| DEPARIMENT OF HEALTH A   | MEDIC            | ARE/MEDICAI                                    |   |                               | AND TRANSMITTAL   | ID: LSCM  |  |  |
|--|------------------|--|---|-------------------------------|---|---|--|--|
|  | PART I -         | TO BE COMPI                                    | LETED BY T                                  | HE STAT                       | <b>FE SURVEY AGENCY</b>   | Facility ID: 00730  |  |  |
| 1. MEDICARE/MEDICAID PROVIDER NO<br>(L1) 245299  | ).               | 3. NAME AND AL<br>(L3) FRAZEE CA               |   |                               |   | 4. TYPE OF ACTION: <u>7 (</u> L8)   |  |  |
| 2.STATE VENDOR OR MEDICAID NO.<br>(L2) <b>972153000</b>  |                  | (L4) 219 WEST M<br>(L5) FRAZEE, M              |   | UE, PO BO                     | OX 96<br>(L6) 56544   | 1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint |  |  |
| 5. EFFECTIVE DATE CHANGE OF OWN<br>(L9) 11/01/2004   | ERSHIP           | 7. PROVIDER/SU<br>01 Hospital                  | IPPLIER CATEG<br>05 HHA                     | ORY<br><b>09 ESRD</b>         | <u>02</u> (L7)<br>13 PTIP 22 CLIA   | 7. On-Site Visit 9. Other<br>8. Full Survey After Complaint   |  |  |
| <ul> <li>6. DATE OF SURVEY</li> <li>8. ACCREDITATION STATUS:</li> <li>0 Unaccredited</li> <li>1 TJC</li> <li>2 AOA</li> <li>3 Other</li> </ul> | 6 (L34)<br>(L10) | 02 SNF/NF/Dual<br>03 SNF/NF/Distinct<br>04 SNF | 05 IIIA<br>06 PRTF<br>07 X-Ray<br>08 OPT/SP | 10 NF<br>11 ICF/IID<br>12 RHC | 14 CORF   | FISCAL YEAR ENDING DATE: (L35)<br>09/30   |  |  |
| 11LTC PERIOD OF CERTIFICATION  |                  | 10.THE FACILITY                                | IS CERTIFIED                                | AS:                           |   |   |  |  |
| From (a):<br>To (b):   |                  | Compliance                                     | equirements<br>e Based On:                  |                               | And/Or Approved Waivers Of<br>2. Technical Personnel<br>3. 24 Hour RN<br>4. 7-Day RN (Rural SN  | 6. Scope of Services Limit<br>7. Medical Director   |  |  |
| 12. Total Facility Beds  | 74 (L18)         | 1. A   | cceptable POC                               |                               |   | · _   |  |  |
| 13.Total Certified Beds  | <b>74</b> (L17)  |  | liance with Progra                          |                               | 5. Life Safety Code   | 9. Beds/Room  |  |  |
|  |                  | Requirements                                   | and/or Applied V                            | Vaivers:                      | * Code: A   | (L12)   |  |  |
| 14. LTC CERTIFIED BED BREAKDOWN  | 10.015           | 105  |   |                               | 15. FACILITY MEETS  | (115)   |  |  |
| 18 SNF 18/19 SNF<br>74   | 19 SNF           | ICF  | IID   |                               | 1861 (e) (1) or 1861 (j) (1):   | (L15)   |  |  |
| (L37) (L38)  | (L39)            | (L42)  | (L43)                                       |                               |   |   |  |  |
| 16. STATE SURVEY AGENCY REMARKS  | S (IF APPLICA    | ABLE SHOW LTC CA                               | NCELLATION I                                | DATE):                        |   |   |  |  |
| See Attached Remarks   |                  |  |   |                               |   |   |  |  |
| 17. SURVEYOR SIGNATURE   |                  | Date :   |   |                               | 18. STATE SURVEY AGENCY   | APPROVAL Date:  |  |  |
| Denise Erickson, HFE NEII  |                  | 1  | 2/27/2016                                   | (L19)                         | Mark Meath, Enforcement Specialist 02/17/2017 (L20)   |   |  |  |
| PART I   | I - TO BE        | COMPLETED I                                    | BY HCFA RE                                  | GIONAI                        | OFFICE OR SINGLE S  | TATE AGENCY   |  |  |
| <ul> <li>19. DETERMINATION OF ELIGIBILITY</li> <li>_X_ 1. Facility is Eligible to Particip</li> <li> 2. Facility is not Eligible</li> </ul>    | pate<br>(L21)    |  | IPLIANCE WITH<br>ITS ACT:                   | I CIVIL                       | <ol> <li>1. Statement of Financial Solvency (HCFA-2572)</li> <li>2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>3. Both of the Above :</li> </ol> |   |  |  |
| 22. ORIGINAL DATE 23   |                  | MENT   |   | TENT                          |   | (1.20)  |  |  |
| OF PARTICIPATION 23.   | LTC AGREE        |  | 4. LTC AGREEN<br>ENDING DAT                 |                               | 26. TERMINATION ACTION:<br>VOLUNTARY _00  |   |  |  |
| 11/01/1985   | DEGININING       | JDAIL  | ENDING DAI                                  | L                             | 01-Merger, Closure<br>02-Dissatisfaction W/ Reimburse   | 05-Fail to Meet Health/Safety   |  |  |
| (L24)  | (L41)            |  | (L25)                                       |                               | 03-Risk of Involuntary Terminatio   | n   |  |  |
| 25. LTC EXTENSION DATE: 27.  |                  | VE SANCTIONS                                   |   |                               | 04-Other Reason for Withdrawal  | 07-Provider Status Change   |  |  |
|  | A. Suspension    | n of Admissions:                               | (L44)                                       |                               |   | 00-Active   |  |  |
| (L27)  | B. Rescind St    | uspension Date:                                | (144)                                       |                               |   |   |  |  |
|  |                  |  | (L45)                                       |                               |   |   |  |  |
| 28. TERMINATION DATE:  | 29               | . INTERMEDIARY/                                | CARRIER NO.                                 |                               | 30. REMARKS   |   |  |  |
|  |                  | 03001  |   |                               |   |   |  |  |
| (  | L28)             |  |   | (L31)                         |   |   |  |  |
| 31. RO RECEIPT OF CMS-1539   | 32               | 2. DETERMINATION                               | OF APPROVAL                                 | DATE                          |   |   |  |  |
| (  | L32)             | 12/15/2016                                     |   | (L33)                         | DETERMINATION APPI  | ROVAL   |  |  |

CENTERS FOR MEDICARE & MEDICAR SERVICES

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: LSCM PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00730

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

#### CCN: 24 5299

On December 21, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 21, 2016 the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 24, 2016. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of December 14, 2016. We have determined, based on our visit, that the facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 24, 2016.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 21, 2016.

In addition, the Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of November 10, 2016:

- Civil money penalty for the deficiency cited at F310, remain in effect. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F318, remain in effect. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323, remain in effect. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective January 24, 2017, be rescinded. (42 CFR 488.417 (b))

Since the facility achieved compliance prior to the denial of payment for new admissions, the NATCEP prohibition would also be rescinded.

Refer to the CMS 2567b forms for health and life safety code.

Effective December 21, 2016, the facility is certified for 74 skilled nursing facility beds.



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245299

February 14, 2017

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

Dear Mr. Anderson:

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 December 21, 2016 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 eNotice.

Sincerely,

# Mark meath

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



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered December 27, 2016

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

RE: Project Number S5299028

Dear Mr. Prince:

On November 10, 2016, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective November 15, 2016. (42 CFR 488.422)

In addition, on November 10 2016, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- Civil money penalty for the deficiency cited at F310. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F318. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective January 24, 2017. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on October 24, 2016. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On December 21, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 21, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 24, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 14, 2016. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 24, 2016, as of December 21, 2016.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 21, 2016.

Frazee Care Center December 27, 2016 Page 2

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of November 10, 2016:

• Civil money penalty for the deficiency cited at F310, remain in effect. (42 CFR 488.430 through 488.444)

• Civil money penalty for the deficiency cited at F318, remain in effect. (42 CFR 488.430 through 488.444)

• Civil money penalty for the deficiency cited at F323, remain in effect. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective January 24, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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.

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

Sincerely,

mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

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

# **POST-CERTIFICATION REVISIT REPORT**

|                    | MULTIPLE CONSTRUCTION<br>A. Building |                                       |   | DATE OF REVIS | SIT |
|--------------------|--------------------------------------|---------------------------------------|---|---------------|-----|
|                    | B. Wing                              | Y                                     | 2 | 12/21/2016    | Y3  |
| 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).

| ITE                   | М                 |                    | DATE                | ITEM            |        |                 | DATE              | ITEM       |                  |               | DATE       |
|-----------------------|-------------------|--------------------|---------------------|-----------------|--------|-----------------|-------------------|------------|------------------|---------------|------------|
| Y4                    |                   |                    | Y5                  | Y4              |        |                 | Y5                | Y4         |                  |               | Y5         |
| ID Prefix             | F0201             |                    | Correction          | ID Prefix       | F0241  |                 | Correction        | ID Prefix  | F0242            |               | Correction |
| Reg. #                | 483.12(a)(2)      |                    | Completed           | Reg. #          | 483.15 | i(a)            | Completed         | Reg. #     | 483.15(b)        |               | Completed  |
| LSC                   |                   |                    | 12/21/2016          | LSC             |        |                 | 12/21/2016        | LSC        |                  |               | 12/21/2016 |
| ID Prefix             | E0244             |                    | Correction          | ID Prefix       | E0249  | ,               | Correction        | ID Prefix  | E0270            |               | Correction |
| ID I Tellx            |                   |                    | Conection           | ID I Tellx      |        |                 | Conection         | ID I Tellx |                  | 0/1/)/1)      | Confection |
| Reg. #                | 483.15(c)(6)      |                    | Completed           | Reg. #          | 483.15 | <b>(</b> ()( 1) | Completed         | Reg. #     | 483.20(d), 483.2 | U(K)(T)       | Completed  |
| LSC                   |                   |                    | 12/21/2016          | LSC             |        |                 | 12/21/2016        | LSC        |                  |               | 12/21/2016 |
| ID Prefix             | F0280             |                    | Correction          | ID Prefix       | F0282  | 2               | Correction        | ID Prefix  | F0309            |               | Correction |
|                       | 483.20(d)(3), 4   | 33.10(k)           |                     |                 |        | )(k)(3)(ii)     | -                 |            | 483.25           |               |            |
| Reg. #                | (2)               |                    | Completed           | Reg. #          |        | ()())()         | Completed         | Reg. #     |                  |               | Completed  |
| LSC                   |                   |                    | 12/21/2016          | LSC             |        |                 | 12/21/2016        | LSC        |                  |               | 12/21/2016 |
| ID Prefix             | F0310             |                    | Correction          | ID Prefix       | F0311  |                 | Correction        | ID Prefix  | F0312            |               | Correction |
| Reg. #                | 483.25(a)(1)      |                    | Completed           | Reg. #          | 483.25 |                 | Completed         | Reg. #     | 483.25(a)(3)     |               | Completed  |
| LSC                   |                   |                    | 12/21/2016          | LSC             |        |                 | 12/21/2016        | LSC        |                  |               | 12/21/2016 |
| ID Prefix             | F0314             |                    | Correction          | ID Prefix       | F0318  | }               | Correction        | ID Prefix  | F0323            |               | Correction |
| Reg. #                | 483.25(c)         |                    | Completed           | Reg. #          | 483.25 | i(e)(2)         | Completed         | Reg. #     | 483.25(h)        |               | Completed  |
| LSC                   |                   |                    | 12/21/2016          | LSC             |        |                 | 12/21/2016        | LSC        |                  |               | 12/21/2016 |
| REVIEW<br>STATE A     |                   | REVIEW<br>(INITIAL | /ED BY<br>.s) LB/mm | DATE<br>12/27/2 | 016    | SIGNATURE OF    | SURVEYOR<br>31256 | <u> </u>   |                  | DATE<br>12/21 | /2016      |
| REVIEWED BY<br>CMS RO |                   |                    | DATE                |                 | TITLE  |                 |                   |            | DATE             |               |            |
| Form CM               | IS - 2567B (09/9) | 2) FF (11          | /06)                |                 |        | Page 1 of 2     |                   |            | EVENT ID:        | LSCM1         | 2          |

Form CMS - 2567B (09/92) EF (11/06)

EVENT ID:

# **POST-CERTIFICATION REVISIT REPORT**

|                    | MULTIPLE CONSTRUCTION<br>A. Building |                                       |   | DATE OF REVIS | SIT |
|--------------------|--------------------------------------|---------------------------------------|---|---------------|-----|
|                    | B. Wing                              | Y2                                    | 2 | 12/21/2016    | Y3  |
| 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).

