improve skin integrity. The policies and procedures for comprehensively assessing the residents' skin condition and risk factors were reviewed and found appropriate. An evaluation of the resident's skin condition, skin risk factors, and tissue tolerance will continue to be completed at the time of admission, readmission from the hospital, quarterly, and with significant changes in condition. The physician and dietary manager are notified of open lesions and	

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F 686	Continued From page 10 A Sitting/Tissue Tolerance Evaluation dated 7/6/18, indicated R20 required assistance with repositioning every three hours however, handwriting on the form indicated R20 should be repositioned every 2.5-3 hours. R20's Lying/Tissue Tolerance Evaluation form dated 7/7/18, indicated R20 should be repositioned every three hours when lying. R20's skin care plan dated 7/19/18, indicated R20 was at risk for impaired skin integrity related to impaired mobility and bladder incontinence with a goal of: skin will be free of signs of skin breakdown related to pressure and incontinence. R20's transfer care plan dated 10/4/18, indicated R20 required assist of two staff with a walker and gait belt for pivot transfers, or use of the standing lift if R20 had increased weakness. The care plan further directed staff to reposition R20 every 2.5-3 hours and as needed while sitting, but indicated R20 often refused repositioning and directed staff to re-approach and notify the nurse if she continued to refuse. R20's Braden Scale (tool to evaluate pressure ulcer risk)/Comprehensive Skin Risk Data Collection dated 10/3/18, indicated R20 was at moderate risk for pressure ulcers and R20's mobility was very limited, which was defined as: makes occasional slight changes in body or extremity position but was unable to make frequent or significant changes independently. The evaluation section on the Braden Scale indicated R20 had a stage 2 pressure ulcer on the right side of the coccyx related to new wheelchair and indicated as a result, a new cushion had been implemented. The evaluation further indicated R20 should be	F 686	the plan of care is revised to reflect skin related interventions. The resident's turning and repositioning frequency is communicated to the direct care givers who routinely inform the charge nurse of any skin problems noted during cares. Observation of skin on all areas of the body is part of the bathing protocol. During the mandatory educational meeting December 17, 2018, the nursing staff will be instructed on the facility's policies and procedures related to maintaining/improving skin integrity. Discussion will include the need to reposition residents according to their plan of care. The certified nursing assistants will be counseled that the performance expectations include being aware of and following the resident's individualized plan of care for turning and repositioning. The skin of resident number 20 was reassessed by a registered nurse on November 24 and December 8, 2018. It was noted that the right coccyx area was intact with no redness. Routine skin monitoring will continue. The resident's care plan was reviewed and found appropriate. To monitor compliance, the Director of Nursing/Designee will randomly observe the frequency of repositioning of residents who require extensive assistance or who are totally dependent in bed mobility and/or transferring for three weeks. If the residents are not being turned and	

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F 686	Continued From page 11 toileted/transferred every 2.5-3 hours. R20's skin progress note dated 10/3/18, indicated a pressure area to the right side of R20's coccyx had remained closed with epithelial tissue for four weeks with the implementation of intervention including: pressure reducing cushion, dietary supplement, repositioning schedule of every 2-3 hours, and good incontinence hygiene. During observation on 11/14/18 at 9:18 a.m., R20 was observed sitting in her wheelchair in the dining room with her eyes closed. R20's wheelchair was reclined approximately 30 degrees. A hospice nursing assistant (HNA)-A was sitting beside the resident and stated she had assisted R20 to the toilet with a standing lift around 8:30-8:45 a.m.. HNA-A said when she'd helped R20 to the toilet earlier, the resident had been incontinent of urine which was typical for her. At 9:40 a.m. on 11/14/18, R20 remained in seated in her wheelchair. R20 was leaning slightly forward and was eating her breakfast from a breakfast tray. At 9:47 a.m., R20 put her head down and closed her eyes. The wheelchair continued to be in the slightly reclined position. R20 remained in that position until 10:11 a.m. when the activity director (AD) asked her if she would like to go attend a communion service which R20 agreed to do. AD was observed to wheel R20 out of the dining room, but did not attempt or offer repositioning prior to taking R20 out of the dining room. At 10:50 a.m., R20 was wheeled back to the dining room and was parked next to a family member (FM). FM stated he had not attended the service, and R20 had been taken directly from the chapel back to the dining	F 686	repositioned according to their plan of care, additional staff education and monitoring will be done. Compliance will be reviewed during the January quarterly Quality Assurance and Performance Improvement (QAPI) Committee meeting. Skin issues are reviewed by the QAPI Committee on an ongoing basis.	

