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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: DQYO

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: **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) **11/01/2004**

6. DATE OF SURVEY **08/12/2014** (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:
X A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 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):

17. SURVEYOR SIGNATURE
Denise Erickson, HFE NEII
Date : 08/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist
Date: 10/27/2014 (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 10/27/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/26/2014
(L33)

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DQYO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00730

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(L5) **FRAZEE, MN** (L6) **56544**

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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 **06/26/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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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

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Compliance Based On:
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And/Or Approved Waivers Of The Following Requirements:
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___ 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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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	74			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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Denise Erickson, HFE NEII 08/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 08/22/2014 (L20)

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_____ 2. Facility is not Eligible
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23. LTC AGREEMENT BEGINNING DATE
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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)

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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 08/26/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 1973

July 10, 2014

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

RE: Project Number S5299025

Dear Mr. Huhta:

On June 26, 2014, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - 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, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858

Phone: (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 August 5, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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 September 26, 2014 (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 December 26, 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

Mark Meath, Enforcement 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 5299s14.rtf

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 _____	06/26/2014

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 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 ensure fall interventions were appropriately implemented to prevent further falls for 1 of 2 residents (R27) identified at risk for falls. Findings include: Review of R27's Problem List identified R27 had diagnoses which included dementia, blindness and cerebrovascular accident (CVA). R27's quarterly Minimum Data Set (MDS) dated 4/11/14	F 323	POC for R27 has been reviewed and updated as indicated. All residents at risk for falls may be affected by this practice and POC have been reviewed and updated as indicated. Education for nursing staff has been completed on 7/23/14 and 7/24/14 to ensure that all residents with fall risks have POC followed for safety. DON/ Designee will complete weekly audits for 3 months to ensure that residents have been assessed for fall risk and POC indicates individual interventions are in place and being followed.	

8/5/14 OK Lo

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

Andrew C. Hubata — Executive Director — 7/24/2014

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.

RECEIVED
JUL 28 2014
MN Dept of Health
Fergus Falls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 1 indicated R27 had moderately impaired cognition, required extensive assistance for all mobility and was unable to balance without human assistance. R27's Care Area Assessment (CAA) dated 10/15/13, identified R27 had confusion, disorientation, or forgetfulness, was blind, had difficulty negotiating the environment, and required standby or physical assistance due to cognition/comprehension. R27's care plan reviewed 2/26/14, identified R27 was at risk for falls related to a history of falls, unsteady gait, incontinence, CVA and poor judgment. The care plan listed various interventions which included assistance of one with transfers, the use of a personal safety alarm in bed and chair, verbal reminders not to transfer and use call light. During observation on 6/25/14, at 7:10 a.m. nursing assistant (NA)-A applied a transfer belt around R27's waist, assisted R27 to stand. With verbal cues R27 grasped the handle grips of the wheeled walker. NA-A then directed R27 with verbal cues and hands on assist to walk behind the walker into the bathroom. At 7:15 a.m. with R27 seated on the toilet, NA-A exited the bathroom and shut the door. R27 remained seated on the toilet seat in the bathroom unsupervised, and no personal safety alarms were attached to R27. Review of R27's Resident Incident Report dated 5/22/14 revealed R27 had attempted to transfer self from the toilet, missed the grab bar, fell and hit her back. The follow up documentation after the fall indicated "Training done with NAR (Nursing assistant) as resident has bed/chair	F 323	Results of audits will be reported at the QA meetings for further review and recommendations. Date to be completed by: 8/5/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 2 alarm and should not be left alone in bathroom." During interview on 6/25/14, at 9:11 a.m. NA-A confirmed R27 used a personal safety alarm for use in bed and in the wheel chair. NA-A confirmed she had left R27 left alone in the bathroom with the door closed. She indicated she routinely left R27 alone in the bathroom. During interview on 6/25/14, at 9:19 a.m. the assistant director of nursing (ADON) confirmed R27's current care plan and she would expect R27 should not be left alone in the bathroom. The ADON stated the facility protocol was residents that utilized personal safety alarms were not to be left alone when seated in the bathroom. During interview on 6/26/14, at 10:52 a.m. the director of nursing (DON) confirmed the facility protocol included not to leave a resident alone in the bathroom if a bed and chair alarm were utilized by the resident. The DON further stated staff were expected to follow resident care plans and in cases where a resident who utilized personal safety alarms was able to be in the bathroom without staff, it would be written in the care plan. The facility policy titled Care Plans -Comprehensive dated 4/1/2008, identified the care plan services were furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being. The policy identified care plan interventions would be developed to meet the individual needs of each resident.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 3 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 develop non-pharmacological interventions and failed to conduct ongoing monitoring of the effectiveness of those interventions for 1 of 2 residents, (R79) who were received anti pyschotic medications. Findings Include:	F 329	Resident R79's Plan of Care has been reviewed and updated to include non-pharmacological interventions and targeted behaviors to coincide with his anti-psychotic medications. Other Residents with behaviors and anti-psychotic medications will continue to be reviewed by IDT team for possible reductions and to ensure targeted behaviors and non-pharmacological interventions are in place. Nursing staff have been trained on 7/23/14 and 7/24/14 in regards to reviewing patients non pharmacological interventions as behaviors occur. DON/ Designee will complete weekly audits for 3 months to ensure that residents have non pharmacological interventions as well as targeted behaviors if they are receiving anti- psychotic medications. Results of audits will be reported at the QA meetings for further review and recommendations. Date of completion: 8/5/14	

