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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LQGV

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 **05/05/2020** (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 **60** (L18)
13.Total Certified Beds **60** (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
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 07/29/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/29/2020 (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
03/10/2020
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 29, 2020

CMS Certification Number (CCN): 245299

Administrator
Frazee Care Center
219 West Maple Avenue, Po Box 96
Frazee, MN 56544

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 12, 2020 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 29, 2020

Administrator
Frazee Care Center
219 West Maple Avenue, Po Box 96
Frazee, MN 56544

RE: CCN: 245299
Survey Start Date: January 16, 2020

Dear Administrator:

On May 20, 2020 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 12, 2020. Per the CMS Memo QSO-20-20-All, enforcement remedies were suspended from March 23, 2020 to May 31, 2020 and will be evaluated at a later date.

The CMS Region V Office may notify you of their determination regarding any remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LQGV

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(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 **01/16/2020** (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**	
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FISCAL YEAR ENDING DATE: (L35)
09/30

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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
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Beth Nowling, HFE NE II 02/14/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 03/09/2020 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

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3. Both of the Above :
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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
(L33)

DETERMINATION APPROVAL

Electronically delivered
February 5, 2020

Administrator
Frazee Care Center
219 West Maple Avenue, Po Box 96
Frazee, MN 56544

RE: CCN: 245299
Cycle Start Date: January 16, 2020

Dear Administrator:

On January 16, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 16, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 16, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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 _____	C 01/16/2020

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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 1/13/20 to 1/16/20, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 1/13/20 thru 1/16/20 a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found not to be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found unsubstantiated: H5299024C H5299025C H5299026C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		2/24/20

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

Electronically Signed | 02/14/2020

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.

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 _____	C 01/16/2020

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 582	Continued From page 1 §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's	F 582		

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 _____	C 01/16/2020

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 582	Continued From page 2 per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure residents received the skilled nursing facility advanced beneficiary notice (SNFABN) form upon termination of Medicare A benefits for 2 of 2 residents (R30, R4) remaining in the facility and 1 of 1 (R150) who was discharged from the facility. In addition the facility failed to provide the required Notice of Medicare Non-Coverage (NOMNC) upon termination of Medicare A benefits for 1 of 1 residents (R150) who was discharged from the facility. Findings include: R30's medicare part A skilled services began on 6/20/19, and ended on 7/12/19. R30 was provided the NOMNC on 7/10/19, however; was not provided the required SNFABN. R4's medicare part A skilled services began on 10/9/19, and ended on 11/30/19. R4 was provided the NOMNC on 11/27/19, however; was not provided the required SNFABN.	F 582	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible	

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 _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 582	Continued From page 3 R150's medicare part A skilled services began on 7/16/19, and ended on 8/6/19. R150 was not provided the required SNFABN nor the NOMNC, and was discharged from the facility on 8/7/2019. On 1/15/2020, at 11:14 a.m. the business office manager (BOM) verified R150 had no paperwork indicating that notices had been given to this resident. The BOM identified the facility was aware of R150's end of skilled services and was unsure why the notices had not been given. On 1/16/2020, at 9:16 a.m. the BOM indicated she had been confused as to what forms were to be utilized for residents with discharge from Medicare A services. The BOM indicted she had different forms in the computer system and was unsure which forms were correct. On 1/16/2020, at 3:09 p.m. the director of nursing (DON) verified the expectation that residents be provided the appropriate Medicare A discharge forms, in the correct time frame. The facility policy titled Admission, Transfer and Discharge revised 9/22/2017, identified the facility was to follow all stated and federal regulations regarding admission, transfers, and discharge.	F 582	allegation of compliance. 1) Resident #150 was discharged from the facility. Resident's #30 and #4 received their SNF ABN notice for the time period noted. 2) Residents who are Medicare eligible have the potential to be affected. An Audit was completed of all Medicare discharges within the past 2 weeks of survey exit date. No other discrepancies were noted. 3) The Business Office Manager, MDS Coordinator, Director of Social Services, and the Nursing Home Administrator were educated on the NOMNC forms and process. 4) Medicare discharge NOMNC forms will be audited weekly for 4 weeks; then monthly for 2 months by the Business Office Manager or designee to ensure accuracy of notices. Results of the audits will be presented quarterly to the facility QAPI committee.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:	F 661		2/24/20

