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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 1NO7
Facility ID: 00730

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245299**

2. STATE VENDOR OR MEDICAID NO. (L2) **972153000**

3. NAME AND ADDRESS OF FACILITY
(L3) **FRAZEE CARE CENTER**
(L4) **219 WEST MAPLE AVENUE, PO BOX 96**
(L5) **FRAZEE, MN** (L6) **56544**

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 **09/19/2013** (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 **74** (L18)

13. Total Certified Beds **74** (L17)

10. THE FACILITY IS CERTIFIED AS:

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: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	74			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Marian Thornquist, HFE NE II 09/23/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 12/19/2013 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_X_ 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 **11/01/1985** (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
Posted 01/07/2014 CO. 1NO7

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **09/27/2013** (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

24-5299

At the time of the standard survey completed August 2, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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 are required. The facility was given an opportunity to correct before remedies were imposed.

On September 19, 2013 the Minnesota Department of Health completed a Post Certification Revisit (PCR) and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on August 2, 2013, effective September 5, 2013. Therefore, the remedies outlined in our letter dated August 19, 2013, will not be imposed.
See attached the CMS 2567B form for the results of the September 19, 2013 revisit.

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5299 December 19, 2013

Mr. Andrew Huhta, Administrator
Frazee Care Center
219 West Maple Avenue, P.O. Box 96
Frazee, Minnesota 56544

Dear Mr. Huhta:

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 September 5, 2013 the above facility is certified for:

74 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 74 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

September 23, 2013

Mr. Andrew Huhta, Administrator
Frazee Care Center
219 West Maple Avenue
PO Box 96
Frazee, Minnesota 56544

RE: Project Number S5299024

Dear Mr. Huhta:

On August 19, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 2, 2013. 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 September 19, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 2, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 5, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 2, 2013, effective September 5, 2013 and therefore remedies outlined in our letter to you dated August 19, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: 612-201-4124 Fax: 651-215-9697

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245299	A. Building B. Wing	9/19/2013

Name of Facility	Street Address, City, State, Zip Code
FRAZEE CARE CENTER	219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	**09/05/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**09/05/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**09/05/2013**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	**09/05/2013**	ID Prefix **F0327** Reg. # **483.25(i)** LSC	**09/05/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**09/05/2013**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	**09/05/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	**09/05/2013**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GA/AK	09/23/2013	31593	09/19/2013
CMS RO				

Followup to Survey Completed on: 8/2/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Protecting, Maintaining and Improving the Health of Minnesotans

September 23, 2013

Mr. Andrew Huhta, Administrator
Frazee Care Center
219 West Maple Avenue
PO Box 96
Frazee, Minnesota 56544

Re: Enclosed Reinspection Results - Project Number S5299024

Dear Mr. Huhta:

On September 19, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 2, 2013 with orders received by you on August 22, 2013 . At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: 612-201-4124 Fax: 651-215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

AH Form Approved
9/23/2013

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00730	A. Building B. Wing	9/19/2013

Name of Facility	Street Address, City, State, Zip Code
FRAZEE CARE CENTER	219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	**09/05/2013**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp.** LSC	**09/05/2013**	ID Prefix **20940** Reg. # **MN Rule 4658.0525 Subp.** LSC	**09/05/2013**
ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp.** LSC	**09/05/2013**	ID Prefix **21400** Reg. # **MN Rule 4658.0810 Subp.** LSC	**09/05/2013**	ID Prefix **21415** Reg. # **MN Rule 4658.0815 Subp.** LSC	**09/05/2013**
ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	**09/05/2013**	ID Prefix **21540** Reg. # **MN Rule 4658.1315 Subp.** LSC	**09/05/2013**	ID Prefix **21980** Reg. # **MN St. Statute 626.557 Sul** LSC	**09/05/2013**
ID Prefix **21995** Reg. # **MN St. Statute 626.557 Sul** LSC	**09/05/2013**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GA/AK	09/23/2013	31593	09/19/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/2/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1NO7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00730

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245299**

2. STATE VENDOR OR MEDICAID NO. (L2) **972153000**

3. NAME AND ADDRESS OF FACILITY
(L3) **FRAZEE CARE CENTER**
(L4) **219 WEST MAPLE AVENUE, PO BOX 96**
(L5) **FRAZEE, MN** (L6) **56544**

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) **11/01/2004**

6. DATE OF SURVEY **08/02/2013** (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 **74** (L18)

13. Total Certified Beds **74** (L17)

10. THE FACILITY IS CERTIFIED AS:

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
	74			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE NE II 08/29/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Program Specialist 09/27/2013 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_X_ 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 **11/01/1985** (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 **09/27/2013** (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN #245299

