Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 14, 2024

Administrator
Frazee Care Center
219 West Maple Avenue
Frazee, MN 56544

RE: CCN: 245299
Cycle Start Date: November 6, 2024

Dear Administrator:

On November 6, 2024, a 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 6, 2025 (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 6, 2025 (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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

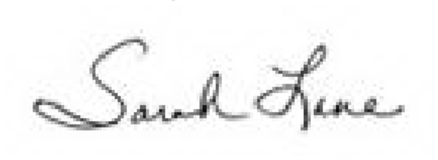
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	219 WEST MAPLE AVENUE FRAZEE, MN 56544

(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 On 11/4/24 to 11/6/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/4/24 to 11/6/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		12/2/24

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

Electronically Signed | 11/22/2024

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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F 641	Continued From page 1 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately code the oral/dental section of the Minimum Data Set (MDS) for identified dental issues for 1 of 1 residents (R13) reviewed for dental services. Findings include: R13's quarterly MDS dated 8/7/24, identified R13 had severe cognitive impairment, and diagnoses which included: Alzheimer's disease, anxiety, and depression. R13's significant change MDS dated 2/7/24, identified R13 had no natural teeth or fragments. R13's significant change Care Area Assessment (CAA), dated 2/15/24, identified R13 lacked natural teeth, did not report complications and denied need for dental check-up at that time. Identified R13 wore upper dentures and staff were to assist with cleaning and placement as needed and R13 refused lower dentures. R13's Dental/Oral Data Collection Tool dated 5/6/24, identified R13 only wore upper dentures, no teeth lower jaw, and did not wish dental visit as nothing had worked in the past and was fine. R13's Dental/Oral Data Collection Tool dated 8/5/24, identified R13 only wore upper dentures, no teeth lower jaw, and did not wish dental visit as nothing had worked in the past and was fine. R13's Dental/Oral Data Collection Tool dated	F 641	F641 - Accuracy of Assessment Corrective Action: A modification to the MDS for R 13 was completed to accurately reflect oral/dental status. Identify Other Residents: All residents have the potential to be affected by the alleged deficient practice. Action to Prevent a Recurrence: A review of other residents will be completed to ensure the most recent Dental/Oral Data Collection Tool accurately reflects the status of other identified residents, and to ensure that section L is coded correctly based on the Dental/Oral Data collection tool. MDS modifications will be completed for other residents as needed based on the findings. The policy for Nursing Documentation was reviewed and remains current. Licensed nursing staff will be retrained on the policy. Alleged Date of Compliance: 12/2/24 Ongoing Monitoring: Weekly clinical review audits will be conducted to ensure Dental/Oral Data Collection tools are completed accurately,	

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F 641	Continued From page 2 8/22/24, identified R13 had own teeth and upper partial. R13 was seen by ATD hygienist, likely root tips in upper right (UR) and decay in upper left (UL). R13 mandible (lower jaw) was edentulous (toothless) with minimal ridge remaining. R13's Dental/Oral Data Collection Tool dated 11/4/24, identified R13 only wore upper dentures, no teeth lower jaw, and did not wish dental visit as nothing had worked in the past and was fine. R13's care plan revised 8/20/24, identified R13 was at risk for complications with deficits with activities of daily living (ADL)s related to current medical/physical status. R13's interventions included set up, assist of one as needed for hygiene and oral care completed. R13's care plan identified at risk for complications with dental status, and upper dentures and no teeth on bottom. Interventions included to coordinate arrangements for dental care, transportation as needed/as ordered. provide dental care as needed. R13's Apple Tree Dental Oral/Dental Assessment Form dated 8/22/24, identified likely root tips in upper right UR and decay in upper left UL. Mandible was edentulous with minimal ridge remaining. R13 would like to see doctor of dental surgery (DDS) for broken teeth. During an observation on 11/4/24 at 11:40 a.m., R13 was sitting in recliner in room, eyes closed, dressed in street clothes. Partial was noted in water in dental cup by sink. During an interview on 11/6/24 at 9:30 a.m., registered nurse (RN)-A confirmed R13's Dental/Oral Data Collection Tool had been	F 641	and dental status is coded correctly on the corresponding MDS. Three weekly audits will be conducted as follows: " 5x weekly for 2 weeks, then " 3x weekly for 2 weeks, then " Weekly x 2 week A summary of audit results will be reviewed by the IDT during the monthly QAPI meeting for further auditing recommendations. Monitored by: DON/Designee	