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F 661	Continued From page 4 (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an accurate discharge summary was completed for 1 of 1 residents (R137) reviewed who discharged to a residential supportive living services facility (group home). Findings include: R137's progress note dated 12/2/19, identified R137 was transported to a group home by the group home company van. The note identified R137's personal belongings had been sent with the resident. Discharge paperwork was reviewed	F 661	1) Resident #137 was discharged from the facility. 2) Residents who are discharged from the facility have the potential to be affected. An audit was completed of all discharges within the past 30-days of survey exit date. No other discrepancies were found. 3) The Unit Managers and Interdisciplinary team have been educated on the Discharge Summary policy. 4) Discharged resident's summaries will be audited weekly for 1 month; then	

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F 661	Continued From page 5 and signed by R137. The progress note described R137's mood. R137's clinical record lacked a comprehensive discharge summary. A facility unnamed and undated form identified R137 required assistance of two staff with areas of daily living,EZ stand lift for transfers, two staff in room at all times, May walk away if abusive to staff. incontinent of bowel and bladder. On 1/16/2020, at 1:54 p.m. the nurse manager (NM)-A indicated she was responsible to complete paperwork which included where the resident was transferred, transportation to the new location, needed community services, and to review the medication list. NM-A identified the above unnamed form was sent to the new facility with a list of medications. NM-A indicated the facility practice was not to complete a comprehensive discharge summary. On 1/16/2020, at 3:08 p.m. the director of nursing (DON) verified the expectation of a summary of the residents stay be completed when discharged. The facility policy titled Discharge summary, revised 11/2016, identified a discharge summary is prepared by the interdisciplinary team upon anticipated discharge and includes, but not limited to, the following: a recapitulation of the residnet's stay, to include diagnosis, cause of illness, treatment or therapy, and pertinent lab, radiology, and consultation results; a final summary of the resident's status that is available for release to authorized persons and agencies if needed, with the consent of the residnet or legal guardian.	F 661	monthly for 2 months by the Director of Nursing (DON) or designee to ensure compliance. Results of audits will be presented to the quarterly facility QAPI committee.	

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F 677	Continued From page 6	F 677		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely incontinence care for 1 of 3 residents (R11) who were dependent upon staff for assistance with activities of daily living. Findings include: R11's annual Minimum Data Set (MDS), dated 10/31/19, identified R11 had diagnoses which included diabetes, traumatic brain injury (TBI), seizure disorder and was severely cognitively impaired. The MDS indicated R11 required total assistance of staff for all activites of daily living (ADL)'s, was always incontinent of bowel and bladder and and was not on a bowel or bladder toileting program. R11's Bowel and Bladder Functional Evaluation dated 10/3/19, indicated R11 was incontinent of bowel and bladder, unaware of the need to toilet, TBI history, non-verbal and R11 was totally dependent on staff for all ADL's, repositioning, cares, mobility and transfers. The assessment indicated R11 was on a check and change program. R11's care plan, revised 11/20/19, identified R11 had alteration in elimination related to lack of bowel and bladder control related to her TBI. The	F 677	1) Resident#11 received ADL care for incontinence at the time of the survey. 2) Residents who are totally dependent on staff for ADL care have the potential to be affected. An audit was completed, and no other discrepancies were found. 3) The nursing staff was re-educated on the need to provide ADL incontinent care timely and as directed by their care plan. 4) Residents who are dependent on staff will be audited for incontinent care weekly for 4 weeks; then monthly for 2 months by the Director of Nursing (DON) or designee to ensure compliance. Results of audits will be presented to the quarterly facility QAPI committee.	2/24/20

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F 677	Continued From page 7	F 677		

care plan listed various interventions which directed staff totally assist to R11 with checking and changing upon rising, before and after meals, before bedtime, and with round during the night hours. The care plan indicated staff were to provide prompt incontinence cares and R11 wore incontinent products.