| ITEM                        | DATE                            | ITEM                   | DATE  | ITEM                    |              | DATE       |
|-----------------------------|---------------------------------|------------------------|---|-------------------------|--------------|------------|
| Y4                          | Y5                              | Y4                     | Y5  | Y4                      |              | Y5         |
| ID Prefix F0334             | Correction                      | ID Prefix F0353        | Correction  | ID Prefix               | F0412        | Correction |
| Reg. # 483.25(n)            | Completed                       | Reg. # 483.30          | (a) Completed   | Reg. #                  | 483.55(b)    | Completed  |
| LSC                         | 12/21/2016                      | LSC                    | 12/21/2016  | LSC                     |              | 12/21/2016 |
| ID Prefix F0431             | Correction                      | ID Prefix F0441        | Correction  | ID Prefix               | F0520        | Correction |
| 483.60(b), (d), (d)         |                                 | 483.65<br>Reg. #       |   | Reg. #                  | 483.75(o)(1) | Completed  |
| LSC                         | 12/21/2016                      | LSC                    | 12/21/2016  | LSC                     |              | 12/21/2016 |
|                             |                                 |                        |   |                         |              |            |
|                             |                                 |                        |   |                         |              |            |
|                             |                                 |                        |   |                         |              |            |
|                             |                                 |                        |   |                         |              |            |
|                             |                                 |                        |   |                         |              |            |
|                             |                                 |                        |   |                         |              |            |
|                             |                                 |                        |   |                         |              |            |
|                             |                                 |                        |   |                         |              |            |
|                             |                                 |                        |   |                         |              |            |
|                             |                                 |                        |   |                         |              |            |
| REVIEWED BY<br>STATE AGENCY | REVIEWED BY<br>(INITIALS) LB/mm | <b>DATE</b> 12/27/2016 | SIGNATURE OF SURVEYOR<br>31256                                  |                         | DATE<br>12/2 | 1/2016     |
| REVIEWED BY<br>CMS RO       | REVIEWED BY<br>(INITIALS)       | DATE                   | TITLE   |                         | DATE         |            |
| FOLLOWUP TO SURVEN          | COMPLETED ON                    | CHECK FOR<br>UNCORREC  | I<br>R ANY UNCORRECTED DEFICIEI<br>CTED DEFICIENCIES (CMS-2567) | NCIES. WAS<br>SENT TO T |              | s 🗆 no     |

# **POST-CERTIFICATION REVISIT REPORT**

|                       | MULTIPLE CONSTRUCTION          |                                       |   | DATE OF REVIS | ίT |
|-----------------------|--------------------------------|---------------------------------------|---|---------------|----|
| IDENTIFICATION NUMBER | A. Building 01 - MAIN BUILDING |                                       |   |               |    |
| 245299 <sub>Y1</sub>  | B. Wing                        | Y2                                    | 2 | 11/20/2016    | Y3 |
| 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).

| ITEM<br>Y4   | <b>DATE</b><br>Y5   | ITEM<br>Y4                       | DATE<br>Y5  | ITEM<br>Y4                 |                   | DATE<br>Y5                            |
|--|---|----------------------------------|---|----------------------------|-------------------|---------------------------------------|
| ID Prefix<br>Reg. # NFPA 101<br>LSC K0018            | Correction<br>Completed<br>11/17/2016   | ID Prefix<br>Reg. #<br>LSC K0025 | Completed   | ID Prefix<br>Reg. #<br>LSC | NFPA 101<br>K0062 | Correction<br>Completed<br>11/17/2016 |
| ID Prefix<br>Reg. # NFPA 101<br>LSC K0072            | Correction Completed 11/17/2016   | ID Prefix<br>Reg. #<br>LSC       | Correction Completed  | ID Prefix<br>Reg. #<br>LSC |                   | Correction<br>Completed               |
| ID Prefix<br>Reg. #<br>LSC                           | Correction Completed  | ID Prefix<br>Reg. #<br>LSC       | Correction Completed  | ID Prefix<br>Reg. #<br>LSC |                   | Correction<br>Completed               |
| ID Prefix<br>Reg. #<br>LSC                           | Correction Completed  | ID Prefix<br>Reg. #<br>LSC       | Correction Completed  | ID Prefix<br>Reg. #<br>LSC |                   | Correction<br>Completed               |
| ID Prefix<br>Reg. #<br>LSC                           | Correction Completed  | ID Prefix<br>Reg. #<br>LSC       | Correction Completed  | ID Prefix<br>Reg. #<br>LSC |                   | Correction<br>Completed               |
| REVIEWED BY<br>STATE AGENCY<br>REVIEWED BY<br>CMS RO | REVIEWED BY<br>(INITIALS) TL/mm<br>REVIEWED BY<br>(INITIALS)<br>EY COMPLETED ON |                                  | SIGNATURE OF SURVEYOR<br>365<br>TITLE<br>R ANY UNCORRECTED DEFICIEN<br>CTED DEFICIENCIES (CMS-2567) | NCIES. WAS                 | A SUMMARY OF      | 20/2016<br>ES 🔲 NO                    |



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered December 27, 2016

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

Re: Reinspection Results - Project Number S5299028

Dear Mr. Prince:

On December 21, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 24, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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.

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

Sincerely,

# Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

### STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / | MULTIPLE CONSTRUCTION |                                       |    | DATE OF REVIS | SIT |
|------------------------------|-----------------------|---------------------------------------|----|---------------|-----|
| IDENTIFICATION NUMBER        | A. Building           |                                       |    |               |     |
| 00730 <sub>Y1</sub>          | B. Wing               | Ň                                     | Y2 | 12/21/2016    | Y3  |
| NAME OF FACILITY             |                       | STREET ADDRESS, CITY, STATE, ZIP CODE |    |               |     |
| FRAZEE CARE CENTER           |                       | 219 WEST MAPLE AVENUE, PO BOX 96      |    |               |     |
|                              |                       | FRAZEE, MN 56544                      |    |               |     |

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

| ITE               | EM                                | DATE                | ITEM             |                                | DATE                   | ITEM      |                            |               | DATE       |
|-------------------|-----------------------------------|---------------------|------------------|--------------------------------|------------------------|-----------|----------------------------|---------------|------------|
| Y4                | 1                                 | Y5                  | Y4               |                                | Y5                     | Y4        |                            |               | Y5         |
| ID Prefix         | 20255                             | Correction          | ID Prefix        | 20555                          | Correction             | ID Prefix | 20560                      |               | Correction |
| Reg. #            | MN Rule 4658.0070                 | Completed           |                  | MN Rule 4658.0405<br>Subp. 1   | ;<br>Completed         | Reg. #    | MN Rule 4658.04<br>Subp. 2 | 05            | Completed  |
| LSC               |                                   | 12/21/2016          | LSC              |                                | 12/21/2016             | LSC       |                            |               | 12/21/2016 |
| ID Prefix         | 20565                             | Correction          | ID Prefix        | 20690                          | Correction             | ID Prefix | 20800                      |               | Correction |
| Reg. #            | MN Rule 4658.0405<br>Subp. 3      | _<br>Completed      |                  | MN Rule 4658.0465<br>Subp. 3   | Completed              | Reg. #    | MN Rule 4658.05<br>Subp. 1 | 10            | Completed  |
| LSC               |                                   | 12/21/2016          | LSC              |                                | 12/21/2016             | LSC       |                            |               | 12/21/2016 |
| ID Prefix         | 20830                             | Correction          | ID Prefix        | 20885                          | Correction             | ID Prefix | 20900                      |               | Correction |
| Reg. #            | MN Rule 4658.0520<br>Subp. 1      | Completed           |                  | MN Rule 4658.0525<br>Subp. 1   | completed              | Reg. #    | MN Rule 4658.05<br>Subp. 3 | 25            | Completed  |
| LSC               |                                   | 12/21/2016          | LSC              |                                | 12/21/2016             | LSC       |                            |               | 12/21/2016 |
| ID Prefix         | 20915                             | Correction          | ID Prefix        | 20920                          | Correction             | ID Prefix | 21375                      |               | Correction |
| Reg. #            | MN Rule 4658.0525<br>Subp. 6 A    | Completed           |                  | MN Rule 4658.0525<br>Subp. 6 B | Completed              | Reg. #    | MN Rule 4658.08<br>Subp. 1 | 00            | Completed  |
| LSC               |                                   | 12/21/2016          | LSC              |                                | 12/21/2016             | LSC       |                            |               | 12/21/2016 |
| ID Prefix         | 21426                             | Correction          | ID Prefix        | 21435                          | Correction             | ID Prefix | 21620                      |               | Correction |
| Reg. #            | MN St. Statute 144A.04<br>Subd. 3 | Completed           |                  | MN Rule 4658.0900<br>Subp. 1   | )<br>Completed         | Reg. #    | MN Rule 4658.13            | 45            | Completed  |
| LSC               |                                   | 12/21/2016          | LSC              |                                | 12/21/2016             | LSC       |                            |               | 12/21/2016 |
|                   |                                   |                     |                  |                                |                        |           |                            |               |            |
|                   |                                   |                     | DATE             | CIONATUR                       |                        |           |                            | DATE          |            |
| REVIEW<br>STATE A |                                   | NED BY<br>LS) LB/mm | DATE<br>12/27/20 |                                | E OF SURVEYOR<br>31256 |           |                            | DATE<br>12/21 | /2016      |
| REVIEW<br>CMS RO  |                                   | WED BY<br>LS)       | DATE             | TITLE                          |                        |           |                            | DATE          |            |
|                   |                                   |                     | 1                | Page 1 of 2                    | )                      |           | EVENT ID.                  | LSCM12        | 1          |

### STATE FORM: REVISIT REPORT

|             |                                       |             | DATE OF REVIS  | SIT   |
|-------------|---------------------------------------|-------------|--|---|
| A. Building |                                       |             | l  |   |
| B. Wing     | Y                                     | <u>′</u> 2  | 12/21/2016   | Y3  |
|             |                                       |             |  |   |
|             | STREET ADDRESS, CITY, STATE, ZIP CODE |             |  |   |
|             | 219 WEST MAPLE AVENUE, PO BOX 96      |             |  |   |
|             | FRAZEE, MN 56544                      |             |  |   |
|             |                                       | A. Building | A. Building<br>B. Wing Y2<br>STREET ADDRESS, CITY, STATE, ZIP CODE<br>219 WEST MAPLE AVENUE, PO BOX 96 | A. Building<br>B. Wing '12/21/2016<br>STREET ADDRESS, CITY, STATE, ZIP CODE<br>219 WEST MAPLE AVENUE, PO BOX 96 |