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F 641	Continued From page 3 completed on 11/4/24. R13 stated R13 had upper dentures, did not want dental visit and staff assisted her to brush her dentures. RN-A reviewed R13's electronic medical record, verified R13 was seen by Apple Tree Dental in August and FM-A wanted R13 to be seen by DDS for root tips in UR and decay in UL. At 12:31 p.m., during follow up interview, RN-A verified had just assessed R13, and verified R13 had two upper natural teeth that needed some treatment and R13 wore a partial. RN-A stated MDS's were completed off site and RN-A confirmed her assessment completed on 11/4/24, was not accurate. During an interview on 11/6/24 at 12:06 p.m., director of nursing (DON) confirmed the above findings of R13's Dental/Oral Data Collection Tool dated 11/4/24, and MDS was not accurate. DON stated the expectation was assessments and MDS were to be completed accurately. The facility policy titled Nursing Documentation (General) revised 2/23, identified the facility would document in a standardized manner of the care and services provided to a resident. The policy identified MDS completion as per Centers for Medicare & Medicaid Services (CMS) and Medicare guidelines. Back-up documentation from nursing staff was also completed.	F 641		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		12/2/24

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F 689	Continued From page 4 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions for 1 of 1 residents (R28) who had repeated falls in the facility and remained at high risk for falls. In addition, the facility failed to ensure an environment that was free of accident hazards, related to hot water temperatures in 4 of 6 resident rooms (R6, R10,R13, R185) tested for safe water temperatures. This deficient practice had the ability to affect all 4 residents who used water from the water faucets. Findings include: FALLS R28's quarterly Minimum Data Set (MDS) dated 9/27/24, identified R28 had moderate cognitive impairment and had diagnoses which included diabetes mellitus (DM), hypertension (elevated blood pressure), and anxiety disorder. Indicated R28 required supervision with toileting and transfers. Identified R28 had one fall since the last assessment. R28's annual Care Area Assessment (CAA) dated 8/2/24, identified R28 had reduced safety awareness and required staff assistance during transfers and ambulation. Identified staff would proceed with supportive care and functional status would be addressed in care plan. R28's Fall Risk Screening Tool dated 9/23/24, identified R28 had three or more falls in the past	F 689	F689 – Accidents/Hazards/Supervision Corrective Action: Nursing staff received re-education regarding following the Care planned intervention to prevent falls for residents who are at high risk for falls. The hot water temperature was adjusted and tested to ensure water temperatures remain in the recommended water temperature zone. Identify Other Residents: Other high fall risk residents are at risk to be affected by the alleged deficient practice. Other residents on the identified unit are at risk of being affected by the alleged deficient practice regarding hot water temperatures. Action to Prevent a Recurrence: Other high- risk fall residents were identified. Staff was re-educated regarding their individual care plan intervention. The policy titled Accidents/Falls-HDGR was reviewed and remains current. Nursing Staff will be educated on the policy. The mixing valve was adjusted to ensure water was being mixed at appropriate temperatures. The facility policy Water Temperatures	