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 _____	06/26/2014

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 329	Continued From page 4 R79 received a Seroquel (antipsychotic medication) 150 milligrams (mg) twice a day and Seroquel 500 mg at bedtime for a diagnosis of personality disorder since 4/22/14. In addition, R79 received Olanzapine (antipsychotic medication 5 mg every bedtime for a diagnosis of personality disorder since 4/22/14 and clonazepine (antipsychotic medication) 1mg at bedtime since 5/29/14. Review of R79's clinical record revealed the lack of ongoing monitoring of target behaviors, non pharmacological interventions used when the behaviors occurred and the effectiveness of those interventions. R70's admission Minimum Data Set (MDS) dated 4/28/14, indicated R79 had diagnoses which included psychotic disorder,non Alzheimer dementia, anxiety disorder and depression. The MDS identified R79 had severe cognitive impairment, behaviors, did not reject cares and required extensive assistance for all activities of daily living (ADL). R79's care plan, dated 5/5/14, indicated R79 had repetitive chanting related to psychiatric illness. The care plan included interventions were to note frequency, duration, interventions and results and to notify medical doctor (MD) of increase chanting. The care plan lacked non pharmacological interventions to be used when the behaviors occurred. Review of R79's nurses notes from 4/28/14 to 6/25/24 revealed the following: On 4/28/14, R79 room door was closed and staff could hear R79 chanting loudly.	F 329		

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 _____	06/26/2014

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 329	Continued From page 5 On 5/2/14, R79 chanting. On 5/4/14 , R79 chanting in room off and on during the shift. Door was closed and it was disturbing to others. On 5/6/14, R79 chanting in room this a.m., door was closed but still able to hear resident. On 5/14/14, R79 chanting in the a.m. about having 200 million dollars. On 5/20/14, R79 chanting in room two times during the p.m. hours. On 6/10/14, R79 refused cares. On 6/24/14, R79 refused cares. On 6/25/14, R79 chanting for a short period of time. The nurses notes lacked documentation of non pharmacological interventions used when the behaviors occurred, and the effectiveness of those interventions. On 6/26/14 at 12:54 p.m. the assistant director of nurses (ADON) verified R79's record lacked documentation of ongoing monitoring of target behaviors, non pharmacological interventions to use and the effectiveness of those interventions. The ADON stated the usual facility practice was to identify target behaviors for residents receiving anti psychotic medications and documentation would be done when the behavior occurred. On 6/26/14, at approximately 1:00 p.m., registered nurse (RN)-B verified R79 did not have any non-pharmalogical interventions developed to utilize when the target behaviors occurred. On 6/26/14 at 9:34 a.m., during a phone interview conducted with the consultant pharmacist (CP) confirmed she reviewed R79's medication regimen monthly and stated she	F 329		