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

| ITEM<br>Y4                                    | DATE<br>Y5                      | ITEM<br>Y4             |                       | DATE<br>Y5        | ITEM<br>Y4                                    | <b>DATE</b><br>Y5      |
|---|---------------------------------|------------------------|-----------------------|-------------------|---|------------------------|
| ID Prefix 21805                               | Correction                      | ID Prefix 21870        |                       | Correction        |   |                        |
| Reg. # MN St. Statute 14<br>Subd. 5           | 4.651<br>Completed              | Reg. # MN St. Subd.    | Statute 144.651<br>18 | Completed         |   |                        |
| LSC   | 12/21/2016                      | LSC                    |                       | 12/21/2016        | _   |                        |
|   |                                 |                        |                       |                   |   |                        |
|   |                                 |                        |                       |                   |   |                        |
|   |                                 |                        |                       |                   |   |                        |
|   |                                 |                        |                       |                   |   |                        |
|   |                                 |                        |                       |                   |   |                        |
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|   |                                 |                        |                       |                   |   |                        |
|   |                                 |                        |                       |                   |   |                        |
|   |                                 |                        |                       |                   |   |                        |
|   |                                 |                        |                       |                   |   |                        |
|   |                                 |                        |                       |                   |   |                        |
|   |                                 |                        |                       |                   |   |                        |
|   |                                 |                        |                       |                   |   |                        |
|   |                                 |                        |                       |                   |   |                        |
|   |                                 |                        |                       |                   |   |                        |
| REVIEWED BY<br>STATE AGENCY                   | REVIEWED BY<br>(INITIALS) LB/mm | <b>DATE</b> 12/27/2016 | SIGNATURE OF          | SURVEYOR<br>31256 | 1   | <b>DATE</b> 12/21/2016 |
|   | REVIEWED BY<br>(INITIALS)       | DATE                   | TITLE                 |                   |   | DATE                   |
| FOLLOWUP TO SURVEY COMPLETED ON<br>10/24/2016 |                                 |                        |                       |                   | NCIES. WAS A SUMMARY<br>SENT TO THE FACILITY? |                        |

| DEPARTMENT OF HEALT                            | H AND HUMA       | N SERVICES                        |                    |            | <b>CENTERS FOR MED</b>  | DICARE & MEDICAID SERVICES  |
|--|------------------|-----------------------------------|--------------------|------------|---|---|
|  | MEDICA           | ARE/MEDICAL                       | D CERTIFIC         | CATION A   | AND TRANSMITTAL   | ID: LSCM  |
|  | PART I -         | TO BE COMPI                       | LETED BY T         | THE STAT   | TE SURVEY AGENCY  | Facility ID: 00730  |
| 1. MEDICARE/MEDICAID PROVIDE<br>(L1) 245299    | ER NO.           | 3. NAME AND AI<br>(L3) FRAZEE CA  |                    |            |   | 4. TYPE OF ACTION: <u>2 (</u> L8)   |
| 2.STATE VENDOR OR MEDICAID N<br>(L2) 972153000 | NO.              | (L4) 219 WEST M<br>(L5) FRAZEE, M |                    | UE, PO B   | OX 96<br>(L6) 56544   | 1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint |
| 5. EFFECTIVE DATE CHANGE OF (                  | OWNERSHIP        | 7. PROVIDER/SU                    | JPPLIER CATEG      | ORY        | <u>02</u> (L7)  | 7. On-Site Visit 9. Other   |
| (L9) <b>11/01/2004</b>                         |                  | 01 Hospital                       | 05 HHA             | 09 ESRD    | 13 PTIP 22 CLIA   | 8. Full Survey After Complaint  |
| 6. DATE OF SURVEY 10/24                        | 4/2016 (L34)     | 02 SNF/NF/Dual                    | 06 PRTF            | 10 NF      | 14 CORF   |   |
| 8. ACCREDITATION STATUS:                       | (L10)            | 03 SNF/NF/Distinct                | 07 X-Ray           | 11 ICF/III | 15 ASC  | FISCAL YEAR ENDING DATE: (L35)  |
| 0 Unaccredited 1 TJC<br>2 AOA 3 Other          |                  | 04 SNF                            | 08 OPT/SP          | 12 RHC     | 16 HOSPICE  | 09/30   |
| 11LTC PERIOD OF CERTIFICATION                  | N                | 10.THE FACILITY                   | IS CERTIFIED       | AS:        |   | I   |
| From (a):                                      |                  | A. In Complia                     | ince With          |            | And/Or Approved Waivers Of                                      | The Following Requirements:   |
| To (b) :                                       |                  |                                   | equirements        |            | 2. Technical Personnel  | 6. Scope of Services Limit  |
|  |                  |                                   | e Based On:        |            | 3. 24 Hour RN   | 7. Medical Director   |
| 12. Total Facility Beds                        | 74 (L18)         | 1. A                              | cceptable POC      |            | 4. 7-Day RN (Rural SN   | · _   |
| 13.Total Certified Beds                        | <b>74</b> (L17)  | X B. Not in Con                   | npliance with Prog | gram       | 5. Life Safety Code   | 9. Beds/Room  |
|  |                  |                                   | and/or Applied V   |            | * Code: <b>B</b> *  | (L12)   |
| 14. LTC CERTIFIED BED BREAKDO                  | WN               |                                   |                    |            | 15. FACILITY MEETS  |   |
| 18 SNF 18/19 SNF                               | 19 SNF           | ICF                               | IID                |            | 1861 (e) (1) or 1861 (j) (1):                                   | (L15)   |
| 74   |                  |                                   |                    |            |   |   |
| (L37) (L38)                                    | (L39)            | (L42)                             | (L43)              |            |   |   |
| 16. STATE SURVEY AGENCY REM.                   | ARKS (IF APPLICA | ABLE SHOW LTC CA                  | NCELLATION I       | DATE):     |   |   |
| See Attached Remarks                           |                  |                                   |                    |            |   |   |
| 17. SURVEYOR SIGNATURE                         |                  | Date :                            |                    |            | 18. STATE SURVEY AGENCY   | APPROVAL Date:  |
| Sherri Softing, HFE N                          | VEII             | 1                                 | 2/14/2016          | (L19)      | Mark meath  | , Enforcement Specialist 12/15/2016 (L20)   |
| PAI  | RT II - TO BE    | COMPLETED I                       | BY HCFA RE         | ( )        | <b>COFFICE OR SINGLE S</b>                                      |   |
| 19. DETERMINATION OF ELIGIBIL                  | JTY              | 20. COM                           | IPLIANCE WITH      | I CIVIL    | 21. 1. Statement of Finan                                       | ncial Solvency (HCFA-2572)  |
| <b>X</b> 1. Facility is Eligible to P          | Participata      |                                   | HTS ACT:           |            | <ol> <li>Ownership/Contro</li> <li>Both of the Above</li> </ol> | l Interest Disclosure Stmt (HCFA-1513)  |
| 2. Facility is not Eligible                    | -                |                                   |                    |            | 5. Both of the Above  | · · · · · · · · · · · · · · · · · · ·   |
| 2. Tuenty is not English                       | (L21)            |                                   |                    |            |   |   |
| 22. ORIGINAL DATE                              | 23. LTC AGREE    | MENT 24                           | 4. LTC AGREEM      | IENT       | 26. TERMINATION ACTION:   | (L30)   |
| OF PARTICIPATION                               | BEGINNING        | <b>B</b> DATE                     | ENDING DAT         | ГЕ         | VOLUNTARY 00  | INVOLUNTARY   |
| 11/01/1985                                     |                  |                                   |                    |            | 01-Merger, Closure  | 05-Fail to Meet Health/Safety   |
| (L24)  | (L41)            |                                   | (L25)              |            | 02-Dissatisfaction W/ Reimburse                                 | 6   |
| 25. LTC EXTENSION DATE:                        | 27. ALTERNATI    | VE SANCTIONS                      |                    |            | 03-Risk of Involuntary Termination                              | OTHER   |
|  | A. Suspension    | n of Admissions:                  |                    |            | 04-Other Reason for Withdrawal                                  | 07-Provider Status Change   |
| (L27)  | B Rescind St     | uspension Date:                   | (L44)              |            |   | 00-Active   |
|  | D. Resente St    | aspension Date.                   | (L45)              |            |   |   |
| 28. TERMINATION DATE:                          | 29               | . INTERMEDIARY                    |                    |            | 30. REMARKS   |   |
|  |                  | 03001                             |                    |            |   |   |
|  | (L28)            | 00001                             |                    | (L31)      |   |   |
|  |                  |                                   |                    |            |   |   |
| 31. RO RECEIPT OF CMS-1539                     | 32               | 2. DETERMINATION                  | OF APPROVAL        | DATE       |   |   |
|  | (L32)            |                                   |                    | (L33)      | DETERMINATION APPE  | ROVAL   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

#### ID: LSCM Facility ID: 00730

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

CCN: 24 5299

On October 24, 2016, the Departments of Health and Public Safety completed a survey to verify the facility is in compliance with Federal participation requirements. The survey found the facility not in substantial compliance. The current survey found the most serius deficiencies in the facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level

G), whereby corrections are required. As of September 1, 2016, CMS policy required that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of actual harm or above cited at the current survey, and on any survey between the current survey and any survey within the last two calendar years. A level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy) whereby significant corrections were required was issued pursuant to a survey completed on November 23, 2015. Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following Category 1 remedy:

• State Monitoring effective November 15, 2016. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F310. (42 CFR 488.430 through 488.444)

• Civil money penalty for the deficiency cited at F318. (42 CFR 488.430 through 488.444)

• Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid Admissions, effective January 24, 2017. (42 CFR 488.417 (b))

If Mandatory denial of payment for new Medicare and Medicaid Admissions, goes into effect. The facility would be subject to a two year loss of NATCEP, beginning January 24, 2016.

Refer to the CMS 2567 for both health and life safety code along with the facility's pllan of correction. Post Certification Revisit (PCR) to following.



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered November 10, 2016

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

RE: Project Number S5299028

Dear Mr. Molgard:

On October 24, 2016, 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 constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 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.

Frazee Care Center November 10, 2016 Page 2

# 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 Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: gail.anderson@state.mn.us Phone: (218) 332-5140 Fax: (218) 332-5196

# NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of actual harm or above cited at the current survey, and on any survey between the current survey and any survey within the last two calendar years. A level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy) whereby significant corrections were required was issued pursuant to a survey completed on November 23, 2015. The current survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G). Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

• State Monitoring effective November 15, 2016. (42 CFR 488.422)

The Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F310. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F318. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid Admissions, effective January 24, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

# ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

• 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 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

Frazee Care Center November 10, 2016 Page 4 Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

# VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 January 24, 2017 (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 April 24, 2017 (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 Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

Frazee Care Center November 10, 2016 Page 5

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc</a> 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

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

|                     | ENT OF HEALTH AND HUMAN SERVICES<br>FOR MEDICARE & MEDICAID SERVICES  |  |  | AH<br>"A" FORM   |  |  |  |  |  |
|---------------------|---|--|--|--|--|--|--|--|--|
|                     | OF ISOLATED DEFICIENCIES WHICH CAUSE  | PROVIDER #   | MULTIPLE CONSTRUCTION  | DATE SURVEY  |  |  |  |  |  |
|                     | TTH ONLY A POTENTIAL FOR MINIMAL HARM   |  | A. BUILDING:   | COMPLETE:  |  |  |  |  |  |
| FOR SNFs AN         | ND NFs  | 245299   | B. WING  | 10/24/2016   |  |  |  |  |  |
| NAME OF PR          | OVIDER OR SUPPLIER  |  | CITY, STATE, ZIP CODE  |  |  |  |  |  |  |
| FRAZEE (            | CARE CENTER   | 219 WEST MAP<br>FRAZEE, MN   | LE AVENUE, PO BOX 96   |  |  |  |  |  |  |
| ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIE  | ENCIES   |  |  |  |  |  |  |  |
| F 156               | 483.10(b)(5) - (10), 483.10(b)(1) NO  | TICE OF RIGHTS, I  | RULES, SERVICES, CHARGES   |  |  |  |  |  |  |
|                     | <ul> <li>The facility must inform the resident this or her rights and all rules and regulin the facility. The facility must also punder §1919(e)(6) of the Act. Such neresident's stay. Receipt of such inform</li> <li>The facility must inform each resident admission to the nursing facility or, wiservices that are included in nursing fabe charged; those other items and services and the amount of charges for those sea and services specified in paragraphs (and services not covered under Medicare of The facility must furnish a written des A description of the requirements and</li> </ul> | lations governing responsible the resident version of the resident version of the resident version of the resident become active services under vices that the facility services; and inform e (5)(i)(A) and (B) of the facility and of clor by the facility's per version of legal right ting personal funds, to  | sident conduct and responsibilities dur,<br>with the notice (if any) of the State dev<br>hade prior to or upon admission and du<br>doments to it, must be acknowledged in<br>ledicaid benefits, in writing, at the time<br>ones eligible for Medicaid of the items<br>the State plan and for which the resident may<br>ach resident when changes are made to<br>his section.<br>e of admission, and periodically durin<br>harges for those services, including any<br>r diem rate.<br>ts which includes:<br>under paragraph (c) of this section; | ing the stay<br>veloped<br>uring the<br>n writing.<br>e of<br>s and<br>ent may not<br>be charged,<br>o the items<br>g the<br>y charges for |  |  |  |  |  |
|                     | A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.   |  |  |  |  |  |  |  |  |
|                     | the State survey and certification agen<br>protection and advocacy network, and<br>file a complaint with the State survey   | elephone numbers of all pertinent State client advocacy groups such as<br>ncy, the State licensure office, the State ombudsman program, the<br>d the Medicaid fraud control unit; and a statement that the resident may<br>and certification agency concerning resident abuse, neglect, and<br>y in the facility, and non-compliance with the advance directives |  |  |  |  |  |  |  |
|                     | The facility must inform each resident for his or her care.   | t of the name, special   | ty, and way of contacting the physicia   | n responsible  |  |  |  |  |  |
|                     | The facility must prominently display<br>applicants for admission oral and writ<br>benefits, and how to receive refunds for   | ten information abou   | t how to apply for and use Medicare a  |  |  |  |  |  |  |