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F 686	Continued From page 12	F 686		

room. At 11:03 a.m., FM was observed to leave the dining room, and R20 continued to sit at the dining room table in the same reclined position. R20 remained in the dining room in the same position until 12:37 p.m. when NA-C wheeled R20 from the dining room to her room. At that time, NA-G adjusted R20's wheelchair to a 90 degree position. The two NAs then used a standing lift to stand R20, and pulled down her slacks and dry incontinent brief. R20 was cooperative. At that time, R20's right upper buttock was observed to have a pink area where the pressure ulcer had been and the lower right side of the pink area had a pinpoint open area.

During an interview on 11/14/18, at 12:40 p.m., NA-C stated she had not previously noticed the small open area on R20's right buttock. NA-C stated she would write down the times she checked on/repositioned/toileted a resident on her care sheet, and when time allowed, she would add the documentation to the resident's electronic medical record (EMR). NA-C stated R20 had last been toileted by HNA-A at about 8:30 a.m. NA-C verified at 10:14 a.m. R20 had been in the chapel and after that had been in the dining room eating lunch so she had not offered/attempted to reposition or toilet R20. NA-C stated R20 was supposed to be repositioned every 2.5-3 hours, and confirmed R20 had not been repositioned/offloaded for a little over 4 hours. NA-C then added an EMR entry regarding toileting that reflected R20 had been toileted at 9:11 a.m. was incorrect because at 9:11 a.m., R20 had been leaning to her left side so she (NA-C) had boosted/shifted R20 to sit straight in the chair. NA-C also confirmed that position change would not have relieved pressure to R20's coccyx.

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F 686	Continued From page 13	F 686		

During an observation on 11/14/18 at 12:45 p.m., NA-H entered R20's room, observed R20's bottom, confirmed the presence of the pinpoint opening on R20's right upper buttock, and stated she had not previously seen the pinpoint opening.

During an interview and observation on 11/14/18 at 2:17 p.m., registered nurse (RN)-A stated a stage 2 pressure ulcer had closed a few weeks ago and further stated, once wounds were closed they were monitored for four weeks to ensure ongoing interventions were implemented to prevent the areas from re-opening. RN-A stated resident's repositioning/toileting schedules were expected to be implemented to prevent skin breakdown. RN-A stated the NAs should have worked around the activity program for R20 in order to offer toileting/repositioning cares. RN-A further added, if a resident refused, staff were supposed to re-approach the resident, and stated any continued refusals should be communicated to the nurse who would document the behavior.

R20's progress note dated 11/14/18 at 6:13 p.m., indicated the resident had a small pin prick observed to the right side of the coccyx on the edge of scar tissue from a previous pressure injury. The progress note indicated Sensicare (a skin protectant cream), had been applied and the resident had been repositioned.

During an interview and observation on 11/15/18, at 7:34 a.m. RN-A stated she had assessed R20's right buttock yesterday afternoon, and confirmed there had been a pinpoint opening. RN-A stated she had written her assessment on a piece of paper but had not yet entered the documentation into the EMR. At 7:58 a.m., RN-A

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F 686	Continued From page 14 observed R20's right upper buttock with the surveyor and the pinpoint open area was no longer visible. During an interview on 11/15/18 at 10:56 a.m., the director of nursing (DON) stated R20 should have been offloaded, off the area of pressure, for at least one full minute. The DON stated repositioning schedules were supposed to be implemented as identified in a resident's care plan, so R20 should have been repositioned/offered repositioning before or after the communion service in the chapel. The DON further stated shifting/boosting R20 would not have been enough to relieve pressure to the area, but reiterated pressure point areas would need to be offloaded for at least two minutes for tissue re-perfusion to occur. The facility's 2/2013 Skin Integrity policy included: Residents receive services to prevent impairment, if impairment is present services are designed to promote healing and prevent infection... Care Planning: a) Care plans are developed to address and minimize risks based on the comprehensive assessment. b) the plan of care focuses on services that maintain skin integrity, prevent pressure ulcers, and provide treatment as prescribed, based upon the underlying problem which caused the formation...Prevention: a) Residents whom are unable to reposition themselves, have a repositioning schedule implemented based upon the Tissue Tolerance assessment.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688		12/24/18