At the time of the August 2, 2013 standard survey, the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5278

August 19, 2013

Mr. Andrew Huhta, Administrator
Frazee Care Center
219 West Maple Avenue, PO Box 96
Frazee, Minnesota 56544

RE: Project Number S5299024

Dear Mr. Huhta:

On August 2, 2013, 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Gail Anderson
Minnesota Department of Health
1505 Pebble Lake Road, Suite #300
Fergus Falls, Minnesota 56537

Telephone: (218) 332-5140

Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 11, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 11, 2013 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 November 2, 2013 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.
We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 2, 2014 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5299s13.rtf

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

PRINTED: 08/19/2013
FORM APPROVED
OMB NO. 0938-0391

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 ____	08/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	219 WEST MAPLE AVENUE, PO BOX 96 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 000	INITIAL COMMENTS 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.	F 000	Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	Policies and procedures were reviewed regarding residents to resident altercations and the investigation process, including immediate reporting to the Common Entry Point (CEP)/ State Agency (SA). Staff has been educated on the policy and procedure on 8/27/13 and 8/28/13. Education includes facility VA policy, investigating events and reporting events to the Administrator immediately.	8/29/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrew C. [signature]
TITLE: Administrator
(X6) DATE: 8/28/13

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 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct thorough investigations and immediately report to the State agency (SA), resident to resident altercations between 2 of 2 residents (R56 and R57) involved in resident to resident altercations. In addition, the facility failed to immediately report to the State agency, injuries of unknown origin for 1 (R110) of 6 vulnerable adult reports reviewed in the sample. Findings include: The facility had not thoroughly investigated and immediately reported to the SA resident to resident altercations involving R56 and R57. R57 had diagnoses which included bipolar disease, dementia and anxiety. The quarterly Minimum Data Set (MDS) dated 6/18/13, identified R57 had severe cognitive impairment. Review of a Resident Incident Report dated 7/2/13, identified staff had witnessed R57 and	F 225	Any reported cases will be reviewed daily during IDT meetings to assure proper reporting and investigation has taken place and proper interventions are in place. A log of events will be kept for tracking. Administrator and/or designee will complete random audits x4 weeks of tracking logs to assure compliance and results will be reported at the QA meetings for further review and recommendations. Date of completion: 9/5/13	

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F 225	Continued From page 2 R56 in a hallway of the facility. When R57 got near R56, R57 reached out and hit R56 on the right arm and stated "you haven't been in church." The report indicated R56 hit R57 back after having been struck, staff then intervened and separated the two residents. The report identified the family and facility administrator had been notified, however, the report lacked documentation the incident had been thoroughly investigated and lacked documentation the resident to resident altercation had been reported to the SA. On 8/1/13 at 1:39 p.m., nursing assistant (NA)-K stated she was aware R57 did not like another resident in the facility (R56.) She stated "She hates him." On 8/1/13, at 1:58 p.m., NA-M confirmed R57 did not like the other resident (R56.) NA-M stated she thought R56 reminded R57 of someone from the past. NA-M indicated she was unaware of R56 having bothered R57 in the past. On 8/1/13 at 2:48 p.m., registered nurse (RN)-B stated R57 "hates" R56. RN-B went on to state R57 has said R56 is a "bum" and "the devil." RN-B stated R57 has previously received psychiatric care and has been identified with a history of zeroing in on one individual to release her anger and frustration. She confirmed R57 continues to single out R56 because she feels R56 is a worthless bum, and has pointed him out in the facility. During interview on 8/2/13, at 4:00 p.m. the director of nursing (DON) stated she was aware R57 did not like R56, and that R57 referred to R56 as "the devil." The DON confirmed the lack	F 225		

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F 225	Continued From page 3 of documentation of a thorough investigation of the resident to resident altercation. She stated the administrator had been notified, however verified the incident had not been reported to the SA. Review of a Resident Incident Report for R110, dated 1/22/13 at 10:05 p.m., revealed a nursing assistant had reported R110 had a bruise to the right forearm. The report indicated R110 was unable to say what had happened due to cognitive deficits from Alzheimer's disease. The bruise had been described as a purple bruise that measured 11 centimeters (cm) by 10.4 cm on the forearm. The cause of the bruise was unknown. The report indicated the physician and administrator had been notified of the bruise on 1/23/13 at 1:45 a.m. Review of the report sent to the SA revealed the bruising injury of unknown origin had not been reported to the SA until 1/24/13 at 1:00 p.m.. R110's quarterly Minimum Data Set assessment dated 12/30/12, identified R110 had severely impaired cognition and was totally dependent on facility staff for assistance with all activities of daily living. On 8/2/13, at 11:29 a.m. the DON confirmed the current facility Abuse Prevention policy directed staff to notify the SA immediately of any injuries of unknown origin and confirmed R110's incident had not been reported timely. Review of facility policy titled, "Abuse prevention/resident treatment" updated 11/2011, indicated incidents of potential abuse were to be thoroughly investigated and reported immediately to the facility administrator and State Agency in accordance with State law.	F 225		