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F 689	Continued From page 5 six months and was at high risk for falls. R28's care plan revised 10/2/24, identified R28 had a history of falls and was non compliant with therapy recommendations for ambulation and transfers. R28's interventions included: encourage resident to use Front wheeled walker when transferring in room, Call light positioned for easy access and staff to place w/c legs in wheelchair bag on back of w/c when resident in room to prevent from tripping on them. Identified R28 required assistance with dressing, toilet use, and transfers. R28's Kardex undated, identified staff were to place wheelchair legs (foot pedals) in wheelchair bag on back of wheelchair when resident was in her room to prevent from tripping on them. Review of R28's progress notes from 7/1/24 to 11/4/24, identified the following: -7/12/24 at 6:25 p.m., found sitting on the floor with legs out in front of her facing recliner. R28 stated she was transferring from wheelchair to the recliner and tripped and fell. R28 had several skin tears to right arm and elbow, no other injuries noted. Intervention: staff to place wheelchair legs in wheelchair bag when R28 was in her room. -8/4/24 at 8:00 p.m., found laying on left side with back towards the bed in room. R28 stated she was trying to turn oxygen concentrator on. two skin tears to left forearm, no other injuries noted. Intervention: oxygen concentrator moved next to bedside. -10/1/24 at 4:50 p.m., found on floor next to	F 689	was reviewed and remains current. Maintenance staff will be re-educated on the policy. Alleged Date of Compliance: 12/2/24 Ongoing Monitoring: Weekly visual audits will be conducted to ensure care planned interventions are implemented as indicated by the plan of care for residents who are evaluated to be at high risk for falls. Three weekly visual audits will be conducted as follows: • 5x weekly for 2 weeks, then • 3x weekly for 2 weeks, then • Weekly x 2 week Weekly water temperature audits will be conducted to ensure water temperatures remain in the recommended water temperature zone. A summary of audit results will be reviewed by the IDT during the monthly QAPI meeting for further auditing recommendations. Monitored By: DON/Designee	

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F 689	Continued From page 6	F 689		

nightstand. Skin tear to left forearm, no other injuries noted. R28 was self transferring. Intervention: anti roll backs on wheelchair.

-10/11/24 at 9:00 a.m., Found on floor in room. R28 attempted to place clothes in hamper and fell on floor. Intervention: Therapy screen, lowered back of wheelchair seat.

During an observation on 11/4/24 at 1:27 p.m., R28 was seated in her room in a recliner with a wheelchair on her right side which had two foot pedals applied and a large empty black bag on the back of the wheelchair.

During an observation on 11/4/24 at 3:47 p.m., R28 was coming out of the bathroom in her room seated in a wheelchair which had two foot pedals applied and a large empty black bag on the back of the wheelchair.

During an observation on 11/5/24 at 8:48 a.m., R28 was seated in her room in a recliner with a wheelchair on her left side which had two foot pedals applied and a large empty black bag on the back of the wheelchair.

During an observation on 11/5/24 at 9:53 a.m., R28 remained seated as noted above in her recliner with a wheelchair on her left side which had two foot pedals applied and a large empty black bag on the back of the wheelchair.

During a joint interview on 11/5/24 at 9:55 a.m., nursing assistant (NA)-A and registered nurse (RN) -C verified R28 was seated in a recliner in her room with a wheelchair next to her which had two foot pedals applied. NA-A stated the foot pedals should not have been on R28's wheelchair

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F 689	Continued From page 7 because she had tripped on the wheelchair pedals and fell in the past. RN-C stated her expectation was that R28's wheelchair foot pedals would have been placed in the black bag behind R28's wheelchair anytime R28 was in her room. During an interview on 11/5/24 at 10:05 a.m., RN manager (RN-M) verified R28 had several falls in the facility. RN-C stated one of R28's falls had been related to R28 tripping over her wheelchair pedals while in her room therefore R28's wheelchair pedals were to be placed in the bag on the back of R28's wheelchair anytime R28 was not being transported by staff. RN-M indicated her expectation was that care planned interventions would have been followed. During an interview on 11/5/24 at 1:19 p.m., director of nursing (DON) verified R28 had several falls in the facility. Verified R28's wheelchair pedals were to be placed in a bag in the back of the wheelchair anytime R28 was in her room as a fall intervention. DON indicated her expectation was that care planned interventions would have been followed. HOT WATER On 11/4/24 at 12:02 p.m., during resident screening the water temperature in R6, R10, R13, and R185, felt very warm to the touch after running water for only a few minutes. On 11/4/24 at 12:32 p.m., maintenance director (MD) verified the water in R6, R10, R13, and R185's room felt too hot and used a thermometer to measure the water temperatures using the facility thermometer in resident rooms registered	F 689		

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F 689	Continued From page 8	F 689		

as follows:

-R6's room 213 water was 122.2 degrees F.
-R10's room 214 water was 122 degrees F.
-R13 room 120 water was 122.2 degrees F.
-R185 room 125 water was 122 degrees F.