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	245431	A. BUILDING _____ B. WING _____	11/15/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 15 §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to maintain range of motion (ROM) of extremities for 1 of 1 (R41) resident reviewed for ROM. The findings include: A Hospital Discharge Summary dated 7/25/18, indicated R41 was admitted to the facility after a fall at a previous living facility which resulted in a left hip fracture. The Discharge Summary also included: "current functional status ...exercises after hip fracture repair surgery: heel slides, active assisted hip flexion, active assisted hip abduction, ankle pumps, heel cord stretch, and upper extremity strengthening." Recommendations were documented on the Summary for R41 to have physical therapy evaluate and treat in the facility (nursing home).	F 688	Field Crest Care Center provides comprehensive care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being of all residents. The goal of Field Crest Care Center staff is to ensure that residents who enter the facility without limited range of motion do not experience a reduction in range of motion unless the resident's clinical condition demonstrates that a reduction is unavoidable. Based on the initial comprehensive assessment and routine subsequent reassessments, a resident with limited range of motion receives appropriate treatment and services to increase range of motion capability to the highest possible level and/or prevent further limitation in	

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F 688	Continued From page 16 On 11/13/18 at 3:39 p.m., R41 was observed lying in bed in a semi-fowler's position (semi-seated with head and trunk elevated, in this case R41's trunk was elevated approximately 30 degrees). R41's hips were observed to be flexed and her legs were extended. R41 was observed to have some scissoring of her legs, with her left leg crossing the right, and her ankles were extended so her toes were pointed out, and her arms were flexed at elbows and pulled in toward the center of her torso. On 11/13/18 at 6:35 p.m., R41 was observed sitting in the dining area in semi-fowler's position in a Broda chair (a wheeled chair that allows a person to be tilted back). Again, R41's hips were flexed, her knees were slightly flexed, but her ankles were extended. R41 was observed to keep her arms pulled in towards her body. 11/14/18 at 9:44 a.m., R41 was observed during a sensory activity. R41 was in Broda chair with hips flexed, knees slightly flexed and arms pulled in towards body. At 10:30 a.m., R41 was observed to be taken to church positioned in the same manner. On 11/14/18 at 12:05 p.m., R41 was observed in the dining room, positioned in the same manner. On 11/14/18 at 3:14 p.m. R41 was observed in bed with her hips flexed and knees bent, turned on her right side without a pillow placed between knees to prevent her left hip from internal rotation. Arms pulled in toward center of body. When questioned about R41's ROM, nursing assistant (NA)-B was observed at that time to attempt to assist R41 with ROM. NA-B turned R41 onto her back and assisted the resident to	F 688	range of motion. The range of motion component of the resident-centered plan of care is based on the physical and occupational therapist recommendations, a nursing assessment of the resident's functional status, and rehabilitative/restorative goals and participation preferences. Appropriate referrals to the physician and/or therapist are made if there is a decline in functional status. The policies and procedures for implementing therapy recommendations were reviewed and revised. During the mandatory meeting December 17, 2018, the nursing staff will be instructed on the procedures for assessing the resident for contractures and the need for range of motion exercises, as well as initiating the exercises. Resident number 41 - The resident's need for restorative services has been reassessed. The resident is receiving hospice services and is not a candidate for restorative/rehabilitative range of motion exercises due to pain during the exercises. Gentle range of motion which does not cause the resident discomfort will continue to be provided with dressing/grooming/bathing activities. The resident will continue to be positioned in good body alignment with the goal to prevent further contractures. The care plan was reviewed and revised accordingly.	

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F 688	Continued From page 17 raise her left arm upward at the shoulder joint. An audible pop could be heard and R41 grimaced. The resident's arm was extended straight out and could not go higher without discomfort. The NA-B was observed to lift R41's right arm, and was able to assist R41 to raise it above her head. During the observation, both elbows remained slightly flexed. At that time, lower extremity ROM was attempted, but R41 was stiff in the hip and knee joints and NA-B said she could not fully extend either joint. No further attempts were made due to R41 becoming resistive. On 11/15/18 at 7:17 a.m., R41 was observed in the dining area in a semi-fowler's position in her Broda chair. R41 was observed holding her left arm up with her right arm, elbows tucked in and right hand at chin level. Review of R41's record indicated R41 had been admitted to Hospice services on 8/27/18, and a significant change Minimum Data Set (MDS) assessment had been completed. The MDS dated 9/3/18, indicated R41 had limited ROM of lower extremities on one side. According to interview with registered nurse (RN)-A on 11/14/18 at 1:55 p.m., when asked if staff conducted ROM exercises with residents who had been admitted to hospice, RN-A stated R41 had not been assessed to have contractures, but that they would do ROM exercises if it was reported that R41 was developing them. RN-A stated she hadn't received any report of concerns. RN-B, the facility's MDS nurse, was interviewed on 11/14/18 at 2:43 p.m.. RN-B confirmed that R41 had limited range of motion on one side	F 688	To ensure that residents with limited range of motion are receiving range of motion exercises as appropriate, the Director of Nursing/designee will audit the records of all residents who have who have functional limitation in range of motion identified on the minimum data set (MDS). The records of new residents will be monitored for 60 days to ensure that appropriate treatment and services are initiated for residents with range of motion limitations coded on the MDS. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the January quarterly Quality Assurance and Performance Improvement Committee meeting.	