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

The above isolated deficiencies pose no actual harm to the residents

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

| CENTERS             | FOR MEDICARE & MEDICAID SERVICES   | _  |  | "A" FORM  |
|---------------------|--|--|--|---|
| STATEMENT           | OF ISOLATED DEFICIENCIES WHICH CAUSE   | PROVIDER #   | MULTIPLE CONSTRUCTION  | DATE SURVEY   |
| NO HARM W           | ITH ONLY A POTENTIAL FOR MINIMAL HARM  |  | A. BUILDING:   | COMPLETE:   |
| FOR SNFs AN         | ID NFs   | 245299   | B. WING  | 10/24/2016  |
| NAME OF PR          | OVIDER OR SUPPLIER   |  | , CITY, STATE, ZIP CODE  | ·   |
| FRAZEE (            | CARE CENTER  | 219 WEST MA<br>FRAZEE, MN  | PLE AVENUE, PO BOX 96  |   |
| ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIE   | NCIES  |  |   |
| F 156               | Continued From Page 1  |  |  |   |
|                     | This REQUIREMENT is not met as e<br>Based on interview and document revi<br>liability notices, received the required<br>Services (CMS) Form 10123, informin<br>Medicare coverage, 48 hours prior to o<br>Findings include:<br>R52 was provided a Notice of Medicaa<br>would end when she was discharged fr<br>Although R52 received the Notice of N<br>skilled therapy. R52 was given the rig<br>party, a note had been documented wh<br>On 10/24/16 at 10:36 a.m., the assistan<br>required the Notice of Non Coverage 4<br>they (residents) are to have a 2 day not<br>that R52 would have continued therapy<br>services ended on the 6/23/16.<br>A policy was requested, but not provid | ew, the facility faile<br>Notice of Medicare<br>of them of their right<br>discontinuation of s<br>re Non Coverage of<br>om therapy services<br>Non-Coverage, it want<br>to appeal the not<br>ich indicated R52 v<br>ant director of nursin<br>48 hours prior to dist<br>tice." The ADON<br>y services up until h | Non-Coverage Centers for Medicare<br>tts to an appeal an expedited review of<br>killed services.<br>A 6/22/16 which indicated her skilled c<br>s on 6/23/16 due to therapy goals being<br>as not provided 48 hours prior to disco-<br>ice, and just below the signature of the<br>would be discharging home on 6/24/16<br>g (ADON) confirmed R52 had not rec<br>scontinuation of skilled care. The ADO<br>verified she could not find any other do | and Medicaid<br>their<br>overage<br>g met.<br>ntinuation of<br>responsible<br>eived the<br>DN stated, "<br>ocumentation |
|                     |  |  |  |   |
| 031099              | E  | vent ID: I SCM11   |  | If continuation sheet 2   |

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|                          |  | AND HUMAN SERVICES   |                    |     |   |               | APPROVED                   |
|--------------------------|--|--|--------------------|-----|---|---------------|----------------------------|
|                          |  | & MEDICAID SERVICES  |                    |     | 0   | <u>MB NO.</u> | 0938-0391                  |
|                          | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | E CONSTRUCTION  |               | E SURVEY<br>PLETED         |
|                          |  | 245299   | B. WING            |     |   | 10/           | 24/2016                    |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  | -             |                            |
| FRAZEE                   | CARE CENTER  |  |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE          | (X5)<br>COMPLETION<br>DATE |
| F 000                    | INITIAL COMMENT  | rs   | FO                 | 000 |   |               |                            |
|                          | signature is not req<br>page of the CMS-2  | led in ePOC and therefore a<br>uired at the bottom of the first<br>567 form. Electronic<br>POC will be used as<br>bliance.   |                    |     |   |               |                            |
| F 201<br>SS=D            | revisit of your facilit<br>validate that substa<br>regulations has bee<br>your verification.<br>483.12(a)(2) REAS  | acceptable POC an on-site<br>y may be conducted to<br>untial compliance with the<br>en attained in accordance with<br>ONS FOR<br>IARGE OF RESIDENT                 | F 2                | 201 |   |               | 12/14/16                   |
|                          | the facility, and not<br>resident from the fa<br>discharge is necess   | ermit each resident to remain in<br>transfer or discharge the<br>acility unless the transfer or<br>sary for the resident's welfare<br>needs cannot be met in the   |                    |     |   |               |                            |
|                          | the resident's healtl  | charge is appropriate because<br>h has improved sufficiently so<br>ger needs the services<br>ility;  |                    |     |   |               |                            |
|                          | The safety of individent endangered;   | duals in the facility is   |                    |     |   |               |                            |
|                          | The health of individent of individent of the second secon | duals in the facility would ngered;  |                    |     |   |               |                            |
|                          | appropriate notice,<br>under Medicare or<br>For a resident who   | iled, after reasonable and<br>to pay for (or to have paid<br>Medicaid) a stay at the facility.<br>becomes eligible for Medicaid<br>a nursing facility, the nursing |                    |     |   |               |                            |
|                          |  | DER/SUPPLIER REPRESENTATIVE'S SIGN   | NATURE             |     | TITLE   |               | (X6) DATE                  |
| Electron                 | ically Signed  |  |                    |     |   |               | 11/30/2016                 |

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.

PRINTED: 12/15/2016

| CENTER                   |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA   | (X2) MUL            | TIPLE | FORI<br>OMB NO   | D: 12/15/2016<br>MAPPROVED<br>D. 0938-0391<br>TE SURVEY |
|--------------------------|--|--|---------------------|-------|--|---|
| AND PLAN C               | F CORRECTION   | IDENTIFICATION NUMBER:   |                     |       |  | MPLETED   |
|                          |  | 245299   | B. WING             |       | 10   | 0/24/2016   |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                     |       | REET ADDRESS, CITY, STATE, ZIP CODE  |   |
| FRAZEE                   | CARE CENTER  |  |                     |       | 9 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>YMUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIZ<br>TAG | x     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE                              |
| F 201                    | charges under Med<br>The facility ceases<br>This REQUIREMEN<br>by:<br>Based on interview<br>facility failed to ensu-<br>inappropriately disc<br>of 1 (R103) resider<br>requirements.<br>Findings include:<br>R103's undated dia<br>diagnoses which ind<br>liver with ascites, he<br>induced insomnia, u<br>chronic obstructive<br>R103's Admission A<br>10/20/16, identified<br>had clear speech. F<br>revealed R103 was<br>was full weight beau<br>R103's Individual R<br>10/20/16, identified<br>and was independe<br>(ADL's) including ar<br>Review of R103's n | a resident only allowable<br>icaid; or<br>to operate.<br>T is not met as evidenced<br>and document review, the<br>ure residents are not<br>harged from the facility for 1<br>hts reviewed for discharge<br>gnoses list identified<br>cluded, alcohol cirrhosis of the<br>epatic encephalopathy, alcohol<br>uncontrolled diabetes and<br>pulmonary disease (COPD).<br>Assessment form dated<br>R103 was alert, oriented and<br>R103's assessment also<br>independent in mobility and<br>ring.<br>esident Care Plan dated<br>R103 was alert and oriented<br>ont with activities of daily living<br>mbulation.<br>urses progress notes from | F 2                 | 201   | <ul> <li>F 201 Reason for transfer/discharge of a resident</li> <li>Resident # 103 was discharged from the facility on 10-20-2016.</li> <li>All residents have the potential to be affected in this area. By educating our staff and monitoring our systems, this will ensure compliance in this area.</li> <li>Mandatory education provided to nursing staff on 11-16-2016 and 11-17-2016 on the procedure titled, Transferring a Resident to Another Facility or Hospital with a focus on the ensuring residents are not discharged from the facility without just cause and physician notification. The physician must document why the residents needs are not able to be met within the facility. The bed hold notice must be completed at the time of the transfer. The facility must use all resources available to avoid an acute ER visit/unexpected transfer/discharge from facility.</li> </ul> |   |
|                          | 10/20/16 to 10/21/1<br>-10/20/16, at 2:00 p<br>facility, was indeper   | 6 revealed the following:<br>c.m. R103 was admitted to the<br>ndent with ambulation, had<br>the facility and was forgetful at  |                     |       | 4. An audit has been developed to<br>monitor the documentation on resident<br>transfers to the hospital for appropriate<br>transfer discharge. The audit will be<br>completed by the DON or designee on all  |   |

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|                          |  | AND HUMAN SERVICES   |                    |     |  | FORM  | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|--------------------|-----|--|---|-------------------------------------|
| STATEMENT                | T OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                |     | E CONSTRUCTION   | (X3) DATE   | E SURVEY<br>PLETED                  |
|                          |  | 245299   | B. WING            |     |  | 10/2  | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |  | <u> </u>           | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |   |                                     |
| FRAZEE                   | CARE CENTER  |  |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |   |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)  | BE  | (X5)<br>COMPLETION<br>DATE          |
| F 201                    | times.<br>-10/20/16, 5:45 p.m<br>answered questions<br>at the evening mea<br>- 10/21/16, at 6:00 a<br>short periods of tim<br>stomach ache and<br>for insomnia) and h<br>times during the nig<br>-10/21/16, at 8:30 a<br>attempted to reach<br>had left a message<br>had been wandering<br>been fluctuating. R <sup>-</sup><br>consultant and had<br>the staff member at<br>had verbally threate<br>been sitting on a dir<br>occupied by other reach<br>the facility. The note<br>nurse spoke with R<br>obtained to send R <sup>-</sup><br>- 10/21/16, late entre<br>been up wandering<br>redirected to return<br>R103 was observed<br>room, made the staff<br>somewhere." R103<br>own and stated to the<br>took all of his a.m. r<br>and he was all done<br>towards the nurse, f<br>had reported to the<br>the bruises on his a | <ul> <li>n. R103 was alert, asked and<br/>s appropriately and ate poorly<br/>l.</li> <li>a.m. R103 had only slept for<br/>e. R103 requested Tums for a<br/>Melatonin (supplement used<br/>lad been up to the bathroom 3</li> </ul> | F 2                | 201 | resident transfers to the hospital to<br>monitor the documentation of a cha<br>condition with an SBAR assessmer<br>documentation from primary care<br>physician on why the facility cannot<br>the needs of the resident, notificatio<br>the POA/responsible party and the<br>of a signed bed hold. Audits will be<br>completed weekly X 4 weeks, then<br>monthly X 2 months. Audit findings<br>reported monthly to the QA commit<br>months with follow-up to Committee<br>recommendations.<br>5. Deficient practice will be correct<br>December 14, 2016 | meet<br>on to<br>receipt<br>will be<br>tee x 3<br>e |                                     |

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|                          |   | AND HUMAN SERVICES  |                    |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|--------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | · /                |     | E CONSTRUCTION  | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING            | i   |   | 10/2      | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |           |                                     |
| FRAZEE                   | CARE CENTER   |   |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 201                    | the facility nurse ha<br>room to stop hitting<br>R103's room. R103<br>escalate and act er<br>arrived at 9:00 a.m.<br>the emergency roor<br>and shoes sent with<br>Review of R103 soc<br>10/20/16 to 10/21/1<br>-10/20/16, R103 ha<br>following a 3 month<br>an altered mental s<br>with various relative<br>R103 had orders fo<br>had not been detern<br>declined to complet<br>he requested to pla<br>-10/21/16, at 3:30 p<br>the emergency roor<br>R103 acting erratica<br>staff and residents.<br>Immediate Discharg<br>where R103 had be<br>notified R103's dau<br>facility and the daug<br>guardian several we<br>manager from Whit<br>R103 was a membe<br>contacted Hennepin<br>open case) and Wr<br>admission and disc<br>Review of R103's p | <ul> <li>and heard R103 yelling in his</li> <li>him, though no person was in</li> <li>B's behavior continued to</li> <li>ratically, the ambulance</li> <li>and R103 was transported to</li> <li>m with his clothing, glasses</li> <li>h him.</li> <li>cial services notes from</li> <li>6 revealed the following:</li> <li>ad been admitted to the facility</li> <li>h hospital stay which was for</li> <li>tatus. R103 had been living</li> <li>es in the last year and a half.</li> <li>or therapy and length of stay</li> <li>mined at that time. R103 had</li> <li>te the admission paperwork as</li> <li>by bingo.</li> <li>o.m. R103 was transported to</li> <li>m following a 911 call due to</li> <li>ally and had been threatening</li> <li>R103 was issued a Notice of</li> <li>ge via fax to the hospital</li> <li>een transported to. SW had</li> <li>ofter had applied for a</li> <li>eeks prior with a case</li> <li>te Earth Reservation where</li> <li>er. The note also revealed SW</li> <li>n County (where R103 had an</li> <li>hite Earth regarding R103's sharge.</li> </ul> | F 2                | 201 |   |           |                                     |