R11's current Nursing Aid Care Sheets, dated 1/8/20 indicated R11 was to be toileted upon rising, before and after meals, before bed and with rounds.

During continuous observations on 1/15/20 at 7:12 a.m. R11 was lying in bed on her back covered with the head of the bed slightly elevated, call light within reach,and sleeping.
- at 7:23 a.m. R11 remained in bed lying on her back sleeping.
- at 8:05 a.m. R11 remained in bed lying on her back sleeping.
- at 8:33 a.m. R11 remained in bed lying on her back sleeping.
- at 9:04 a.m. R11 remained in bed lying on her back sleeping.
- at 9:08 a.m. R11 remained lying in bed on her back covered up sleeping with the head of the bed slightly elevated. Nursing assistant (NA)-A entered R11's room and proceeded to glove her hands, gather supplies and clothes to assist R11 with morning cares. NA-A proceeded to wash her face, arms and remove her gown and washed the front of her peri area. At 9:17 a.m. NA-A briefly left the room and returned with nurse manager (NM)-B.
- at 9:19 a.m. NM-B rolled R11 to her right side and NA-A removed R11 incontinent brief that was saturated with strong odorous urine and threw it in the garbage. R11's draw sheet and sheets

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F 677	Continued From page 8	F 677		

were also saturated with strong odorous urine half way up her back and half way down to her knees and across the entire surface of her bed. R11 had a foam dressing intact on her lower left buttocks area dated 1/12/20. R11 skin on her buttocks was brownish/red, very moist, wrinkled and puckered. NA-A and NM-B rolled R11 side to side and placed a clean incontinent brief, pulled up her pants and placed the lift sling under her. NA-A and NM-B proceeded to transfer R11 into her wheel chair via mechanical lift and continued to provide personal hygiene and oral cares for R11.

On 1/15/20 at 11:36 a.m. NA-B stated she helped NA-A around 6:45 a.m. to reposition and check/change R11 and had not been in R11's room since to assist with cares. NA-B confirmed R11 was incontinent of bowel/ bladder and needed staff assistance with all of her ADL's and needed to be checked/changed and repositioned every two hours.

On 1/16/20 at 10:07 a.m. NA-A indicated R11 had a current pressure ulcer on her left lower buttocks. NA-A reviewed her pocket care plan and indicated R11 was to be check and changed upon rising, before and after meals, before bedtime and with rounds. NA-A confirmed she should have checked and changed R11 before breakfast and verfied she did not because they were running behind for breakfast. NA-A confirmed the last time she had checked and changed R11 was around 6:45 a.m.

On 1/15/20 at 12:01 p.m. licensed pratical nurse (LPN)-A confirmed R11 was incontinent of bowel/ bladder and needed staff assistance with all of her ADL's and needed to be checked/changed

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F 677	Continued From page 9 and repositioned every two hours. LPN-A indicated she would expect staff to make sure R11 was kept dry and to follow her care plan. On 1/15/20 at 1:15 p.m. the director of nursing (DON)confirmed R11 needed staff assistance with checking/changing her incontinent brief and she would expect staff to follow her care plan as written and to provide cares in a timely manner according to careplan for incontinent cares. The DON indicated the "general rule is every 2 hours" after meals and indicated R11 should of been provided incontinence cares to keep her dry. Review of facility policy titled, Bowel and Bladder Management revised on 11/2016, indicated there is a system to ensure that each resdient with bowel and bladder incontinence will receive appropriate treatment and services to achieve or maintain as much normal elimination function as possible. A resident who is incontinent of bladder and fecal will receive appropriate treatment and services to prevent urinary tract infections and restore continence and bowel function as possible.	F 677		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		2/24/20