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F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow their abuse prevention policies by failing to complete thorough investigations of resident to resident altercations and immediately report to the Sate Agency (SA) for 2 of 2 residents (R56, R57) and failed to timely report incidents to the SA for 1 of 6 vulnerable adult reports (R110) reviewed. Findings include: Review of facility policy titled, "Abuse prevention/resident treatment" updated 11/2011, indicated incidents of potential abuse were to be thoroughly investigated and reported immediately to the facility administrator and State Agency in accordance with State law. The facility had not thoroughly investigated and immediately reported to the SA resident to resident altercations involving R56 and R57. R57 had diagnoses which included bipolar disease, dementia and anxiety. The quarterly Minimum Data Set (MDS) dated 6/18/13, identified R57 had severe cognitive impairment. Review of a Resident Incident Report dated	F 226	The Vulnerable Adult Policy was reviewed in regards to resident to resident altercations and injuries of unknown origin and our investigation process, which includes immediate reporting to the CEP/SA. Staff has been educated on the Vulnerable Adult Policy and reporting guidelines on 8/27/13 and 8/28/13. Education includes facility VA policy, investigating events and reporting events to the Administrator immediately. Any reported cases will be reviewed daily during IDT meetings to assure proper reporting and investigation has taken place and proper interventions are in place. A log of events will be kept for tracking. Administrator and/or designee will complete random audits x4 weeks of tracking logs to assure compliance and results will be reported at the QA meetings for further review and recommendations. Date of completion: 9/5/13	

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F 226	Continued From page 5 7/2/13, identified staff had witnessed R57 and R56 in a hallway of the facility. When R57 got near R56, R57 reached out and hit R56 on the right arm and stated "you haven't been in church." The report indicated R56 hit R57 back after having been struck, staff then intervened and separated the two residents. The report identified the family and facility administrator had been notified, however, the report lacked documentation the incident had been thoroughly investigated and lacked documentation the resident to resident altercation had been reported to the SA. On 8/1/13 at 1:39 p.m., nursing assistant (NA)-K stated she was aware R57 did not like another resident in the facility (R56.) She stated "She hates him." On 8/1/13, at 1:58 p.m., NA-M confirmed R57 did not like the other resident (R56.) NA-M stated she thought R56 reminded R57 of someone from the past. NA-M indicated she was unaware of R56 having bothered R57 in the past. On 8/1/13 at 2:48 p.m., registered nurse (RN)-B stated R57 "hates" R56. RN-B went on to state R57 has said R56 is a "bum" and "the devil." RN-B stated R57 has previously received psychiatric care and has been identified with a history of zeroing in on one individual to release her anger and frustration. She confirmed R57 continues to single out R56 because she feels R56 is a worthless bum, and has pointed him out in the facility. During interview on 8/2/13, at 4:00 p.m. the director of nursing (DON) stated she was aware R57 did not like R56, and that R57 referred to	F 226		

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F 226	Continued From page 6 R56 as "the devil." The DON confirmed the lack of documentation of a thorough investigation of the resident to resident altercation. She stated the administrator had been notified, however verified the incident had not been reported to the SA. In addition, the facility failed to immediately report to the state agency, an injury of unknown origin for 1 (R110) of 6 vulnerable adult reports reviewed in the sample. Review of a Resident Incident Report for R110, dated 1/22/13 at 10:05 p.m., revealed a nursing assistant had reported R110 had a bruise to the right forearm. The report indicated R110 was unable to say what had happened due to cognitive deficits from Alzheimer's disease. The bruise had been described as a purple bruise that measured 11 centimeters (cm) by 10.4 cm on the forearm. The cause of the bruise was unknown. The report indicated the physician and administrator had been notified of the bruise on 1/23/13 at 1:45 a.m. Review of the report sent to the SA revealed the bruising injury of unknown origin had not been reported to the SA until 1/24/13 at 1:00 p.m.. R110's quarterly Minimum Data Set assessment dated 12/30/12, identified R110 had severely impaired cognition and was totally dependent on facility staff for assistance with all activities of daily living. On 8/2/13, at 11:29 a.m. the DON confirmed the current facility Abuse Prevention policy directed staff to notify the SA immediately of any injuries of unknown origin and confirmed R110's incident had not been reported timely. On 8/2/13, at 12:02 p.m., the facility administrator	F 226		