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F 688	Continued From page 18	F 688		

upon admission, and that according to the most recent MDS she continued to have limited ROM on one side. RN-B stated when a resident is unable to follow direction, such as R41, she talks to direct care staff to find out about the resident's level of mobility. RN-B further stated it was unlikely R41 would change much unless she would "go downhill." When asked if staff assist R41 with ROM exercises to maintain her current functional status, RN-B said the nursing assistants will move her arms and legs during care, but RN-B was unsure whether that was recorded anywhere. RN-B also confirmed R41's care plan did not include an intervention for staff to perform ROM exercises. On 11/14/18 later in the afternoon, R41's care plan was noted to have been revised to include; "gentle ROM as resident can tolerate." However, the resident's progress notes lacked any documentation regarding a current assessment of R41's ROM capabilities or limitations.

During an interview on 11/14/18 at 3:43 p.m., certified occupational therapy assistant (COTA)-A stated R41 was demonstrating a decline in condition since admission. COTA-A furhter stated, "A hip fracture would certainly reduce her ROM." COTA-A confirmed the therapy department had not sent a recommendation to nursing for ROM for R41. COTA-A also said therapy could work with residents to help set up a plan for ROM even if the resident was receiving hospice services.

According to the Physical Therapy (PT) Plan of Care initiated 7/26/18, R41 had been referred to PT as she "would benefit from continued therapy for strength, ROM, balance, transfers and gait to maximize functional mobility and safety." The

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F 688	Continued From page 19 notes indicated R41 had been discharged from PT on 8/26/18 to the care of hospice. A hospice nurse progress note dated 11/8/18, indicated R41 had the following problems: contracture, history of falls, limited range of motion and weakness. Further, the hospice standing orders indicated R41 could have a PT evaluation as needed. During an interview on 11/15/18 at 10:27 a.m., the director of nursing (DON) stated the MDS nurse might assess ROM by reading charting or by conducting interviews with the direct care staff. When asked if a nursing assistant could identify whether a person was getting contractures, the DON stated they could not. As to whether ROM exercises should be implemented for a resident, the DON said it was her expectation that a discussion regarding decreased mobility would occur during interdisciplinary team (IDT) meetings, and with the family. R41's progress notes were reviewed and failed to indicate whether ROM exercises had been discussed with the IDT or with the family. A facility policy related to assessment of range of motion or performance of range of motion was requested but not provided.	F 688		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F 732		12/24/18

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F 732	Continued From page 20 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to update the staff posting when staffing changed. This had the potential to affect all 44 residents residing at the facility as well as family/visitors.	F 732	As required Field Crest Care Center posts the following information in a clear and readable format in a prominent location: (I) Facility name.	

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F 732	Continued From page 21 Findings Include: Staff postings and schedules were reviewed from 10/12/18 to 11/15/18; no staff postings were updated, even when staffing changes occurred on the actual staffing. The Staffing posted 10/19/18, indicated for the day shift 66.25 hours for the number of assistants/techs. The daily unit assignments indicated for the day shift, one nursing assistant called in and the facility was working on finding a replacement. No changes had been made to reflect the actual hours worked on the Staff posting. The Staffing posted 11/6/18, indicated for the day shift 68 hours for the number of assistants/techs. The daily unit assignments indicated for the day shift, one trained medication aide (TMA) had called in and did not reflect the TMA hours had been covered. No changes had been made to reflect the actual hours worked on the Staff posting. On 11/15/18, at 12:05 p.m. the staff development coordinator verified the Staff postings did not reflect the changes made in staffing when the schedules were changed. On 11/15/18, at 12:53 p.m. the director of nursing (DON) stated, "I was not aware the schedules that were posted should reflect the changes in staffing." The DON stated, "we were not doing this but will start." The facility's undated Posting Direct Care Daily Staffing Numbers policy included: "3. Shift staffing information shall be recorded on the Daily	F 732	(ii) The current date. (iii) The total number and the actual hours worked by the registered nurses, licensed practical nurses, and certified nursing assistants directly responsible for resident care per shift. (iv) Resident census. The policy and procedures for preparing and posting the staffing/census information were reviewed and revised. During the mandatory meeting December 17, 2018, the staff will be informed that the person taking a call from a member of the nursing staff who will not be arriving for a scheduled shift has the responsibility to update the posted staffing information sheet to reflect any staffing level changes. The charge nurse will continue to update the posting to reflect changes in the resident census. The Director of Nursing will monitor compliance through random checks of the accuracy of the staff posting for 10 days. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed during the January quarterly Quality Assurance and Performance Improvement Committee meeting.	