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 _____	06/26/2014

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 329	Continued From page 6 would allow a new resident 3 months before any suggested medications changes are made. She indicated R79 had diagnoses of dementia, and personality disorder and she would expect behaviors to be monitored ongoing. A facility policy tilted Unnecessary Drugs-Antipsychotic Drugs-HDGR, dated April, 2009, revealed if the resident was admitted or readmitted to the facility with antipsychotic medication, the following must be completed: a. Appropriate diagnosis made that meets the criteria for the use of an antipsychotic; b. Target behaviors documented for the continued use; and c. AIMS or DISCUS assessment must be completed within the initial assessment period.	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 consultant pharmacist (CP) failed to identify and report to the facility a lack of behavior monitoring for the use of antipsychotic medications for 1of 2 residents(R79) currently receiving anti psychotic	F 428	Resident R79 has a targeted behavior monitoring sheet in place. Other residents with anti-psychotic medications have behavior monitoring sheets in place. Training has been done with nurses on 7/23/14 and consultant pharmacist in regards to required monitoring to be completed for residents with anti-psychotic medications.	

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 _____	06/26/2014

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 428	Continued From page 7 medications. Findings Include: R79 received a Seroquel (antipsychotic medication) 150 milligrams (mg) twice a day and Seroquel 500 mg at bedtime for a diagnosis of personality disorder since 4/22/14. In addition, R79 received Olanzapine (antipsychotic medication 5 mg every bedtime for a diagnosis of personality disorder since 4/22/14 and clonazepine (antipsychotic medication) 1mg at bedtime since 5/29/14. Review of R79's clinical record revealed the lack of ongoing monitoring of target behaviors, development of non pharmacological interventions to be used when the behaviors occurred and the effectiveness of those interventions. R79's care plan, dated 5/5/14, indicated R79 had repetitive chanting related to psychiatric illness. The care plan included interventions were to note frequency, duration, interventions and results and to notify medical doctor (MD) of increase chanting. The care plan lacked non pharmacological interventions to be used when the behaviors occurred. Review of R79's monthly drug regimen review revealed on 5/31/14 the consulting pharmacist (CP) had identified the daily dose of clonazapine had been decreased to 1 milligram daily and a discus had been conducted for R79. On 6/18/14, the CP identified R79 was not tolerating a dietary supplement. However, both reviews lacked identification of the lack of ongoing behavior monitoring which included target behaviors, non pharmacological interventions to be used when the target behaviors occurred and the	F 428	DON/ Designee will complete weekly audits for 3 months to ensure that behavior monitoring is done and reviewed to assess for opportunities for medication reduction. Results of audits will be reported at the QA meetings for further review and recommendations. Date of completion: 8/5/14	

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 _____	06/26/2014

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 428	Continued From page 8 effectiveness of those interventions. On 6/26/14, at approximately 1:00 p.m., registered nurse (RN)-B verified R79 did not have any non-pharmalogical interventions developed to utilize when the target behaviors occurred. On 6/26/14 at 9:34 a.m., during a phone interview conducted with the consultant pharmacist (CP) confirmed she reviewed R79's medication regimen monthly and stated she would allow a new resident 3 months before any suggested medications changes are made. She indicated R79 had diagnoses of dementia, and personality disorder and she would expect behaviors to be monitored ongoing. A facility policy tilted Unnecessary Drugs-Antipsychotic Drugs-HDGR, dated April, 2009, revealed if the resident was admitted or readmitted to the facility with antipsychotic medication, the following must be completed: a. Appropriate diagnosis made that meets the criteria for the use of an antipsychotic; b. Target behaviors documented for the continued use; and c. AIMS or DISCUS assessment must be completed within the initial assessment period.	F 428		
F 441 SS=D	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	F 441	R27 has had no ill effects from deficient practice. All residents at FCC have the potential to be affected by deficient practice.	