During an interview on 11/4/24 at 2:40 p.m., registered nurse (RN)-C verified all four residents were at risk for potential burns when the water was too hot.

During an interview on 11/5/24 at 8:00 a.m. MD verified the above rooms were too hot according to State and Federal guidelines. MD stated he had completed random audits of water temps in the past month. MD stated at some point in the last month, the aerators (a device that screws into a faucet to control the amount of water that comes out of the faucet) had been adjusted so there was more hot water coming from the faucets than should have been which could affect the temperature of the water coming from the above faucets. MD stated his expectation was that the water temperatures in all resident rooms would not exceed federal guidelines as water over 120 degrees F. had the potential to burn someone.

During an interview on 11/5/24 at 1:16 p.m., administrator stated his expectations were that the water temperatures would remain within the Federal guidelines.

Review of a facility policy titled Accidents/Falls-HDGR reviewed 11/23, identified the facility strived to promote safety, dignity, and overall quality of life for its residents by providing an environment that was free from any hazards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	219 WEST MAPLE AVENUE FRAZEE, MN 56544

(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 689	Continued From page 9 for which the facility had control and by providing appropriate supervision and interventions to prevent avoidable accidents. Identified, resident care plans should be evaluated and updated with each fall with a new and applicable intervention based on root cause. The focus was to be on prevention and maintaining a safe environment. further identified the resident's individualized care plan was to be updated with any changes or new interventions post fall/incident/accident, communicated to appropriate staff, and implemented. The facility policy Water Temperatures dated 1/22, identified Frazee Care Center would check hot water temperatures at least once a week randomly to ensure water temperatures were between 105-120 degrees F. (or as specified by State requirements). Indicated staff were to check resident rooms at the end of each wing on a rotating basis per facility policy.	F 689		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;	F 791		12/2/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	11/06/2024

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F 791	Continued From page 10 §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide arrangements for follow-up care with a dentist for 1 of 1 residents (R13) reviewed for dental care. Findings include: R13's quarterly Minimum Data Set (MDS) dated 8/7/24, identified R13 had severe cognitive impairment, and diagnoses which included:	F 791	F791 – Dental Services SNF Corrective Action: A dental appointment was scheduled for R 13. Identify Other Residents: All residents are at risk of being affected by the alleged deficient practice.	

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F 791	Continued From page 11 Alzheimer's disease, anxiety, and depression. R13's significant change MDS dated 2/7/24, identified R13 had no natural teeth or fragments. R13's significant change Care Area Assessment (CAA), dated 2/15/24, identified R13 lacked natural teeth, and did not report complications and denied need for dental check-up at that time. Identified R13 wore upper dentures and staff were to assist with cleaning and placement as needed and R13 refused lower dentures. R13's Dental/Oral Data Collection Tool dated 8/22/24, identified R13 had own teeth and upper partial. R13 was seen by ATD hygienist, likely root tips in UR and decay in UL. R13 mandible (lower jaw) was edentulous (toothless) with minimal ridge remaining. R13's Dental/Oral Data Collection Tool dated 11/4/24, identified R13 only wore upper dentures, no teeth lower jaw, and did not wish dental visit as nothing had worked in the past, and was fine. R13's care plan revised 8/20/24, identified R13 was at risk for complications with deficits with activities of daily living (ADL)s related to current medical/physical status. R13's interventions included set up, assist of one as needed for hygiene and oral care completed. Identified at risk for complications with dental status, and upper dentures and no teeth on bottom. Interventions included to coordinate arrangements for dental care, transportation as needed/as ordered. Provide dental care as needed. R13's Apple Tree Dental Oral/Dental Assessment Form dated 8/22/24, identified likely root tips in	F 791	Action to Prevent a Recurrence: A review will be completed to ensure any follow-up from the most recent progress notes from the dental hygienist has been completed as indicated. The Dental Services policy was reviewed and remains current. Licensed nursing staff will be educated on the policy. Alleged Date of Compliance: 12/2/24 Ongoing Monitoring: Following visits by the dental hygienist, the DON or designee will review progress notes for any new recommendations and ensure follow-up appointments have been scheduled per recommendations of the dental hygienist. Audits will be conducted following each visit by the dental hygienist for the next 90 days to ensure ongoing compliance. A summary of audit results will be reviewed by the IDT during the monthly QAPI meeting for further auditing recommendations. Monitored by: DON/Designee	