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F 732	Continued From page 22 Staffing Report. The information recorded on the form shall include ...G. The actual time worked during that shift for each category and type of nursing staff."	F 732		

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	245431	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/15/2018**

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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		12/10/2018

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 29 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271	Discharge from Exits	K 271		12/24/18

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K 271 SS=F	Continued From page 2 CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (7.1.7, 19.2.7) This deficient practice could affect the safety of all (44) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/15/2018, observations and staff interview the following: Observed during the walk-through inspection of the facility - egress path at exit doors, east west end of facility - had uneven transition at grade; west end of facility - had separation between concrete slabs at grade This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 271	A metal plate will be installed which allows a gradual transition between the higher and lower concrete surfaces at the east and west egress doors. A metal plate will be installed to bridge the gap between the concrete slabs at the west exit. The maintenance director will be responsible for monitoring compliance.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration	K 291		12/6/18

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K 291	Continued From page 3 is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (7.9., 19.2.9.1) This deficient practice could affect the safety of all (44) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/15/2018, 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	Kestner Electric was contracted to install an emergency light fixture with battery backup in the generator building. The installation was completed December 6, 2018. The maintenance director will be responsible for monitoring compliance.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission	K 341		11/16/18

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K 341	Continued From page 4 paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (NFPA 70, NFPA 72, 19.3.4.1, 9.6, 9.6.1.8) This deficient practice could affect the safety of all (44) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/15/2018, observations and staff interview revealed the following: Observed during the walk-through inspection of the facility - fire alarm system ceiling junction box had a missing cover - above ceiling at smoke barrier adjacent to resident Rm J.T. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 341	A metal cover was installed over the fire alarm ceiling junction box above the ceiling at the smoke barrier adjacent to resident room number 3. The maintenance director will be responsible for monitoring compliance.	
K 346 SS=E	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the	K 346		11/16/18

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K 346	Continued From page 5 fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (9.6.1.6) This deficient practice could affect the safety of all (44) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/15/2018, observation and documentation reviewed revealed the following: Documentation review indicated that the Out of Service policy for the Fire Alarm System is 10 hrs This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 346	The Out of Service policy for the Fire Alarm System has been updated to reflect notification of the authority having jurisdiction and evacuation or an approved fire watch for all parties left unprotected by the shutdown after the alarm system has been out of service for more than four hours in a 24-hour period. The maintenance director will be responsible for monitoring compliance.	
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 _____	K 353		12/24/18

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K 353	Continued From page 6 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: The facility failed to comply with Life Safety Code (9.7.5, 9.7.7, 9.7.8, and NFPA 25) This deficient practice could affect the safety of all (44) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/15/2018, observations and staff interview revealed the following: Observed during the walk-through inspection of the facility - high storage of items in the O2 storage room This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353	The items on the shelves which exceeded the height limit in the oxygen storage room were removed. Storage containers that allow for the required 18-inch clearance will be purchased. During the mandatory educational meeting December 17, 2018, the staff will be instructed on the maximum height of storage containers and the amount of clearance that must be maintained to allow proper function of the fire suppression system. A sign has been placed in the oxygen storage room informing staff of the height limitations. The maintenance director/designee will be responsible for monitoring compliance through random audits of item placement in the storage rooms.	
K 355 SS=E	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:	K 355		11/19/18