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F 226	Continued From page 7 confirmed the facility's policy was to report any incident of possible abuse immediately to the administrator, then to the SA.	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with residents' written plans of care for 2 of 2 residents (R67 and R3) in the sample with current pressure ulcers, and for 1 of 1 resident (R81) at risk for dehydration who required fluid monitoring. Findings include: R67 did not receive timely repositioning as directed by the care plan. R67's care plan revised 5/8/13, identified R67 had a current stage three pressure ulcer and directed staff to turn and reposition every two hours when laying in bed and every one and a half hours when sitting. During observation on 8/2/13 at 8:45 a.m., R67 was seated in a wheelchair at a table in the dining room for the breakfast meal. Following the breakfast meal, R67 was assisted back to her room where she remained seated in the wheel	F 282	POC for residents R67, R3 and R81 have been reviewed and revised as indicated. POC for residents at risk for skin impairment will be revised as indicated. All residents with fluid restrictions will have care plans directing their care and C.N.A POC shall also have this information. Staff has been trained on the use of the POC for nurses and NAR's Random Audits of turning schedules will be visualized by DON and/or Designee along with random audits to assure fluid restrictions are in place. Results will be reported at the QA meetings for further review and recommendations Date of compliance 9/5/13	

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F 282	Continued From page 8 chair until 10:15 a.m. At 10:16 a.m.nursing assistant (NA)-I and NA-J entered the room with a hoyer lift (a full body mechanical lift) and assisted R67 to transfer from the wheel chair to the bed. During interview on 8/2/13, at 10:26 a.m., NA-K stated brief morning (a.m.) cares had been provided for R67 because it was her bath day, so R67 had not been assisted to lay down. NA-K stated R67 had been in the wheel chair from 8:00 or 8:15 a.m. until 10:15 when transferred to bed. (2 hours and 1 minute.) During interview on 8/2/13, at 11:56 a.m., registered nurse (RN)-B verified R67's current care plan identified a repositioning schedule of 2 hours when in bed and 1.5 hours when sitting. RN-B stated staff are expected to follow the plan of care. R3 was not repositioned timely as directed by the care plan. R3's diagnoses included , chronic respiratory failure with ventilator management, cerebral palsy, and degenerative joint disease. The quarterly Minimum Data Set (MDS) dated 5/26/13, identified R3 had moderate cognitive impairment, was at risk for development of pressure ulcers and required total assistance of two staff for all activities of daily living. The document titled "Braden Scale For Predicting Pressure Sore Risk" dated 5/30/13, identified R3 had a high risk, with a score of 14. The care plan revised 2/13/13, identified R3 had a past history of a pressure ulcer and directed staff to reposition R3 every 2 hours and as	F 282		

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F 282	Continued From page 9 needed when in bed. On 8/1/13, at 7:25 a.m., R3 was observed laying on his back in bed. The head of the bed was elevated 30+ degrees, and the resident's eyes were closed. The resident was observed throughout the morning and remained in bed until 9:53 a.m., when NA-L and NA-M assisted R3 to reposition (2 hours and 28 minutes). During interview on 8/1/13 at 12:03 p.m., NA-M verified she had not assisted R3 with any cares prior to the a.m. cares provided and observed at 9:53 a.m.. During interview on 8/1/13, at 2:15 p.m., LPN-C stated she had provided tracheostomy cares for R3 around 7 a.m., but verified she had not repositioned R3 at that time because the night shift had repositioned him at 6:30-6:45 a.m. During interview on 8/2/13, at 3:12 p.m. RN-B verified R3's current plan of care indicated repositioning should be conducted every 2 hours in bed. RN-B stated staff "would be expected to follow the care plan and reposition [R3] every 2 hours. During interview on 8/2/13, at 3:15 p.m. the director of nursing verified the current repositioning schedules and stated she also "would expect staff to follow the care plan." R81, who had been identified as at risk for dehydration, did not receive fluid monitoring as directed in the care plan. R81's care plan dated 7/2/13, directed staff to provide assistance with meals, monitor intakes of foods and fluids at meals and to monitor intake	F 282		

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F 282	Continued From page 10	F 282		

and output.

Review of the Open Breakfast Intake Sheet:July 2013, revealed the facility had monitored fluid intake with the breakfast meal, however, the form lacked documentation of fluid monitoring done between meals.

Review of the Food and Fluid Intake Sheet, July 2013, revealed the facility had monitored fluid intake with the lunch and supper meals, however, had not documented fluid intake between meals.