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245299 B. WING 10/24/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE CARE CENTER FRAZEE, MN 56544 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 201 Continued From page 4 F 201 R103's medical record did not have any futher documentation by R103's physician. On 10/24/16, at approximately 3:00 p.m., during telephone interview with hospital social worker (HSW), she stated R103 had been transferred from the nursing home to the hospital on 10/21/16. The nursing home had sent his personal belongings with him and shortly after he arrived the facility had sent a Notice of Discharge via fax from the nursing home. The fax cover sheet had instructed to give the notice to R103. HSW stated R103 had been admitted because of acute complications from liver problems, presented to the ER "sedated" and with treatment was now alert, cooperative and ambulating himself without difficulty and was ready for discharge from the hospital. She indicated she had been in contact with the nursing home, most recently, 10/24/16, and was told the facility would not be accepting R103 back to the nursing home. HSW indicated she had been told the facility would not take him back due to R103 being a threat to himself and others. HSW stated R103 had told her he was looking forward to returning to the facility, and had told her he liked the staff in the facility and was looking forward to playing bingo. Review of an untitled Frazee Care Center form, dated 10/21/16, revealed a Notice to Discharge Pursuant to Minnesota Statutes 144.651, subd. 29 and 42 U.S.C 1369 r. had been issued to R103 via fax from the facility. A letter head cover sheet timed 10:20 a.m., was attached to the notice requesting the hospital emergency room department to deliver the notice to R103. The notice revealed R103 had been immediately discharged from the facility due to the safety of

FORM CMS-2567(02-99) Previous Versions Obsolete

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|                          |  | AND HUMAN SERVICES  |                   |     |  | FORM | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|-------------------|-----|--|------|-------------------------------------|
|                          | F OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     | E CONSTRUCTION   |      | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING           |     |  | 10/: | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                   |     | STREET ADDRESS, CITY, STATE, ZIP CODE  |      |                                     |
| FRAZEE                   | CARE CENTER  |   |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |      |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>( MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE   | (X5)<br>COMPLETION<br>DATE          |
| F 201                    | individuals had bee<br>been threatening th<br>caregivers in the fac<br>the health of individ<br>endangered. The m<br>administrator (FM.)<br>Review of R103's fa<br>dated 10/21/16, rev<br>the hospital due to<br>floor and sitting on<br>The summary revea<br>the hospital by amb<br>sent with.<br>Review of the hosp<br>assessment dated<br>been admitted with<br>encephalopathy and<br>disturbances since<br>The note revealed R<br>to the facility. The m<br>regarding R103's th<br>sent with R103 to th<br>further revealed R1<br>notice from the faci<br>discharge and the h<br>consult the MN Offi<br>Term Care.<br>On 10/24/16, at 3:5<br>stated he was awar<br>the hospital as well<br>discharged from the<br>stated he had been<br>uncooperative, lying<br>the dining room tab<br>had also threatened | n endangered and R103 had<br>he life of other residents and<br>cility. The notice also revealed<br>luals in the facility would be<br>otice was signed by the facility | F2                | 201 |  |      |                                     |

Facility ID: 00730

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|                          |  | AND HUMAN SERVICES  |                     |    |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|---------------------|----|--|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 |    | E CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING             |    |  | 10/:      | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                     |    | TREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER  |   |                     |    | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | <  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 201                    | service worker at the<br>was not the best platmake sure R103 was<br>care. Administrator<br>operations was com-<br>morning R103 was<br>room and had made<br>R103 from the facility<br>when his acute illner.<br>On 10/24/16, at 4:0<br>stated she had bee<br>admitted on 10/20/-<br>complete all of his a<br>wanted to attend bit<br>was acting out of se<br>evening. SW stated<br>facility the am of 10<br>the hallway by staff<br>staff and residents<br>SW stated it had ta<br>to de-escalate R103<br>room tables. SW st<br>been fearful of R10<br>with the director of<br>note (due to violence<br>R103 was sent to, a<br>in which R103 had<br>vulnerable adult rep<br>she had spoken wit<br>been told R103's be<br>for 6 months and he<br>before his last hosp<br>the previous hospita<br>sending R103 to the<br>physical and occup<br>R103 was independ | hat time and had felt the facility<br>ace for R103 and wanted to<br>as going to receive the best<br>stated the regional director of<br>sulted on 10/21/16, the<br>transferred to the emergency<br>e the decision to discharge<br>ity and not to re-admit R103 | F 2                 | 01 |  |           |                                     |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                    |     | FC   | DRM A        | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|--------------------|-----|--|--------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | E CONSTRUCTION (X3)  | ) DATE       | SURVEY<br>PLETED                    |
|                          |   | 245299  | B. WING            |     |  | 10/2         | 4/2016                              |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |              |                                     |
| FRAZEE                   | CARE CENTER   |   |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |              |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>YMUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | E            | (X5)<br>COMPLETION<br>DATE          |
| F 201<br>F 241<br>SS=D   | paperwork and had<br>stated R103's cogn<br>behavior would also<br>inappropriate. NM-0<br>very well the night b<br>hospital and the mo<br>hospital he had beo<br>staff and residents.<br>operations told ther<br>had made the decis<br>483.15(a) DIGNITY<br>INDIVIDUALITY<br>The facility must pro-<br>manner and in an e<br>enhances each residents | ge 7<br>pleted R103's admission<br>worked with him. NM-C<br>ition had fluctuated and his<br>o fluctuate from appropriate to<br>C stated R103 did not sleep<br>before he was sent to the<br>orning R103 was sent to the<br>one very threatening towards<br>NM-C stated the director of<br>in to call 911 and apparently<br>sion to discharge R103.<br>AND RESPECT OF |                    | 201 |  |              | 12/14/16                            |
|                          | by:<br>Based on observat<br>review the facility fa<br>1 residents (R66) w<br>soiled linens.<br>Findings include:<br>R66's quarterly Min<br>7/13/16 identified R<br>impairment, and wa<br>activities of daily livi<br>more staff to assist<br>further identified R6  | NT is not met as evidenced<br>ion, interview, and record<br>iled to maintain dignity for 1 of<br>ho was observed lying in<br>imum Data Set (MDS), dated<br>66 had severe cognitive<br>is totally dependent of staff for<br>ng (ADLs), and required 2 or<br>with bed mobility. The MDS<br>66 had diagnoses which<br>orain injury, seizure disorder                   |                    |     | <ul> <li>F 241 Resident dignity</li> <li>1. Resident # R66 has clean linen on her bed.</li> <li>2. All incontinent residents have the potential to be affected in this area. All of residents frequently incontinent of ur will be generated and used for facility auditing.</li> <li>3. Mandatory nursing staff education was provided on November 16 and 17, 2016 to educate staff on the procedure titled Linens and Dignity with a focus or the need to change residents soiled</li> </ul> | list<br>rine |                                     |

Event ID:LSCM11

Facility ID: 00730

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                    |     |   | FORM  | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|--------------------|-----|---|---|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                |     | E CONSTRUCTION  | (X3) DATE   | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING            |     |   | 10/2  | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |   |                                     |
| FRAZEE                   | CARE CENTER   |   |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |   |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)   | BE  | (X5)<br>COMPLETION<br>DATE          |
| F 241                    | her bed, on her bac<br>gown. Licensed pra<br>nursing assistant (N<br>room for morning ca<br>R66's white sheet a<br>R66's body and set<br>NA-E was positione<br>LPN-A was positione<br>bed.<br>R66' bottom bed sh<br>several dried brown<br>dried, yellow stain of<br>which extended to t<br>where LPN-A was p<br>R66. The stains we<br>hand on the bed LF<br>with her torso and s<br>multiple browns stre<br>on R66's sheet. LPI<br>streaks and large ye<br>urine, covered the r<br>R66's white cotton I<br>perform R66's morr<br>On 10/19/16, at 1:0<br>facility practice was<br>changed on resider<br>linens became soile<br>received a bath on<br>was today. NA-E in<br>how long R66's beco<br>indicated she thoug<br>repositioned R66 in<br>On 10/19/16, at 1:0 | <ul> <li>05 a.m. R66 was observed in a hospital actical nurse (LPN)-A and VA)-E were present in her ares. LPN-A pulled away and white cotton blanket from both off to R66's right side. Ad on R66's left side of her</li> <li>weet was observed to have a streaks, and a large round, on her white cotton bed sheet the left edge of her bed sheet to perform cares on re next to R66's left arm and PN-A leaned over R66's bed acrub top resting on the eaks and yellow stained areas N-A confirmed multiple brown ellow stain were feces and multiple stained areas with blanket and continued to hing cares.</li> <li>3 p.m. NA-E stated the usual for resident's sheets to be to bath days, and whenever ed. She stated R66 had Monday, and her next bath dicated she was not aware a linens had been soiled, and tht night shift had last bed.</li> <li>6 p.m. NA-D stated facility</li> </ul> | F 2                | 241 | <ul> <li>linens with each incontinent episode</li> <li>4. An audit has been developed to<br/>monitor resident bed linens. The audit<br/>be completed by the DON, or desig<br/>monitor the cleanliness of resident<br/>linens on all three shifts. The audit<br/>completed 2-3 per week on all three<br/>X 4 weeks, the weekly for 4 weeks,<br/>monthly X 2 months. Audit findings<br/>reported to the QA committee x 3 m<br/>with follow-up to committee<br/>recommendations.</li> <li>5. Deficient practice will be correct<br/>December 14, 2016</li> </ul> | o<br>udit will<br>nee to<br>bed<br>will be<br>e shifts<br>then<br>s will be<br>nonths |                                     |
|                          |   | ent bed sheets on their bath<br>hey had an "accident."  |                    |     |   |   |                                     |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                    |     |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|--------------------|-----|--|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                |     | E CONSTRUCTION   | (X3) DATI | E SURVEY<br>PLETED                  |
|                          |  | 245299   | B. WING            |     |  | 10/2      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |  | •                  | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER  |  |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 241                    | Continued From pa  | ge 9   | F 2                | 241 |  |           |                                     |
|                          | facility practice was<br>changed whenever<br>on bath days. She s   | 6 p.m. LPN-A stated the usual<br>for resident's sheets to be<br>the linens became soiled, and<br>stated R66's soiled sheets<br>changed right away when they  |                    |     |  |           |                                     |
|                          | (CM)-A stated resid<br>checked for cleanlin<br>resident care. She s<br>be changed whene<br>and routinely on the<br>should have been v<br>R66's sheets becar          | 53 a.m. clinical manager<br>lent bed sheets should be<br>ness when staff provide<br>stated resident sheets should<br>ver staff notice they are soiled,<br>eir bath days. She stated it<br>rery obvious to staff when<br>ne soiled, and she would<br>nge the sheets right away. |                    |     |  |           |                                     |
| F 242<br>SS=D            | 3/1/14, identified so<br>immediately remove<br>and taken to the lau<br>identified dirty laund<br>person's body and I<br>handling dirty laund<br>laundry to prevent t | blicy, Linens-Handling dated<br>iled linen was to be<br>ed from the resident's room<br>undry room. The policy further<br>dry should not be close to a<br>hands were to be washed after<br>ry and prior to handling clean<br>he spread of infection.<br>ETERMINATION - RIGHT TO | F 2                | 242 |  |           | 12/14/16                            |
|                          | schedules, and hea<br>her interests, asses<br>interact with membrinside and outside t  | e right to choose activities,<br>lth care consistent with his or<br>sements, and plans of care;<br>ers of the community both<br>the facility; and make choices<br>s or her life in the facility that<br>e resident.  |                    |     |  |           |                                     |