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K 355	Continued From page 7 The facility failed to comply with Life Safety Code (19.3.5.12, NFPA 10) This deficient practice could affect the safety of all (44) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/15/2018, observations and staff interview revealed the following: Observed during the walk-through inspection of the facility - last date of inspection recorded on fire extinguisher(s) tags was 07/XX/18 - no specific date This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 355	All fire extinguishers have been inspected by the maintenance staff and dated and initialed to verify inspection. Fire extinguisher inspections are included on the monthly maintenance task list. The maintenance director/designee will be responsible for monitoring compliance with required fire extinguisher inspections.	
K 511 SS=F	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: The facility failed to comply with Life Safety Code	K 511	Installation of an additional dryer is	12/24/18

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K 511	Continued From page 8 (NFPA 54, 19.5.1.1, 9.1.1, 9.1.2) This deficient practice could affect the safety of all (44) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/15/2018, observations and staff interview revealed the following: Observed during the walk-through inspection of the facility - Laundry Rm - flex dryer exhaust hose and looping of the hose Observed during the walk-through inspection of the facility - unsecured electrical panel in the resident corridors: adjacent to Med Rm; adjacent to east hallway smoke barrier doors; across the hallway from Rm #3 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 511	planned for December 10, 2018. As part of the installation process, all flexible dryer hoses will be replaced with rigid dryer exhaust piping. All electrical panels in resident care areas will be secured. The lock will be replaced on one panel. All other electrical panels in the resident care areas have been locked. The security of the wall panels will be checked on a quarterly basis. The security checks will be added to the quarterly maintenance task list. The maintenance director/designee will be responsible for monitoring compliance.	
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.	K 712		12/24/18

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K 712	Continued From page 9 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.7.1.4 through 19.7.1.7) This deficient practice could affect the safety of all (44) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/15/2018, observation and documentation reviewed revealed the following: Documentation review indicated that the Facility does not records confirming that 3rd shift conducted fire drills in 3rd 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 Environmental Services/Maintenance Assistant who is starting employment December 10, 2018 will be instructed on the regulations addressing the frequency and timing of fire drills as well as the procedures for conducting and documenting the drills. The maintenance director will be responsible for monitoring compliance.	
K 918 SS=F	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 under load 30 minutes 12 times a year in 20-40	K 918		12/6/18

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K 918	Continued From page 10 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: The facility failed to comply with Life Safety Code (NFPA 110 - 5.6.5.6, 5.6.5.6.1) This deficient practice could affect the safety of all (44) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/15/2018, observations and staff interview revealed the following: Observed during the walk-through inspection of the facility - the emergency generator did not have an remote or externally mounted E-stop (emergency stop) button	K 918	Kestner Electric Company installed an emergency stop button with a weather proof cover on the outside of the emergency generator building December 6, 2018. The maintenance director will be responsible for monitoring compliance.	

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K 918	Continued From page 11 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 918		
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: The facility failed to comply with Life Safety Code (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 deficient practice could affect the safety of all	K 920	All sixplex electrical adapters and nonconforming power strips have been removed from service. During the mandatory educational meeting December 17, 2018, the staff will be	12/17/18

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K 920	Continued From page 12 (44) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/15/2018, observations and staff interview revealed the following: Observed during the walk-through inspection of the facility - six-plex electrical adapters connected to duplex outlet in: Nurses Office and Social Services Office Observed during the walk-through inspection of the facility - power-strips daisy-chained together in Finance Office; power strip found above ceiling being used as permanent wiring - located by cross-over to Crest View Villa fire doors; Refrigerator connected to power-strip - Admin. Office; Microwave and toaster connected to power-strip in Employee Break Rm This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920	informed of the regulations and facility policies addressing use of electrical adapters, extension cords and power strips. The maintenance director/designee will be responsible for monitoring compliance through observing for nonconforming electrical equipment during the routine safety inspections.	
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 limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing	K 923		12/17/18

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K 923	Continued From page 13 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: The facility failed to comply with Life Safety Code (5.1.3.3.2 and 5.1.3.3.3) This deficient practice could affect the safety of all (44) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/15/2018, observations and staff interview revealed the following:	K 923	Empty and full oxygen cylinders are now stored separately. Use of two labeled, color-coded storage racks will be implemented to assist the staff is identifying placement of empty versus full oxygen cylinders. During the mandatory educational meeting December 17, 2018, the staff will be informed of the oxygen storage related regulations and facility procedures.	

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K 923	Continued From page 14 Observed during the walk-through inspection of the facility - oxygen cylinders are mixed with full and empty in the O2 storage room. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923	The maintenance director will be responsible for monitoring compliance through random observation of oxygen storage practices.	