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F 812	Continued From page 10 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean and sanitary air vent located above the cook stove and grill observed in the main kitchen of the faclity. In addition, the faclity failed to store bulk food in a manner to prevent cross contamination related to ongoing storage of plastic scoops in the bulk dry milk container This deficient practice had the potential to affect 36 of 37 residents who currently resided in the facility, visitors and staff who consumed food from the kitchen. . Findings include: On 1/13/20, at 1:11 p.m. during initial kitchen tour with dietary manager (DM)-A, the air vent above the kitchen stove and grill had moderate to heavy amounts of brown streaked areas with multiple areas of brown fuzzy substance on it. DM-A indicated if the vents were not clean, the dust could potentially fall into the food. DM-A indicated the facility maintenance department was responsible to clean the vents above the stove and grill. DM-A indicated she thought the last time they were cleaned was about 2 months ago. During observation of the kitchen cupboards, a plastic white scoop was observed inside the dry	F 812	1) The Air Vent in the main kitchen was cleaned at the time of survey. The plastic scoop was removed from the bulk, dry milk container was removed from the container at the time of survey. 2) Residents, visitors and staff who consume food from the kitchen have the potential to be affected. No foodbourne illness were noted. 3) The Dietary staff were educated on general Food Sanitary Conditions and the vent cleaning schedule was updated to twice monthly. 4) The Dietary Manager will audit vent cleaning and sanitary conditions in the kitchen weekly for 2 weeks; then monthly for 2 months. Results of audits will be presented to the quarterly facility QAPI committee.	

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F 812	Continued From page 11	F 812		

milk plastic covered container. DM-A confirmed the finding and indicated scoops which were reused were not to be left in the containers.

The facility form titled Monthly Cleaning of Kitchen Vents, undated, reviewed from 3/14/19, to 1/13/20, identified by date and initials that the vents had been cleaned monthly, and they last date initialed was 12/16/19.

The facility forms titled Weekly Cleaning List, undated, reviewed from 10/7/19, to 1/13/20, identified by date and staff initials that the last weekly cleaning had been completed on 1/9/20. The list included an item line of bins, flower (flour), sugars and dried milk.

On 1/13/20, at 6:21 p.m. during follow up interview with DM-A and maintenance director (MD)-A, MD-A identified it had been almost a month since the vents above the stove had been cleaned. MD-A indicated the maintenance staff pulled them out, took them to the boiler room, and hosed them off. DM-A confirmed the vents were not clean. DM-A indicated the scoop left in the dry milk container was obviously not clean and had the potential hazard to contaminate the entire product. DM-A indicated she had planned to provide education to the staff member who left the scoop in the dry milk. DM-A indicated she considered putting a note on the bulk containers to remind staff not to leave the scoops in the containers.

The facility policy titled Food Sanitary Conditions (General) revised 11/2016, identified food was stored, prepared, distributed and served in accordance to professional standards for food service safety.

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F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		2/24/20

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F 880	Continued From page 13 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the infection control program included ongoing surveillance, trending and analysis of resident infections. This had the potential to affect all 37 residents currently residing in the facility. Findings include: Review of the facilty's untitled infection control logs included the following information: date	F 880	1) No residents were affected. 2) Residents residing in the facility have the potential to be affected. 3) The Director of Nursing was educated on the Infection Surveillance / trending / and analysis of resident infections. The Infection Control tracking log was expanded and implemented to monitor all types of infections and other illnesses. 4) The tracking log will be audited weekly for 4 weeks; then monthly for 2	

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F 880	Continued From page 14 noted, resident name, date of birth, type of infection, medication/antibiotic, interventions, care plan updated, comments, date resolved and interdisciplinary team (IDT) review date. Review of the untitled infection control logs from 7/1/19 to 1/16/20 revealed the following: July 2019- five residents were treated with antibiotics for UTI's, one was treated with antibiotics for cellulitis, one was treated with antibiotics for vascular ulcers, one was treated with antibiotics for staph infection in legs and one was treated with antibiotics for toe amputation. August 2019- three residents were treated with antibiotics for UTI's, two was treated with antibiotics for pneumonia, one was treated with antibiotics for sepsis, one was treated with antibiotics for wound infection and two were treated with antibiotics for bacteremia. September 2019- three residents were treated with antibiotics for UTI's, one was treated with antibiotics for pneumonia, one was treated with antibiotics for URI and one was treated with antibiotics for infection. October 2019- two residents were treated with antibiotics for UTI's, one was treated with antibiotics for pneumonia, two was treated with antibiotics for URI, one was treated with antibiotics for sepsis, one was treated with antibiotics for osteomyelitis, one was treated with antibiotics for clostridium difficile (c-diff) and three was treated with antibiotics for wound infections. November 2019- one resident was treated with antibiotics for sepsis, one was treated with	F 880	months by the Nursing Home Administrator or designee to ensure compliance. Results of the audits will be presented to the Quarterly facility QAPI Committee.	