Facility ID: 00730

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|                          | OF DEFICIENCIES   | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULT   | IPLE CONSTRUCTION  | OMB NO.<br>(X3) DAT   | E SURVEY                  |
|--------------------------|---|--|---|--|---|---------------------------|
|                          | PF CORRECTION   | IDENTIFICATION NUMBER:   |   | NG   |   | PLETED                    |
|                          |   | 245299   | B. WING _   |  | 10/2  | 24/2016                   |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE  |   |                           |
| FRAZEE                   | CARE CENTER   |  |   | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   | <b>j</b>  |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)   | OULD BE   | (X5)<br>COMPLETIO<br>DATE |
| F 242                    | by:<br>Based on interview<br>facility failed to ensu<br>for bathing frequence   | age 10<br>NT is not met as evidenced<br>w, and document review, the<br>ure each resident's preference<br>cy was provided for 1 of 3<br>no was reviewed for bathing   | F 24  | <ul> <li>F 242 Right to make choices</li> <li>1. Resident R61 is being offer three times per week; R61 s of and bath schedule have been to</li> <li>2. All cognitively intact resident the potential to be affected in the list of residents with a BIMS sci</li> </ul>  | are plan<br>ipdated.<br>nts have<br>nis area. A                         |                           |
|                          | (MDS) dated 7/24/1<br>cognitively intact an<br>included, insulin de<br>heart failure (CHF)<br>identified R61 requi<br>staff with dressing a   | arterly Minimum Data Set<br>6, identified R61 was<br>nd had diagnoses which<br>pendent diabetes, congestive<br>and anxiety. The MDS<br>ired extensive assistance from<br>and bathing.<br>rrent care plan revised   | <ul> <li>a Set</li> <li>a Set</li> <li>greater will be interviewed to a their bathing preferences. Ca be updated to reflect resident bathing preferences. The cog impaired residents bathing new based on assessment and fam</li> <li>3. Mandatory nursing staff ea was provided on November 16 2016 to educate staff on the p titled, Resident Rights with a fameed to offer residents a choic bathing.</li> <li>4. An audit has been develop monitor resident satisfaction a</li> </ul> | etermine<br>e plans will<br>hoice in<br>iitively<br>ds will be<br>ily input.<br>ucation  |   |                           |
|                          | 1/27/16, revealed F<br>with bathing.<br>Review of nursing a<br>by the facility, dated   | A61 required assistance of one<br>assistant care sheet provided<br>d 10/17/16, directed staff to<br>ath 3 times a week, Monday,  |   | <ul> <li>2016 to educate staff on the pr<br/>titled, Resident Rights with a for<br/>need to offer residents a choice<br/>bathing.</li> <li>4. An audit has been develop<br/>monitor resident satisfaction ar<br/>compliance in resident bathing</li> </ul>   | ed to<br>preference   |                           |
|                          | received her bath o<br>enough staff on the<br>been told the staff w<br>bathing on 10/18/16<br>staff on the floor, sh<br>with a bath. R61 sta<br>(NA) do not have en<br>give baths, so she h<br>R61 stated she was<br>week, Monday, We | 6 p.m. R61 stated she had not<br>in Monday 10/17/16, due to not<br>if loor. R61 stated she had<br>would try to help her with<br>6, though due to not enough<br>he had not received assistance<br>ated the nursing assistants<br>nough time during the day to<br>had changed to before bed.<br>is scheduled to have 3 baths a<br>dnesday and Fridays and was<br>3 baths a week due to not |   | <ul> <li>that includes bathing type, freq<br/>time of day. The audit will be of<br/>by the DON, or designee. The<br/>be weekly X 4 weeks, then mon<br/>months. Audit findings will be p<br/>the QA committee with follow-u<br/>committee recommendations</li> <li>5. Deficient practice will be con<br/>December 14, 2016</li> </ul> | uency and<br>ompleted<br>audit will<br>hthly X 2<br>provided to<br>p to |                           |

Facility ID: 00730

|  |  | AND HUMAN SERVICES  |         |   | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |
|--|--|---|---------|---|-------------------------------|-------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |  | (X1) PROVIDER/SUPPLIER/CLIA   |         |   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|  |  | 245299  | B. WING |   | 10/24/2016                    |                                     |
| NAME OF F  | PROVIDER OR SUPPLIER   |   |         | STREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                                     |
| FRAZEE   | CARE CENTER  |   |         | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |   |         | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE                          | (X5)<br>COMPLETION<br>DATE          |
| F 242  | "months" since she<br>and indicated she u<br>lack of nursing staff<br>On 10/20/16, at 1:5<br>understood R61 wa<br>a week in the eveni<br>received her baths<br>On 10/21/16, at 11:1<br>had met with R61 o<br>had not been routin<br>week as care plann<br>On 10/21/16, at 1:3<br>interview, ADON sta<br>to routinely complet<br>on residents prefere<br>staffing shortages.<br>On 10/24/16, at 9:3<br>stated she was una<br>getting done 3 time<br>care plan should be<br>A facility policy titleo<br>1, 2008, revealed a<br>included the right to<br>with reasonable acc<br>needs and preferen<br>residents right to ch | <ul> <li>floor. R61 stated it had been<br/>had received 3 baths a week,<br/>inderstood it was due to the<br/>f.</li> <li>2 a.m. NA-F stated she<br/>as supposed to receive 2 baths<br/>ngs and was not sure if R61<br/>routinely.</li> <li>02 a.m. ADON indicated she<br/>on 10/20/16 and confirmed R61<br/>iely receiving her 3 baths a<br/>ned.</li> <li>7 p.m. during a follow up<br/>ated she felt staff were unable<br/>te the number of baths based<br/>ence, such as R61, due to</li> <li>1 a.m. nurse manager (NM)-A<br/>tware R61's baths were not<br/>s a week. She stated R61's<br/>e followed.</li> <li>d Resident Rights, dated April<br/>list of resident rights which<br/>o receive services in the facility<br/>commodation of individual<br/>nees. The policy also revealed<br/>noose activities, schedules,<br/>nsistent with interests,</li> </ul> | F 242   |   |                               |                                     |
| F 244<br>SS=E  | •  | N/ACT ON GROUP  | F 244   |   |                               | 12/14/16                            |
|  | When a resident or   | family group exists, the facility   |         |   |                               |                                     |

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|  |   | AND HUMAN SERVICES                     |         |  |  | RINTED: 12/15/2016<br>FORM APPROVED<br>MB NO. 0938-0391 |  |  |
|--|---|--|---------|--|--|---|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |         |  | (X3) DATE SURVEY<br>COMPLETED  |   |  |  |
| 245299   |   |  | B. WING |  |  | 10/24/2016  |  |  |
| NAME OF  | PROVIDER OR SUPPLIER  |  | •       | ST   | REET ADDRESS, CITY, STATE, ZIP CODE  | •   |  |  |
| FRAZEE   | CARE CENTER   |  |         | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544 |  |   |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                |  |         | x  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY)  | BE COMPLÉTION   |  |  |
| F 244  | CARE CENTER<br>SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  | F 2     | 244  | a bath<br>plan<br>ated.<br>ated.<br>and<br>to be<br>ent<br>5, and<br>will be<br>by the<br>ances<br>and<br>e plans<br>hoice<br>ively<br>vill be<br>nput.<br>tion<br>I 17,<br>dure<br>on the<br>their<br>Staff<br>liant on |   |  |  |

Facility ID: 00730

PRINTED: 12/15/2016 FORM APPROVED

| DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB                              |  |  |  |     |  |   |                            |  |  |
|---|--|--|--|-----|--|---|----------------------------|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |  |     |  | MB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED                   |                            |  |  |
|   |  | 245299   | B. WING  |     |  | 10/24/2016  |                            |  |  |
| NAME OF F   | PROVIDER OR SUPPLIER   |  |  | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |   |                            |  |  |
| FRAZEE  | CARE CENTER  |  | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544 |     |  |   |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                                   |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)  | BE  | (X5)<br>COMPLETION<br>DATE |  |  |
| F 244   | conferences. She s<br>told her they will loc<br>anything about it. Si<br>weren't getting the of<br>they were short stat<br>director (AD) was a<br>meeting and she wo<br>to the ones she sho<br>not doing any good.<br>R27 stated she was<br>who had brought up<br>long call light wait ti<br>had not given any e<br>concern continued.<br>telling resident court<br>the residents contin<br>again, and again.<br>Review of the reside<br>from 7/27/16, 8/31/<br>-7/27, residents were<br>needs to have their<br>than 2 hours<br>-8/31, residents were<br>long to answer their<br>further identified R2<br>morning at 8:00 a.m<br>answered until 10:0<br>indicated R27 state<br>long because she w<br>morning activities. T<br>residents had the sa | ight waits during her care<br>tated the facility had always<br>ik into it, but they hadn't done<br>he stated she felt residents<br>care they needed because<br>ifed. She stated the activities<br>t every resident council<br>build tell residents she talked<br>build talk to, but evidently it was | F 2  | 244 | <ul> <li>response times.</li> <li>4. An audit has been developed to monitor resident satisfaction, include resident counsel members R27, R1 and R45 and compliance in resider bathing preference that includes batype, frequency and time of day. The audit will be completed by the DON designee. The audit will be weekly weeks, then monthly X 2 months. A findings will be provided to the QA committee with follow-up to commit recommendations</li> <li>5. Deficient practice will be correct December 14, 2016</li> </ul> | led<br>I, R2,<br>at<br>thing<br>he<br>I, or<br>X 4<br>Audit<br>ttee |                            |  |  |
|   | long because she w morning activities.   | vanted to get up to go to<br>The minutes identified other  |  |     |  |   |                            |  |  |

|   |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                   |                |  | FORM       | 12/15/2016<br>APPROVED<br>0938-0391 |
|---|---|---|-------------------|----------------|--|------------|-------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |   |   |                   | E CONSTRUCTION | (X3) DATE SURVEY<br>COMPLETED  |            |                                     |
|   |   | 245299  | B. WING           |                | ·····  | 10/24/2016 |                                     |
| NAME OF I   | PROVIDER OR SUPPLIER  |   |                   | S              | TREET ADDRESS, CITY, STATE, ZIP CODE   |            |                                     |
| FRAZEE CARE CENTER  |   |   |                   |                | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |            |                                     |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D BE       | (X5)<br>COMPLETION<br>DATE          |
| F 244   | <ul> <li>9/28, residents had weren't being answ up to an hour to get time during the day</li> <li>Review of the resid forms from 7/27/16, identified:</li> <li>-7/27, director of nuresident council corrand monitoring had indicated they had resident call lights. concerns were post communication boat morning meetings were post communication boat morning meetings were approved the staff had been asked resident call lights. concerns were post communicated staff director, facility nurse to monitor further complaints at -8/31, nurse consult call light response to the staff. The form lack to be taken to correct concerns and long of -9/28, nurse consult reviewed resident call staff. The form lack to be taken to correct concerns and staffit scheduler, nursing administrator. She indicated the important of the staff.</li> </ul> | a concern that their call lights<br>ered and residents could wait<br>their lights answered at any<br>ent council concern follow-up<br>, 8/31/16, and 9/28/16<br>arsing (DON) identified the<br>neerns and indicated audits<br>been done. DON also<br>room for improvement and all<br>ed to assist in answering<br>DON further indicated the<br>ted in the nursing<br>and and discussed at the<br>with administrator and<br>DON identified she would<br>call lights and address any<br>as needed.<br>tant indicated she witnessed<br>imes on 8/31/16, and<br>fing plans with regional<br>ses and interim administrator.<br>communicated call light<br>d resident concerns to nursing<br>ed documentation of actions<br>for or improve the staffing<br>call lights responses.<br>tant indicated indicated she<br>all light response time<br>ng plan with regional director, | F2                | 244            |  |            |                                     |

Facility ID: 00730

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|   |  | I AND HUMAN SERVICES<br>E & MEDICAID SERVICES   |  |     |  | FORM       | 12/15/2016<br>APPROVED<br>0938-0391 |  |
|---|--|---|--|-----|--|------------|-------------------------------------|--|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA   |  | · ·   |  |     | (X3) DATE SURVEY<br>COMPLETED  |            |                                     |  |
|   |  | 245299  | B. WING  | i   |  | 10/24/2016 |                                     |  |
| NAME OF   | PROVIDER OR SUPPLIER   | •   |  | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  | -          |                                     |  |
| FRAZEE  | CARE CENTER  |   | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544 |     |  |            |                                     |  |
| (X4) ID         SUMMARY STATEMENT OF DEFICIENCIES           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION) |  |   | ID<br>PREF<br>TAG                                    |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE       | (X5)<br>COMPLETION<br>DATE          |  |
| F 244   | of actions to be takk<br>improve the staffing<br>responses.<br>On 10/24/16, at 4:0<br>(AD) stated she coor<br>council meetings and<br>She stated the usual<br>minutes from the lar<br>review any follow up<br>concerns, reviewed<br>and inform resident<br>facility. She stated a<br>over all of the servit<br>asked residents to<br>concerns with any of<br>AD stated R27 rout<br>meetings and R27,<br>voiced concerns re-<br>short-staffed and lo<br>She stated almost of<br>complained about r<br>waits, and not enou-<br>the assistant director<br>resident concerns r<br>and being short sta<br>AD stated she brour<br>resident council als<br>meetings to all dep-<br>concern Follow-up<br>nursing, or put the f | en or monitoring to correct or<br>g concerns and long call lights<br>08 p.m. the activities director<br>ordinated the facility's resident<br>nd typed the meeting minutes.<br>al practice was to review the<br>ast resident council meeting,<br>p or response to previous<br>d old business, new business,<br>ts of upcoming events in the<br>at every meeting she went<br>ce areas individually and<br>speak up if they had any<br>departments.<br>tinely attended resident council<br>R1, R2, R5, and R45 had all<br>garding the facility being<br>ong call light waits.<br>every month residents<br>nursing and long call light<br>ugh staff. She stated she knew<br>or of nursing and the<br>onsultant were aware of<br>regarding long call light waits |  | 244 |  |            |                                     |  |