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	245299	A. BUILDING _____ B. WING _____	11/06/2024

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F 791	Continued From page 12	F 791		

upper right (UR) and decay in upper left (UL). Mandible was edentulous with minimal ridge remaining. R13 would like to see doctor of dental surgery (DDS) for broken teeth.

R13's progress notes reviewed from 8/1/24 to 11/6/24, identified the following;
-8/22/24 at 11:31 a.m., R13 seen today by ATD hygienist. Likely root tips in upper right UR and decay in UL. R13 would like to see DDS for broken teeth.
-9/24/24 at 4:34 p.m., writer followed up with family member (FM)-A regarding resident dental hygienist review. FM-A suggested to follow through with R13 to be seen by DDS for evaluation.
R13's progress notes lacked follow up for DDS evaluation was scheduled or completed.

During a telephone interview on 11/04/24 at 12:39 p.m., family member (FM)-A indicated the facility had spoken to her about having R13 seen by a dentist and she had stated she wanted the appointment to be scheduled. FM-A was not aware if an appointment had been scheduled.

During an interview on 11/6/24 at 9:30 a.m., registered nurse (RN)-A stated R13 had upper dentures, did not want a dental visit and staff assisted her to brush her dentures. RN-A reviewed R13's electronic medical record, verified R13 was seen by Apple Tree Dental in August and FM-A wanted R13 to be seen by DDS.

During an interview on 11/6/24 at 10:10 a.m., social services director (SSD)-A confirmed a call had been placed to FM-A and had agreed R13 was to be seen by DDS. SSD-A stated it was tied up in paper work, and stated she had not yet

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	245299	A. BUILDING _____ B. WING _____	11/06/2024

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F 791	Continued From page 13 finished faxing the request for R13 to be scheduled to be seen by DDS. SSD-A confirmed an appointment had not been scheduled. During an interview on 11/6/24 at 12:06 p.m., director of nursing (DON) stated SSD scheduled follow up appointments and transportation. DON confirmed R13 and FM-A had wanted a follow up appointment with DDS to be scheduled. DON stated if there were no sores or concerns noted, she would expect dental appointment requests be followed up on within a couple of weeks. DON indicated if the family or resident gave the approval to be seen by DDS, DON would expect the appointment to be scheduled within a couple of weeks. DON confirmed an appointment for R13 had not been completed. The facility policy titled Dental Services, revised 8/22, identified the community provided or obtained, from an outside resource, routine and emergency dental services to meet the needs of each resident. The community would assist the resident in making appointments by arranging transportation to and from the dentist's office.	F 791		

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	245299	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**11/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/05/2024. At the time of this survey, Frazee 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 11/22/2024

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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	245299	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**11/05/2024**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Frazee Care Center was constructed at three different times. The original building was constructed in 1971, is 1-story without a basement, and was determined to be of Type II(111) construction. In 1979 the north 200 wing addition was built. It is 1-story without a basement, was determined to be of Type II (000) construction, and is separated with 2- hour fire barriers from the main building. Additions to the 1979 building in 1993 include activities added to the west and the business/ main entrance	K 000		

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	245299	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**11/05/2024**

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FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE FRAZEE, MN 56544**

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K 000	Continued From page 2 addition to the east. These areas were determined to be Type V (111) construction, and the business / main entrance addition is separated from the apartment building with a 2-hour fire barrier. The facility has a capacity of 50 beds and had a census of 33 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		12/2/24

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	245299	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**11/05/2024**