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antibiotics for wound infection, one was treated with antibiotics for ingrown toe nail and one was treated with antibiotics for congestion.

December 2019- one resident was treated with antibiotics for ear infection, one was treated with antibiotics for diarrhea, two residents were treated with antibiotics for wound infections and three were treated with antibiotics for UTI's.

January 2020- no logs were provided.

The logs lacked ongoing surveillance and trending of all infections which included food-borne illness, and other illnesses caused by other viruses or infections.

On 1/16/20 at 1:24 p.m. the infection control program was reviewed with the director of nursing (DON). The DON confirmed she was responsible for the facilities current infection control program and was currently taking the infection prevention program course on line. The DON verified she had not been tracking and trending all infections in the facility and was only been tracking and trending infections treated with antibiotics. The DON also indicated the only infections they were tracking were listed on the infection control logs such as urinary tract infections (UTI), upper respiratory infection (URI), wound infections and did not include other infection caused by viruses or food borne illness. The DON confirmed ongoing surveillance had not been completed and the infection control program had room for improvement.

Review of the facility policy titled, Infection Prevention and Control revised on 11/2016, indicated a system is in place that prevents,

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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 880	Continued From page 16 identifies, reports, investigates, and controls infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals services under the contractual arrangement and following accepted national standards. the infection prevention and control program , investigates, controls, and prevents infections in the facility, determines the procedures, such as isolation, to be applied to an individual resident, maintains a record of incidents and corrective actions related to infections and prohibits employees with communicable disease or infected skin lesions form direct contact with residents or their food is direct contact will transmit the disease.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement an infection control program which included an antibiotic stewardship program. This had the potential to affect all 37 residents currently residing in the facility. Findings include: 1/16/20 at 1:24 p.m. the facility's infection control	F 881	1) No residents were affected. 2) Residents residing in the facility have the potential to be affected. 3) The Director of Nursing was educated on the Antibiotic Stewardship Program and has been identified as the Infection Preventionist. 4) The Antibiotic Stewardship Program will be audited weekly for 4 weeks; then	2/24/20

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F 881	Continued From page 17 program was reviewed. The infection control program identified the facility lacked a functioning antibiotic stewardship program. The infection control program lacked protocols for a facility-wide system to monitor the use of antibiotics including (but not limited to) appropriate prescribing of antibiotics. Further, the overall the program lacked monitoring signs and symptoms, the antibiotic time-out, the determination of appropriate antibiotic use, and reporting of any patterns identified. The untitled infection control logs included the following information: date noted, resident name, date of birth, type of infection, medication/antibiotic, interventions, care plan updated, comments, date resolved and interdisciplinary team (IDT) review date. Review of the untitled infection control logs from 7/1/19 to 1/16/20 revealed the following: July 2019- five residents were treated with antibiotics urinary tract infections (UTI), one was treated with antibiotics for cellulitis, one was treated with antibiotics for vascular ulcers, one was treated with antibiotics for staph infection in legs and one was treated with antibiotics for toe amputation. August 2019- three residents were treated with antibiotics for UTI's, two was treated with antibiotics for pneumonia, one was treated with antibiotics for sepsis, one was treated with antibiotics for wound infection and two were treated with antibiotics for bacteremia. September 2019- three residents were treated with antibiotics for UTI's, one was treated with	F 881	monthly for 2 months by the Nursing Home Administrator or designee. Results of the audits will be presented to the Quarterly facility QAPI Committee.	