Facility ID: 00730

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |  |     | FORM   | : 12/15/2016<br>APPROVED<br>. 0938-0391 |  |  |  |
|--------------------------|---|--|--|-----|--|---|--|--|--|
| STATEMENT                | TATEMENT OF DEFICIENCIES<br>ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |  |  |     | E CONSTRUCTION (X3) DAT  | E SURVEY<br>IPLETED                     |  |  |  |
|                          |   | 245299   | B. WING  |     |  | 24/2016                                 |  |  |  |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |  | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |   |  |  |  |
| FRAZEE                   | CARE CENTER   |  | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544 |     |  |   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG                                    |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE              |  |  |  |
| F 244<br>F 248<br>SS=D   | meeting.<br>The AD confirmed r<br>minutes and follow<br>September. AD stat<br>residents received a<br>call lights were not l<br>was going to be dor<br>Review of facility po<br>Council dated 4/1/0<br>group exists, the fac<br>and act upon their of<br>recommendations of<br>and operational dec<br>care and quality of l<br>483.15(f)(1) ACTIV/<br>INTERESTS/NEED<br>The facility must pro-<br>of activities designed<br>the comprehensive<br>the physical, menta<br>of each resident.<br>This REQUIREMEN<br>by:<br>Based on observat<br>review the facility factors | ext scheduled resident council<br>resident council meetings<br>up forms in July, August, and<br>ted she didn't always feel like<br>a straight answer for why their<br>being answered, and what<br>ne to fix the problem.<br>blicy Resident Council/Family<br>8, identified when a resident<br>cility must listen to their views<br>concerns and<br>of residents concerning policy<br>cisions that affected resident<br>life.<br>ITIES MEET |  | 244 | F 248 Activities meet interests/needs of<br>each resident<br>1. Resident R66 was reassessed for                          | 12/14/16                                |  |  |  |
|                          | assessment for 1 of   | f 3 residents (R66) who was<br>to provide all leisure activities.  |  |     | activities of interest on November 15,<br>2016; R66 s care plan was updated to<br>reflect assessment findings.           |   |  |  |  |
|                          | -   | inimum Data Set (MDS), dated   |  |     | 2. All residents dependent on staff for participation in activities have the potential                                   |   |  |  |  |

Event ID:LSCM11

Facility ID: 00730

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245299 **B** WING 10/24/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE CARE CENTER FRAZEE, MN 56544 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 248 Continued From page 17 F 248 1/11/16 identified R66 had diagnoses which to be affected in this area. A list of included traumatic brain injury, seizure disorder residents dependent on staff for activities and diabetes. The MDS identified R66 had has been generated, sctivity assessment severe cognitive impairment, and was totally and care plans will be reviewed and dependent of staff for activities of daily living updated as needed to ensure dependent (ADLs), and required 2 staff to assist with residents are receiving adequate transfers and locomotion off the unit. The MDS assistance in activities of interest. identified R66 enjoyed listening to music, being around animals such as pets, keeping up with the news, doing things with groups of people, 3. Mandatory nursing and activity staff participating in favorite activities and spending education was provided on November 16 time outdoors. and 17, 2016 on the procedure titled, Activities with a focus on the need for staff R66's Care Area Assessment (CAA), dated to provide 1:1 visits for residents 1/11/16 identified R66 suffered from a traumatic dependent on staff for activities and brain injury, was unable to speak and make providing activities according to resident needs known and was dependent on staff for all interests. her ADL. The CAA further identified R66 followed people with her eyes and blinked to answer yes 4. Residents Therapeutic Recreation 1:1 or no questions and appeared to watch TV when logs will be audited to monitor activity participation and documentation of it was on. activities for residents dependent on staff for activities. Residents requiring R66's care plan dated 2/18/16 identified R66 was a big fan of duck Dynasty and Keeping up with assistance with activities assessments the Kardashians. R66's care plan indicated she and care plans will be reviewed and liked to browse through gossip magazines and updated as needed. The audit will be enjoyed a good book at times. R66's care plan completed by the Activity director, or directed activity staff had posted a sign in her designee, weekly X 4 weeks, then room to inform all staff that she enjoys Duck monthly X 2 months. Audit findings will be Dynasty and Keeping up with the Kardashians, provided to the QA committee monthly x 3 activity staff were to complete 4 1:1 visits a week, months with follow-up to committee and activity staff would provide gossip magazines recommendations. (people, Us Weekly, Star) and would read to her during 1:1 visits and would see if she was up to 5. Deficient practice will be corrected by enjoy story time. R66's care plan further directed December 14, 2016 R66 required a mechanical lift and 2 staff to get her up and into her wheelchair, and R66 would be wheeled to all of her destinations as desired and in a timely manner.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/15/2016

|                          |   | AND HUMAN SERVICES   |                   |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|-------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,               |     | LE CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299   | B. WING           |     |   | 10/;      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER   |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 248                    | Continued From pa   | .ge 18   | F 2               | 248 |   |           |                                     |
|                          | Assessment dated<br>staff indicated they<br>activities to let her of<br>and indicated R66 v<br>assessment further<br>included cards and<br>large group program<br>group activities suc<br>programing would b<br>enjoyed watching th<br>Review of R66's ac<br>dated 7/26/16, iden<br>involvement was fa<br>passive, R66 was u<br>a meaningful way.<br>watched TV on a da<br>watched movies. Th<br>sometimes watch th<br>would rather watch<br>visits by staff each | be needed, and R66 also<br>ne birds and TV.<br>tivities quarterly progress note  |                   |     |   |           |                                     |
|                          | 10/11/16, identified<br>was fair, participation<br>R66 was unable to<br>meaningful way. The<br>also watches movies<br>player. The note fun<br>4, 1:1 visits by active<br>would sometimes re-<br>indicated family visits<br>wheeled her around<br>weather was nice.  | quarterly progress note dated<br>R66's activity involvement<br>on level remained passive and<br>structure her time in a<br>ne note indicated R66 loved TV<br>es on her personal DVD<br>rther identified R66 would have<br>vity staff each week and they<br>ead her a book. The note also<br>ited once per week and<br>d or took her outside if the<br>The progress note identified<br>was appropriate, had met her |                   |     |   |           |                                     |

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|                          |  | AND HUMAN SERVICES  |                   |     |   | FORM     | : 12/15/2016<br>APPROVED<br>. 0938-0391 |
|--------------------------|--|---|-------------------|-----|---|----------|---|
| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     | E CONSTRUCTION  | (X3) DAT | E SURVEY<br>IPLETED                     |
|                          |  | 245299  | B. WING           |     |   | 10/      | 24/2016                                 |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |          |   |
| FRAZEE                   | CARE CENTER  |   |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |          |   |
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| F 248                    | goal for the last 3 m<br>were effective. and<br>recommended for F<br>Review of the facilit<br>residents from 4/16<br>activities per week<br>in such as music, B<br>and manicures.<br>Review of R66's Re<br>Chart forms from 4,<br>R66 consistently wa<br>However, the attend<br>consistent 1:1 visits<br>include attendance<br>acclivities. The mo<br>follows:<br>-4/16, 6 out of 16 op<br>staff for the month,<br>No other document<br>activities or activitie<br>-5/16, 7 out of 18 op<br>staff for the month,<br>activities room, 1 m<br>glasses.<br>-6/16, 9 out of 16 op<br>staff for the month,<br>unable.<br>-7/16, 5 of out 18 op<br>staff for the month,<br>watching, 2 cleanin<br>and 3 unable | nonths, activity interventions<br>no changes were<br>R66's activity program.<br>Ty activity calendar for<br>to 10/16 identified 4-5<br>which R66 had special interest<br>singo, movies, outside walks<br>esident Activity Attendance<br>/1/16 to 10/17/16 revealed<br>atched TV and family visited.<br>dance charts did not include<br>s, and did not consistently<br>at either large or small group<br>nthly documentation as<br>pportunities of 1:1 visits from<br>and 3 unable and 1 refused.<br>ation of large or small group | F2                | 248 |   |          |   |

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|                          |  | AND HUMAN SERVICES  |                    |     |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|--------------------|-----|--|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | E CONSTRUCTION   | (X3) DATE | E SURVEY<br>IPLETED                 |
|                          |  | 245299  | B. WING            | i   |  | 10/:      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   | -         |                                     |
| FRAZEE                   | CARE CENTER  |   |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |           |                                     |
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| F 248                    | the month, 1 bird w<br>1 cleaning glasses,<br>-9/16, 7 out of 18 op<br>the month, 1 outsid<br>unable<br>-10/1-10/24/16, 7 or<br>visits, 1 sitting in far<br>glasses, 1 outside<br>On 10/19/16, during<br>to 10:03 a.m. R66's<br>and her bedroom de<br>observed on her ba<br>hospital gown. R66<br>position with no me<br>and 3 minutes. R66<br>calendar posted on<br>the foot of her bed,<br>sign was posted on<br>recliner and identifie<br>-R66 was to be cha<br>-No more Kardashia<br>-Family Feud on ch<br>-Wheel of fortune<br>-Jeopardy 5:00 p.m<br>-Judge Judy 9:00 a<br>-get movie going ea<br>On 10/19/16, at 10:<br>were in R66's room<br>her recliner. LPN-A<br>going to watch on T<br>those Kardashian g<br>R66 a hard time ab | atching, 1 wheeling, 1 outside,<br>and 1 unable<br>pportunities for 1:1 visits for<br>e, 1 cleaning glasses, and 1<br>ut of 13 opportunities for 1:1<br>mily lounge, 2 cleaning<br>g observation from 7:00 a.m.<br>s room was dark and quiet,<br>oor was open. R66 was<br>tock in bed, dressed in a<br>5 remained in the same<br>vaningful activity for 3 hours<br>5 had a monthly activities<br>her closet door across from<br>and a hand written 8.5 X 11<br>the wall across from R66's<br>ed:<br>unged during check ups<br>ans'!<br>annel 11:00 a.m. | F2                 | 248 |  |           |                                     |

|                          |   | AND HUMAN SERVICES  |                   |     |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,               |     | E CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING           |     |  | 10/2      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER   |   |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |           |                                     |
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| F 248                    | On 10/19/16, at 12:<br>seated in her reclinit<br>type program was of<br>turned away from the<br>window.<br>On 10/20/16, at 9:4<br>dressed in a hospita<br>and her eyes were<br>On 10/18/16, at 12:<br>(FM-A) stated no fat<br>felt no facility staff with<br>had to. She stated as<br>week and a nurse use<br>even when she was<br>now.<br>On 10/21/16, at 10:<br>nurse (LPN-A) state<br>on staff for ADLs. State<br>on 10/24/16, at 10:<br>stated R66 spent ho<br>get 1:1 visits. She state<br>open curtains, and<br>the TV shows she hist<br>stated she didn't kn<br>of her room, and sta<br>sit at the nurses de<br>and missed 1:1 visits or<br>it was hard to provide<br>R66 required so mu-<br>get up. She stated as | age 21<br>10 p.m. R66 was dressed and<br>er, in front of the TV. A political<br>on TV and R66 eyes were<br>he TV and out her bedroom<br>2 a.m. R66 was in her bed<br>al gown. R66's TV was off,<br>focused on the ceiling.<br>17 p.m. family member<br>acility staff visits R66 and she<br>went into her room unless they<br>she visited R66 about twice a<br>used to come and visit R66<br>sn't working, but she was gone<br>24 a.m. licensed practical<br>ed R66 was totally dependent<br>the stated the usual routine<br>up, she spent her day watching<br>08 a.m. activities aide (AA-A)<br>er day watching TV and would<br>stated during 1:1 visits they<br>sit with her talk to her about<br>iked, or put a movie on. She<br>low how often R66 came out<br>ated sometimes they had her<br>sk. She stated R66 slept a lot,<br>ts because she was in bed<br>ated activity staff tried to<br>n an attempt basis. She stated<br>de activities for R66 because<br>uch care, and was difficult to<br>she felt R66 was probably up<br>amily visited, and staff had | F2                | 248 |  |           |                                     |