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K 324	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.3 (9) and 19.3.2.5.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 11/05/2024 at 10:44 AM, it was revealed by observation that the residential stove in physical therapy does not have a locked switch, or a switch located in a restricted location, that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	K324 Cooking Facilities Corrective Action: The power cord to the stove was completely removed from the unit. Identify Other Residents: All residents have the potential to be affected by the alleged deficient practice. Action to Prevent a Recurrence: A sweep of the facility was conducted to ensure that no other cooking equipment was in areas accessible to residents. The stove in the therapy room will remain out of commission indefinitely. If a stove is desired, a new one will be purchased that will have a locked switch, or a switch located in a restricted location, that is on a timer, not exceeding a 120- minute capacity. Alleged Date of Compliance: 12/2/2024 Ongoing Monitoring: An audit will be conducted to ensure the cord is removed from the stove: 1x a week for 2 weeks 1x a week for 2 months Monitored by: Administrator/Plant ops	

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	245299	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**11/05/2024**

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FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE FRAZEE, MN 56544**

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K 324	Continued From page 4	K 324	Directors/Designee	
K 346 SS=C	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 fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire alarm out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/05/2024 between 09:30 AM and 11:30 AM, it was revealed by a review of available documentation that the fire alarm out of service policy that was provided at the time of the survey had outdated contact information for the Deputy Fire Marshal. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 346	K346 – Fire Alarm System – Out of Service Corrective Action: The updated contact information for the deputy fire marshal was updated on the fire alarm out of service policy. Identify Other Residents: All residents have the potential to be affected by the alleged deficient practice. Action to Prevent a Recurrence: The binder holding the life safety policies, including the fire alarm out of service policy was audited to ensure all contact information was correct and up to date. Alleged Date of Compliance: 12/2/24 Ongoing Monitoring: An audit will be conducted to ensure information is up-to-date on the fire alarm	12/2/24

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	245299	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**11/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE FRAZEE, MN 56544**

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K 346	Continued From page 5	K 346	out of service policy: 1x a week for 2 weeks 1x a month for 2 months Monitored by: Administrator/ Plant ops director/ designee	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. This deficient finding	K 353	K353 – Sprinkler System – Maintenance and Testing Corrective Action: The ceiling grid wiring was disconnected from the sprinkler pipe.	12/2/24

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	245299	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**11/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE FRAZEE, MN 56544**

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K 353	Continued From page 6 could have a widespread impact on the residents within the facility. Findings include: On 11/05/2024 at 10:28 AM, it was revealed by observation that the ceiling grid was wired to the sprinkler pipe above the ceiling in the corridor near storage room 100. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	Identify Other Residents: All residents have the potential to be affected by the alleged deficient practice. Action to Prevent a Recurrence: A sweep of the facility was conducted to ensure wiring was not connected to the sprinkler pipes in other locations Alleged Date of Compliance: 12/2/24 Ongoing Monitoring: The facility will do a random inspection of the ceiling grid, throughout the facility: 2x a week for 2 weeks 1x a week for 2 weeks 1x a week for 2 months Monitored by: Administrator/ Plant ops Director/ Designee	
K 354 SS=C	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service.	K 354		12/2/24

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	245299	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**11/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE FRAZEE, MN 56544**

(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
K 354	Continued From page 7 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire sprinkler out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/05/2024 between 09:30 AM and 11:30 AM, it was revealed by a review of available documentation that the fire sprinkler out of service policy that was provided at the time of the survey had outdated contact information for the Deputy Fire Marshal. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 354	K354 Sprinkler System – Out of Service Corrective Action: The updated contact information for the deputy fire marshal was updated on the fire sprinkler out of service policy. Identify Other Residents: All residents have the potential to be affected by the alleged deficient practice. Action to Prevent a Recurrence: The binder holding the life safety policies, including the fire sprinkler out of service policy was audited to ensure all contact information was correct and up to date. Alleged Date of Compliance: Ongoing Monitoring: An audit will be conducted to ensure information is up-to-date on the fire sprinkler out of service policy: 1x a week for 2 weeks 1x a month for 2 months Monitored by: Administrator/ Plant ops Director/ Designee	