STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245431	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Field Crest Care Center	318 Second Street Northeast Hayfield, MN 55940

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure an oxygen tank was handled safely for 1 of 1 resident (R24) reviewed for safety hazards.Findings include: R24's face sheet printed on 2/18/26, included diagnosis of chronic obstructive pulmonary disease (COPD, a lung disease making it difficult to breathe).R24's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R24 required supervision or partial assistance with activities of daily living. R24 used oxygen. R24's physician orders dated 2/4/26, indicated room air - 2 lpm (liters per minute) oxygen via NC (nasal cannula) with exercise/activity to maintain oxygen saturation greater than 88%. R24's care plan with revised date of 2/11/26, indicated the resident had COPD. Oxygen settings: Room air - 2 LPM O2 via NC with exercise/activity - attempt to titrate to room air to maintain oxygen saturations greater than 88%. During an observation on 2/18/26 at 8:00 a.m., an E-size oxygen tank was observed standing unsecured in the hallway outside of the beauty shop. There had been oxygen tubing draped on it. During an interview on 2/18/26 at 8:02 a.m., nursing assistant (NA)-A stated the tank belonged to a resident who was in the beauty salon getting her hair done. NA-A did not know if the tank standing unsecured posed a safety risk. NA-A did not recall specific training on oxygen tank safety. During an interview on 2/18/26 at 8:05 a.m., NA-B approached the tank and said she had asked a nurse about it who said it can't be left unsecured as it created a trip hazard and if knocked over, could explode. NA-B stated she had received oxygen safety training. NA-B stated the beautician had removed the tank from the cart and put it in the hallway. During an interview on 2/18/26 at 8:06 a.m., NA-C brought an oxygen tank hand cart and placed the tank into the cart. NA-C stated an unsecured oxygen tank was a safety risk because the tank could fall over and explode. During an interview on 2/18/26 at 8:14 a.m., beautician (B)-B, stated she did not remove the oxygen tank from R24's wheelchair and place it in the hallway. B-B stated she was aware oxygen could not be used in the salon, but it would not be up to her to remove a tank from a resident. During an interview on 2/18/26, at 10:15 a.m., NA-A stated she had removed the oxygen tank from R24's wheelchair after escorting R24 to the beauty salon, and had placed the tank in the hallway, unsecured. NA-A stated she was now aware oxygen tanks needed to be placed in a cart and not left standing unsecured.During an interview on 2/18/26 at 12:30 p.m., the co-executive director (CED)-A who was also director of social services, stated she had been made aware of the unsecured oxygen tank by staff and would have expected staff to adhere to safe practices per policy. CED-A provided a policy titled Oxygen Storage, Maintenance, Handling and Use dated 1/27/18, which NA-A had signed off on, on 11/6/18 as part of oxygen safety training. The policy indicated oxygen cylinders would be stored in racks with chains, sturdy portable carts, or approved stands. Oxygen cylinders would never be left free-standing.Facility Oxygen Storage, Maintenance, Handling and Use policy dated 1/16/26, indicated oxygen cylinders would be stored in racks with chains, sturdy portable carts, or approved stands. Oxygen cylinders would never be left free-standing.

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.

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