During observation on 8/1/13 at 2:15 p.m., R81 was lying on the bed with her eyes closed. R81's lips were very dry with dried debris on the front surface of her teeth. No water or liquids were observed available for R81 in her room. At 3:40 p.m., R81 continued to rest in bed, with dry lips and thick sticky mucous observed on both corners of her mouth. An unopened straw was noted in a glass of water on the bedside table in the room. Although R81 stated she did not feel thirsty, she stated, "I should probably drink more."

During interview on 8/1/13 at 9:16 a.m., nursing assistant (NA)-C said she was not aware of R81's fluid intake and had not monitored her fluids. She indicated the group worksheets the NAs used also did not direct to monitor R81's fluids.

During interview on 8/2/13, at 11:52 a.m. the food service director (FSD) confirmed R81 was at risk for dehydration and interventions should have been put in place in an attempt to prevent dehydration. She indicated the facility monitored R81's fluids with meals, however, had not been monitoring fluid intake between meals. The FSD confirmed fluid monitoring had not been done for

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F 282	Continued From page 11 R81 and stated "Unfortunately I missed it." The Comprehensive Care Plan policy dated 4/1/08, indicated after a comprehensive assessment was completed, a care plan was developed to meet the individual needs for each resident. The facility policy dated April 1, 2008, titled, Pressure Ulcers/Skin Integrity/Wound Management identified appropriate turning and repositioning schedules would be put in place per assessment.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely repositioning for 2 of 3 residents (R67, R3) identified with a current pressure ulcer and history of pressure ulcers. Findings include: R67 had a current stage 3 pressure ulcer and did	F 314	POC for R76 and R3 have been reviewed and revised as indicated POC for other residents at risk for skin impairment will be revised as indicated per assessments. Policy and procedures for Care Planning have been reviewed. Staff has been trained on the use of the POC for nurses and C.N.A care plans related individual turning schedules. Random audits will be performed by DON and/or Designee weekly x 4 weeks to ensure compliance by staff.	

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	245299	A. BUILDING ______ B. WING ______	08/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	219 WEST MAPLE AVENUE, PO BOX 96 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 314	Continued From page 12 not receive timely repositioning as directed by the care plan. R67's diagnoses included diabetes, dementia, and an open wound on the buttock. The quarterly Minimum Data Set (MDS) dated 7/11/13, identified R67 had severe cognitive impairment, and required extensive assistance from staff with all activities of daily living. The MDS identified R67 had a stage 3 pressure ulcer (full thickness tissue loss, and may include underming and tunneling) which measured 1.2 centimeters (cm) in length, 1.8 cm wide and 5.0 cm deep. R67's Comprehensive Analysis of Skin, dated 4/10/13, identified R67 was at high risk for pressure ulcers, and required reposition every 2 hours when lying. The Braden Scale For Predicting Pressure Sore Risk form dated 7/1/13, identified R67 as high risk for development of further pressure ulcers. R67's care plan revised 5/8/13, identified R67 had a current stage three pressure ulcer and directed staff to turn and reposition every two hours when laying in bed and every one and a half hours when sitting. During observation on 8/2/13, at 8:45 a.m. R67 was seated in a wheelchair at a table in the dining room for the breakfast meal. Following the breakfast meal R67 was assisted back to her room where she remained seated in the wheel chair until 10:15 a.m. At 10:16 a.m. nursing assistant (NA)-I and NA-J entered the room with a hoyer lift (a full body mechanical lift) and assisted R67 to transfer from the wheel chair to the bed. During interview on 8/2/13, at 10:26 a.m., NA-K	F 314	Results will be reported at the QA meetings for further review and recommendations Date of compliance 9/5/13	

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F 314	Continued From page 13 stated brief a.m. cares were provided for R67 as it was her bath day and not assisted her to lay down. NA-K stated R67 had been in wheel chair since 8:00 or 8:15 a.m. until 10:15 when transferred to bed. (a total of 2 hours and 1 minute.) During interview on 8/2/13, at 11:56 a.m., registered nurse (RN)-B verified the current care plan with a repositioning schedule of 2 hours when in bed and 1.5 hours when sitting. RN-B stated staff is expected to follow the plan of care. R3 was identified at risk for development of pressure ulcers, had not repositioned timely as directed by the care plan. R3's diagnoses included , chronic respiratory failure with ventilator management, cerebral palsy, and degenerative joint disease. The quarterly MDS dated 5/26/13, identified R3 had moderate cognitive impairment, was at risk for development of pressure ulcers and required total assistance of two staff for all activities of daily living. The document titled Braden Scale For Predicting Pressure Sore Risk dated 5/30/13, identified R3 had a high risk of developing further pressure ulcers. The care plan revised 2/13/13, identified R3 had a past history of a pressure ulcer and directed staff to reposition R3 every 2 hours and as needed when in bed. On 8/1/13, at 7:25 a.m., R3 was observed laying in bed on his back with the head of the bed elevated 30+ degrees, eyes closed, resting in bed. R3 remained in the same position, in bed	F 314		