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 _____	06/26/2014

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 441	Continued From page 9 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. (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 observation, interview, and document review, the facility staff failed to follow proper infection control practices for 1 of 2 residents (R27) observed during personal cares. Findings include:	F 441	Nursing staff have been educated on 7/23/14 and 7/24/14 on proper infection control practices, including proper glove use and what cross contamination means. DON/Designee will complete weekly audits for 3 months to ensure that Infection Control measures are being taken with all ADL's and staff are using appropriate glove use and hand washing. Results of audits will be reported at the QA meetings for further review and recommendations. Date of completion: 8/5/14	

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 _____	06/26/2014

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 441	Continued From page 10 During observations of morning cares on 6/25/14, beginning at 7:07 a.m. nursing assistant (NA)-A assisted R27 with her morning routine. At 7:21 a.m. NA-A removed a large pink basin from the resident bathroom sink which had contaminated soapy water, that had just been used for the R27's room mate's peri care. While NA-A was removing the basin from the sink, the contaminated water spilled over the edge of the basin soiling NA-A clean gloves. NA-A did not removed her soiled wet gloves and proceeded to assist R27's with oral cares. NA-A touched R27's toothbrush, toothpaste and applied paste to the brush and handed the toothbrush to R27 to brush her teeth. When R27 had completed her tooth brushing, NA-A returned the soiled toothbrush and paste to the basin with her soiled wet gloves. During an interview on 6/25/14, at 7:28 a.m. NA-A confirmed the contaminated water from R27's roommate's basin had spilled on her clean gloves and she did not removed her soiled wet gloves before assisting R27 with oral care. During an interview on 6/25/14, at 7:38 a.m. NA-B confirmed the large pink basin had been used for morning cares including peri cares for R27's room mate. During an interview on 6/26/14, at 10:52 a.m. the Director of Nursing (DON) confirmed the practice of handling multiple resident care items would be a concern for cross contamination. The DON further confirmed she expected staff to wash hands when entering a room, prior to providing cares, after removing gloves, and between cares for example peri care and oral care. A requested applicable facility policy was not	F 441		

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 _____	06/26/2014

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 441	Continued From page 11 provided.	F 441		

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

F5299023

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 _____	**06/24/2014**

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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. 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. The facility was inspected as one building: 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	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
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	**06/24/2014**

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
K 000	Continued From page 1 Installation of Sprinkler Systems (1999 edition). 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 66 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5299

August 15, 2014

Mr. Andrew Huhta, Administrator
Frazee Care Center
219 West Maple Avenue, PO 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 August 5, 2014 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement 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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

August 15, 2014

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

RE: Project Number S5299025

Dear Mr. Huhta:

On July 10, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 26, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On August 12, 2014, 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 June 26, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 5, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 26, 2014, effective August 5, 2014 and therefore remedies outlined in our letter to you dated July 10, 2014, 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement 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 5299f14

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245299	A. Building B. Wing	8/12/2014

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 **F0323** Reg. # **483.25(h)** LSC	**08/05/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**08/05/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	**08/05/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	**08/05/2014**	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		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 /mm	08/15/2014	31256	08/12/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/26/2014

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
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245299	FRAZEE CARE CENTER

Type of Survey (select all that apply):

A					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 31256	08-12-2014	08-12-2014	0.50	1.00	5.50	0.00	1.50	.25 0.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours ..... 0.00 .25

Total Clerical/Data Entry Hours..... 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N