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F 881	Continued From page 18	F 881		

antibiotics for pneumonia, one was treated with antibiotics for upper respiratory infection (URI) and one was treated with antibiotics for infection.

October 2019- two residents were treated with antibiotics for UTI's, one was treated with antibiotics for pneumonia, two was treated with antibiotics for URI, one was treated with antibiotics for sepsis, one was treated with antibiotics for osteomyelitis, one was treated with antibiotics for clostridium difficile (c-diff) and three was treated with antibiotics for wound infections.

November 2019- one resident was treated with antibiotics for sepsis, one was treated with antibiotics for wound infection, one was treated with antibiotics for ingrown toe nail and one was treated with antibiotics for congestion.

December 2019- one resident was treated with antibiotics for ear infection, one was treated with antibiotics for diarrhea, two residents were treated with antibiotics for wound infections and three were treated with antibiotics for UTI's.

January 2020- no logs were provided.

1/16/20 at 1:24 p.m. the antibiotic stewardship program was revived with the director of nursing (DON) and she indicated she was responsible for the program. The DON indicated the facility used currenlty used the McGeer criteria for identifying infections and use of antibiotics. The DON confirmed the infection control logs lacked documentation of the antibiotics prescribed meeting the criteria, identification of symptoms, a time out being completed for use of antibiotics and overall monitoring of antibiotic use in the facility. The DON verified the overall antibiotic

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F 881	Continued From page 19 use in the facility had not been monitored and she was currenlty taking the infection prevention program on line. The DON confirmed the facility policy and indicated the antibiotic stewardship program needed improvement. Review of facility policy titled, Infection Prevention and Control, Antibiotic Stewardship Program dated 10/14/17, indicated it was the policy of Health Dimension Group communities to implement and antibiotic stewardship program, which promotes appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated wit antibiotic use. This policy has the potential to limit antibiotic resistance in the post-acute care setting, while improving treatment efficacy and resident safety, and reducing treatment related cost. The program should include leadership, accountability, drug expertise, action to implement recommended policies or practices, tracking measures, reporting data, education for clinicians, nursing staff, residents and family about antibiotic resistance and opportunities for improvement.	F 881		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. 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 not in compliance with The requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities code "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:	K 000		

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

Electronically Signed | 02/13/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The 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.	K 000		

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K 000	Continued From page 2 The facility is completely sprinkler protected and has a fire alarm system with smoke detection throughout the corridor system and in the common spaces that is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 37 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops	K 321		2/13/20

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K 321	Continued From page 3 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility to maintain 1 combustible storage rooms in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for an undetermined amount of residents, staff and visitors. Findings include: During the facility tour between 8:30 am to 1:00 pm observations revealed a combustible storage room over 50 sq. ft. next to the kitchen that did not have a self closing door. This deficient condition was confirmed by the facility Administrator and the Maintenance Supervisor.	K 321	1. Self closing door system was added to the door next to the kitchen. 2. The self closing device was added on 2/10/20. 3. Director of Maintenance will be the responsible person. The affected door will be added to the Fire Door Inspection Log.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.	K 351		2/24/20

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K 351	Continued From page 4 In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to install the sprinkler system in accordance with NFPA 101 (12) Life Safety Code, section 19.3.5 and NFPA 13 (10) Standard for Installation of Sprinkler Systems, section 8.3.3.2. This deficient practice could delay the operation of the sprinkler system, affecting an undetermined amount of residents, staff and visitors. Findings include: During the facility tour between 8:30 am to 1:00 pm observations revealed the door to the laundry folding room was removed, creating one room for laundry operations. This new room contained two different types of sprinkler heads, quick response and standard This deficient condition was confirmed by the facility Administrator and the Maintenance Supervisor.	K 351	1. The door between folding room and laundry will be replaced. This will create compliance with sprinkler heads. 2. The door will be replaced by February 24, 2020. 3. Director of Maintenance is the responsible person. The door will be added to the Fire Door Inspection Log.	