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F 314	Continued From page 14 until 9:53 a.m., when NA-L and NA-M assisted R3 to reposition. R3 remained in the same position in bed, throughout the entire observation. During interview on 8/1/13 at 12:03 p.m., NA-M verified she had not assisted R3 with any cares prior to the am cares observed. During interview on 8/1/13, at 2:15 p.m., LPN-C stated she had provided tracheostomy cares around 7 a.m., but had not repositioned R3 at that time because the night shift had repositioned him at 6:30-6:45 a.m. During interview on 8/2/13, at 3:12 p.m. RN-B verified the current plan of care with repositioning every 2 hours in bed. RN-B stated staff "would be expected to follow the care plan and reposition [R3] every 2 hours. During interview on 8/2/13, at 3:12 p.m. the director of nursing verified the current repositioning schedules and stated she " would expect staff to follow the care plan." A facility policy dated April 1, 2008, entitled, Pressure Ulcers/Skin Integrity/Wound Management, identified a facility system would be in place for prevention, identification, treatment, and documentation of pressure and non-pressure wounds. The policy also indicated a "head to toe" skin assessment would be conducted by a licensed nurse within 24 hours of admission. Further, appropriate turning and repositioning schedules would be put in place per assessment and an initial/immediate care plan would be initiated. Lastly, the policy identified if a resident	F 314		

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F 314	Continued From page 15 refused or resisted staff interventions, the plan of care would reflect effort to seek alternatives as well as education to the resident and/or family regarding the risks; the education would be documented.	F 314		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide fluid monitoring for 1 of 1 residents (R81) reviewed for hydration. Findings include: R81 had diagnoses which included end stage renal disease, hyponatremia (low sodium level in blood), and hyperkalemia (high potassium level in blood). The admission Minimum Data Set (MDS) dated 6/27/13, identified R81 had moderate cognitive impairment and required assistance with all activities of daily living. The Nutrition Assessment dated 6/20/13, identified R81 to have the following dehydration risk factors: activities of daily living decline, renal disease, infection, diarrhea and use of a diuretic. The assessment also identified R81 to be at high nutritional risk related to peritoneal dialysis. Review of the clinical record revealed a physician	F 327	POC for R81 has been reviewed and revised as indicated POC for other residents with orders for fluid monitoring have been reviewed. Policy and Procedures for hydration have been reviewed and revised as indicated Staff has been educated on properly documenting intake on residents with fluid monitoring. Dietary Manager and/or designee will complete random audits will weekly x 4 weeks on residents who are at risk as they are admitted or as their orders change Results will be reported at the QA meetings for further review and recommendations Date of compliance: 9/5/13	

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F 327	Continued From page 16 order dated 6/24/13, which identified to increase the daily dose of Furosemide (water pill) to 160 milligrams (mg) and to received a regular diet with less than 1500 mg (milligrams) sodium and 2-3 liters of fluid daily. The care plan dated 7/2/13, directed staff to provide assistance with meals, monitor intakes of foods and fluids at meals and monitor intake and output. Review of the Open Breakfast Intake Sheet:July 2013, revealed the facility had monitored fluid intake with the breakfast meal, however, the form lacked documentation of fluid monitoring done between meals. Review of the Food and Fluid Intake Sheet, July 2013, revealed the facility had monitored fluid intake with the lunch and supper meals, however, had not documented fluid intake between meals. During observation on 8/1/13 at 2:15 p.m., R81 was lying on the bed with her eyes closed. R81's lips were very dry with dried debris on the front surface of her teeth. No water or liquids were observed available for R81 in her room. At 3:40 p.m. R81 continued to rest in bed, with dry lips and thick sticky mucous observed on both corners of her mouth. An unopened straw was noted in a glass of water on bedside table in the room. R81 indicated she did not feel thirsty and stated, "I should probably drink more." During interview on 8/1/13 at 9:16 a.m., nursing assistant (NA)-C stated she was not aware of R81's fluid intake and had not monitored her fluids. She indicated the group worksheets the NAs used also did not indicate staff were	F 327		

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F 327	Continued From page 17 supposed to monitor R81's fluids. During interview on 8/1/13 at 1:45 p.m., licensed practical nurse (LPN)-A reported that R81 was not on a special diet, and LPN-A was unsure what R81 needed for fluids each day. LPN-A confirmed that staff were not monitoring R81's intake of fluids between meals and confirmed that staff were not monitoring R81's total fluid intake for each day. During interview on 8/2/13, at 11:52 a.m. the food service director (FSD) confirmed R81 was at risk for dehydration and that interventions should have been put in place in an attempt to prevent dehydration. She indicated that although the facility monitored R81's fluids with meals, they had not been monitoring R81's fluid intake between meals. The FSD confirmed fluid monitoring had not been done for R81 and stated, "Unfortunately I missed it." During interview on 8/2/13 at 4:40 p.m., the DON indicated that she would expect staff to be documenting fluid intake and output for R81. The Comprehensive Care Plan policy dated 4/1/08, indicated after a comprehensive assessment was completed a care plan was developed to meet the individual needs for each resident. The hydration policy dated 4/1/08, indicated that the facility has systems for providing sufficient fluids to maintain proper hydration and health for all residents.	F 327		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		

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F 329 SS=D	Continued From page 18 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify clinical indications for the continued use of an anti-anxiety medication for 1 of 10 residents (R90) reviewed in the sample for unnecessary medications. The findings include: R90's record was reviewed. The resident had	F 329	POC for R90 has been reviewed and revised POC for other residents at risk for deficient practice have been reviewed and revised and a behavior monitoring sheet has been added to R90. All residents on anti-anxiety medications have been reviewed to see that monitoring sheets are in place. Education will be provided to nursing staff to assure they are aware that anti-anxiety medication needs target behavior monitoring. Social Worker and/or designee will complete random audits and will be done on residents that are on anti-anxiety medication and have a targeted behavior flow sheet. Results will be reported at the QA meetings for further review and recommendations Date of compliance: 9/5/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245299	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 08/02/2013

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F 329	Continued From page 19 diagnoses that included: depression, anxiety, and probable dementia. The quarterly Minimum Data Set (MDS) dated 7/19/13, identified R90 had severe cognitive impairment and required assistance with all activities of daily living. The MDS identified R90 had little interest in doing things, felt down, experienced trouble sleeping and had little energy. Further the MDS identified R90 did not have trouble with concentrating,or fidgeting or moved around a lot more than usual. The care plan revised 1/10/13, identified R90 had a history of anxiety and directed staff to monitor for behavior and signs of anxiety. R90's current physician orders identified on 6/4/13 an order for Lorazepam 0.5 milligrams(mg) orally every 8 hours as needed for anxiety. There was no documentation in the medical record to indicate what symptoms R90 exhibited when experiencing anxiety. Review of the PRN Med/Refused Explanation forms from 1/1/3 to 7/28/13 revealed R90 had received Lorazepam 0.5 mg on 7/1/13, 7/2/13 and 7/13/13, with the reason identified for each dose as anxiety or anxious. On 4/28/13,the form indicated a dose was given for anxiety, "I need to relax," on 4/4/13 the medication was given for anxiety, and on 3/11/13 the medication was given for complains of "choking feeling." The forms lacked documentation of a description of specific symptoms exhibited for the use of the medication for R90. During interview on 8/2/13, at 2:17 p.m. registered nurse (RN)-B confirmed the above findings and stated she was "unaware that there were no behavior monitoring sheets for [R90] but, [R90] should have one."	F 329		

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F 329	Continued From page 20 During interview on 8/2/13, at 3:21 p.m. the director of nursing (DON) confirmed monitoring should be done with the use of Lorazepam. The DON stated "Normally they would have a behavior sheet." A requested policy regarding anxiety medication use was not provided.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist reported medication irregularities regarding the use of as needed (PRN) Lorazepam (anti-anxiety medication) for 1 of 10 residents (R90) reviewed for unnecessary medications. Findings include: R90 received an anti- anxiety medication without clinical indications to support the continued use of	F 428	POC for R90 has been reviewed and revised. POC for other residents at risk have been reviewed and revised and behavior monitoring sheet has been added to R90 and all residents on anti-anxiety medications have been reviewed to see that monitoring sheets are in place. Policy and Procedures for Unnecessary Drugs have been reviewed. Nursing staff and Consultant Pharmacist has been trained on the requirement of medication monitoring for anti-anxiety medication.	

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F 428	Continued From page 21 the medications and the pharmacist did not identify the concern. The care plan revised 1/10/13, identified R90 had a history of anxiety and directed staff to monitor for behavior and signs of anxiety. R90's current physician orders identified on 6/4/13, an order for Lorazepam 0.5 milligrams (mg) orally every 8 hours as needed for anxiety. There was no documentation in the medical record to indicate what exhibited symptoms reflected anxiety for R90. Review of the PRN Med/Refused Explanation forms from 1/1/3 to 7/28/13 revealed R90 had received Lorazepam 0.5 mg on 7/1/13, 7/2/13 and 7/13/13, with the reason identified for each dose as anxiety or anxious. On 4/28/13, the form indicated a dose was given for anxiety, "I need to relax," on 4/4/13 the medication was given for anxiety, and on 3/11/13 the medication was given for complains of "choking feeling." The forms lacked documentation of a description of specific symptoms exhibited for the use of the medication for R90. Review of the monthly Pharmacist's Drug Regimen Reviews for R90 from 1/16/13 to 7/30/13 revealed on 1/16/13 the pharmacist had identified R90 received a PRN dose of Lorazepam 0.5 mg for anxiety. However, the reviews lacked documentation of the lack of identification of the specific symptoms exhibited for the use of the medication for R90. During interview on 8/2/13, at 2:17 p.m. registered nurse (RN)-B confirmed the above findings and stated she was "unaware that there were no behavior monitoring sheets for [R90] but,	F 428	Social Worker and/or designee will complete random audits and will be done on residents that are on anti-anxiety medication and have a targeted behavior flow sheet. Results will be reported at the QA meetings for further review and recommendations Date of compliance: 9/5/13	

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F 428	Continued From page 22 [R90] should have one." During interview on 8/2/13, at 3:21 p.m. the director of nursing (DON) confirmed monitoring should be done with the use of Lorazepam. The DON stated "Normally they would have a behavior sheet." On 8/2/13 at 3:45 p.m., attempts to reach the consulting pharmacist via telephone were unsuccessful. A requested policy regarding anxiety medication use was not provided.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	Policies and Procedures were reviewed regarding infection control to include surveillance and investigation of infections. Infection Control nurse, Nurses and NAR's have been educated on 8/27/2013 and 8/28/2013 on the Policy and Procedure and surveillance and investigation of infections. Forms from the APIC Manual have been adopted to be used in the surveillance and investigation of infections	

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F 441	Continued From page 23 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program that included surveillance and investigation of infections that occurred in the facility. This had the potential to affect all 67 residents currently residing the facility. Findings include: During review of the facility's infection control Weekly Infection Control Log (s) from January 2013 through July 2013 the following infections were entered: 1 fever, 1 circulatory, 1 unknown, 1 clostridium difficile (C-Diff), 6 upper respiratory, 8 skin infections and 10 urinary tract infections (UTI's). Of this data the following was not included for infection control surveillance on the Weekly Infection Control Log (s): location of resident within the facility, symptoms, diagnosis, any cultures performed, antibiotic used, and when the infections resolved. The logs were being	F 441	Infection Control Nurse will complete weekly audits x4, monthly audits x4, and quarterly audits x2 to ensure line listing is in place. Results of audits will be reported to the QA committee for review and recommendations. Date of completion: 9/5/13	

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

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FORM APPROVED
OMB NO. 0938-0391

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 ____	08/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544

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F 441	Continued From page 24 completed by the infection control coordinator (ICC), however, the ICC was not analyzing the data to track trends and patterns of the infections within the facility. During interview on 8/2/13 at 2:40 p.m. the ICC reviewed the infection control surveillance and Weekly Infection Control Logs, and confirmed that she did not have documentation to support analysis of the infection control data. The ICC reported that she brings the incomplete Weekly Infection Control Logs to quality assurance (QI) monthly. The ICC confirmed the facility did not follow any guidelines before starting an antibiotic. During interview on 8/2/13 at 3:32 p.m. the director of nursing (DON) reported that the Weekly Infection Control Logs were only a guide for ICC to use, was unable to produce any other documentation to support infection control surveillance within the facility. Review of the facility's policy titled Infection Control (General) dated 4/1/2008, indicated the infection control program investigates, controls and prevents infections in the facility.	F 441		

F5299 022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING 01 - MAIN BUILDING B. WING ______	08/01/2013 ~~07/30/2013~~

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE. PO BOX 96 FRAZEE, MN 56544**

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K 000	INITIAL COMMENTS Surveyor: 03006 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Frazee Care Center 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 a 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 a Type II (000) construction, and is separated with 2- hour fire barriers from the main building. Additions to the 1979 building in 1993 include an activities addition to the west and the business/ main entrance 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, so the Apartment Building was not surveyed at this time. The facility is divided into 5 smoke zones with smoke barrier walls of 30 minutes and 90 minute rated fire barriers. The facility is completely sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition).	K 000		

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

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING **01 - MAIN BUILDING** B. WING ______	8/1/2013 ~~07/30/2013~~

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRAZEE CARE CENTER	**219 WEST MAPLE AVENUE. PO BOX 96** **FRAZEE, MN 56544**

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K 000	Continued From page 1 The facility has a fire alarm system with smoke detection throughout the corridor system and in the common spaces installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). In the 1971 building is now fully sprinkler protected. The facility has a capacity of 74 beds and had a census of 67 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		