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|                          |   | AND HUMAN SERVICES  |                   |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|-------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ` '               |     | E CONSTRUCTION  | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING           |     |   | 10/;      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
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| F 248                    | tried to get her out i<br>difficult.<br>On 10/24/16, at 10:<br>(CM-A) stated staff<br>recliner and she wa<br>because they were<br>bed or her Broda ch<br>the time. She confir<br>and stated she und<br>time with her in her<br>On 10/24/16, at 12:<br>stated activity staff<br>room which told sta<br>and stated R6 also<br>her room. AD indica<br>had wanted to bring<br>Adventure activity, i<br>during the week, bu<br>attend because she<br>stated R66 used to<br>staff struggled with<br>her wheelchair to a<br>she would like R66<br>it was such a hassle<br>her wheelchair, and<br>or recliner. AD confi<br>stated her care plar<br>stated her care plar<br>portable DVD playe<br>activity records and<br>TV. She confirmed<br>R66's care plan had<br>current information. | to story time but it was too<br>53 a.m. clinical manager<br>would get her up in her<br>atched the Kardashians'<br>on a lot, otherwise R66 was in<br>nair in her room the majority of<br>rmed R66's current care plan<br>erstood activities staff spent<br>room.<br>27 p.m. activities director (AD)<br>had posted a sign in R66's<br>aff what TV shows R66 liked<br>had a portable DVD player in<br>ated in the past activities staff<br>g R66 to the Afternoon<br>which was scheduled daily<br>at struggled to get R66 to<br>e was not in her chair. She<br>get her nails done but activity<br>finding staff to get her up in<br>ttend the activity. She stated<br>to attend music programs but<br>e to find staff to get her up in<br>d R66 was usually in her bed<br>firmed R66's care plan and<br>n could be updated. She<br>n was TV focused and the<br>er also. AD confirmed R66's<br>I stated R66 mostly watched<br>the sign posted in room and<br>d not been updated with | F                 | 248 |   |           |                                     |
|                          | stated her care plar<br>portable DVD playe<br>activity records and<br>TV. She confirmed<br>R66's care plan had<br>current information.<br>Review of facility po-<br>identified the facility   | n was TV focused and the<br>er also. AD confirmed R66's<br>I stated R66 mostly watched<br>the sign posted in room and<br>d not been updated with  |                   |     |   |           |                                     |

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|   |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |  |     |   | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |  |  |  |
|---|--|--|--|-----|---|-------------------------------|-------------------------------------|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |  |  |  |     |   | (X3) DATE SURVEY<br>COMPLETED |                                     |  |  |  |
|   |  | 245299   | B. WING  | i   |   | 10/2                          | 24/2016                             |  |  |  |
| NAME OF F   | PROVIDER OR SUPPLIER   |  |  | ST  | REET ADDRESS, CITY, STATE, ZIP CODE   |                               |                                     |  |  |  |
| FRAZEE  | CARE CENTER  |  | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544 |     |   |                               |                                     |  |  |  |
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| F 248   | Continued From pa<br>interests, physical,<br>well-being of each r<br>comprehensive ass   | mental, and psychosocial esident based on  | F2   | 248 |   |                               |                                     |  |  |  |
| F 279<br>SS=D   | 483.20(d), 483.20(k<br>COMPREHENSIVE   |  | F2   | 279 |   |                               | 12/14/16                            |  |  |  |
|   |  | he results of the assessment<br>and revise the resident's<br>n of care.  |  |     |   |                               |                                     |  |  |  |
|   | plan for each reside<br>objectives and time<br>medical, nursing, and   | velop a comprehensive care<br>ent that includes measurable<br>tables to meet a resident's<br>nd mental and psychosocial<br>tified in the comprehensive   |  |     |   |                               |                                     |  |  |  |
|   | to be furnished to a<br>highest practicable<br>psychosocial well-b<br>§483.25; and any s<br>be required under §<br>due to the resident | describe the services that are<br>ttain or maintain the resident's<br>physical, mental, and<br>eing as required under<br>ervices that would otherwise<br>483.25 but are not provided<br>s exercise of rights under<br>he right to refuse treatment<br>). |  |     |   |                               |                                     |  |  |  |
|   | by:<br>Based on observat<br>review the facility fa<br>which included a the<br>motion (ROM) prog  | NT is not met as evidenced<br>ion, interview and document<br>iled to develop a plan of care<br>erapy recommended range of<br>ram for 1 of 4 residents (R66)<br>decline in her upper  |  |     | <ul> <li>F 279 Development of a comprehending care plan</li> <li>1. Resident R 66 was evaluated by therapy with recommendations for land upper extremity splinting. R66s plan was updated.</li> <li>2. All residents with a functional d</li> </ul> | oy<br>ROM<br>s care           |                                     |  |  |  |
|   |  |  |  |     |   | 200                           |                                     |  |  |  |

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| CENTERS F   | FOR MEDICARE  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                    |     | 0  | FORM  | 12/15/2016<br>APPROVED<br>0938-0391 |
|---|---|--|--------------------|-----|--|---|-------------------------------------|
| STATEMENT OF I<br>AND PLAN OF CC  |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                |     |  |   | E SURVEY<br>PLETED                  |
|   |   | 245299   | B. WING            |     |  | 10/2  | 24/2016                             |
| NAME OF PROV  | VIDER OR SUPPLIER   |  |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |   |                                     |
| FRAZEE CA   | RE CENTER   |  |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |   |                                     |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)  | BE  | (X5)<br>COMPLETION<br>DATE          |
| R6<br>7/1<br>inc<br>an<br>se<br>de<br>aci<br>ide<br>of<br>exi<br>or<br>R6<br>ha<br>de<br>Th<br>on<br>dic<br>nu<br>R6<br>1/1<br>all<br>las<br>col<br>R6<br>ap<br>an<br>cal<br>spl<br>da<br>cal | 13/16, identified F<br>cluded traumatic k<br>d diabetes. The N<br>vere cognitive imp<br>pendent on staff f<br>tivities of daily livi<br>entified R66 had f<br>motion on both si<br>tremities, and did<br>restorative nursin<br>66's annual MDS of<br>d severe cognitive<br>pendent on staff f<br>e MDS identified<br>both sides, uppe<br>f not receive thera<br>rsing services.<br>66's Care Area As<br>11/16, identified R<br>ADLs related to t<br>st year, and had d<br>mmunication and<br>66's care plan date<br>hasic (non verbal<br>d was unable to r<br>re plan also ident<br>lints for 2 hours o<br>y, and was to wea<br>re plan failed to ic<br>d did not identify<br>rsing program for<br>cline. | imum Data Set (MDS) dated<br>(66 had diagnoses which<br>orain injury, seizure disorder<br>ADS identified R66 had<br>pairment, and was totally<br>for assistance with all<br>ng (ADLs). R66's MDS<br>unctional limitations in range<br>des, upper and lower<br>not receive therapy services<br>ag services.<br>dated 1/11/16, identified R66<br>e impairment, and was totally<br>for assistance with all ADLs.<br>R66 had functional limitations<br>r and lower extremities, and<br>apy services or restorative<br>sessment (CAA) dated<br>(66 was dependent on staff for<br>raumatic brain injury over the<br>ifficulty with mobility, | F 2                | 279 | <ul> <li>in ROM will be referred to therapy for screening and recommendations. If up with physician/nursing orders or therapy recommendation for ROM a splints have the potential to be affect this area. Care plans of residents of decline in ROM/splints or braces habeen updated as needed.</li> <li>3. Mandatory nursing staff educatives provided on November 16 and 2016 on the procedure titled, Resto Program-ROM and Splinting with a on the need for staff to provide ROM before and following splinting; to av decline in ROM.</li> <li>4. An audit was developed to morp participation and documentation of Restorative nursing interventions, including ROM programs and applie of splints or braces. Care plans wireviewed to ensure care planning for restorative nursing programs ROM splints/braces. The audit will be completed by the DON, or designed weekly X 4 weeks, then monthly X 2 months. Audit findings will be provi the QA committee monthly x 3 mon with follow-up to committee recommendations.</li> <li>5. Deficient practice will be correct December 14, 2016</li> </ul> | Follow<br>and/or<br>cted in<br>with<br>ave<br>tion<br>17,<br>rative<br>focus<br>M<br>oid a<br>hitor<br>cation<br>Il be<br>or<br>and<br>e,<br>2<br>ded to<br>ths |                                     |

Facility ID: 00730

|  |  | I AND HUMAN SERVICES<br>E & MEDICAID SERVICES   |                   |     |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--|--|---|-------------------|-----|--|-----------|-------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     |  | (X3) DATE | E SURVEY<br>PLETED                  |
|  |  | 245299  | B. WING           | i   |  | 10/2      | 24/2016                             |
| NAME OF PROVIDER OR SUPP   | IER.   |   |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  |           |                                     |
| FRAZEE CARE CENTER   |  |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |           |                                     |
| PREFIX (EACH DEFIC   | ENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| <ul> <li>with care's and off every 2 hou on all night. The R66 had contrator or restorative in decline.</li> <li>R66's Admissional and the restoration of the restora</li></ul> | n As<br>and<br>and<br>and<br>and<br>and<br>and<br>and<br>and<br>and<br>and | R66 required total assistance<br>to wear hand splints on and<br>uring the day and leave them<br>de Care Plan did not identify<br>res or that she required a ROM<br>ng program to prevent further<br>ssessment form dated<br>R66 was non verbal, was<br>thad elbow contractures.<br>ssessment form indicated<br>had not been assessed.<br>esident Referral<br>Communication form dated<br>directions for nursing to<br>ssive range of motion (PROM)<br>mities, active range of motion<br>d, and included instruction to<br>d close fingers and to have<br>s hand with her left hand daily<br>h.<br>d Resident Referral from<br>/16, identified R66's hand<br>edule as for R66 to wear splints<br>s off throughout the day and on | F                 | 279 |  |           |                                     |

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|                          |  | AND HUMAN SERVICES   |                     |                                       |  | FORM | APPROVED                     |  |
|--------------------------|--|--|---------------------|---------------------------------------|--|------|------------------------------|--|
|                          | TOF DEFICIENCIES   | & MEDICAID SERVICES  | (X2) MULT           | TIPI                                  |  |      | <u>0938-0391</u><br>E SURVEY |  |
|                          | OF CORRECTION  | IDENTIFICATION NUMBER:   |                     |                                       |  |      | IPLETED                      |  |
|                          |  | 245299   | B. WING _           |                                       |  | 10/: | 24/2016                      |  |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE |  |      |                              |  |
| FR47FF                   | CARE CENTER  |  |                     |                                       | 219 WEST MAPLE AVENUE, PO BOX 96   |      |                              |  |
|                          |  |  |                     | F                                     | FRAZEE, MN 56544   |      |                              |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | ĸ                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE   | (X5)<br>COMPLETION<br>DATE   |  |
| F 279                    | Continued From pa  | ige 26   | F 2                 | 79                                    |  |      |                              |  |
|                          | -1/21/16, R66 was o<br>remote.   | changing TV channels with  |                     |                                       |  |      |                              |  |
|                          | techniques and lack  | es lacked further<br>arding communication skills or<br>ked any documentation of<br>tion, exercises, or decline in  |                     |                                       |  |      |                              |  |
|                          | Review of R66's ph<br>2/9/16 to 10/16/16 i   | ysician progress notes from<br>identified:   |                     |                                       |  |      |                              |  |
|                          | injury in 12/14, had<br>care facility, but fan<br>closer to their home<br>communicate verba<br>did not communicat<br>push her call light b | R66 suffered a traumatic brain<br>been in a former long term<br>nily had requested a transfer<br>e. R66's could not<br>ally. Nursing had reported R66<br>te verbally but was able to<br>putton and could change the<br>with her TV remote. |                     |                                       |  |      |                              |  |
|                          | which involved the physician would ma  | R66 still had some movement<br>left upper extremity, and the<br>ake sure therapy had a<br>en from a contracture and<br>point for R66.  |                     |                                       |  |      |                              |  |
|                          | -10/6/16, identified with left hand.   | R66 could squeeze his fingers  |                     |                                       |  |      |                              |  |
|                          | On 10/19/16, obser<br>a.m. were conducte   | rvations from 7:00 a.m. to 9:47<br>ed:   |                     |                                       |  |      |                              |  |
|                          | back in bed, with he arms were bent at t   | was observed lying on her<br>er eyes closed. Both R66's<br>the elbow, her right hand was<br>her chest, and her left hand   |                     |                                       |  |      |                              |  |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                   |     |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|-------------------|-----|--|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     |  | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299   | B. WING           |     |  | 10/:      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  |           |                                     |
| FRAZEE                   | CARE CENTER   |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |           |                                     |
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| F 279                    | and hand slightly till<br>devices were not of<br>hands, and the splir<br>in her room.<br>-7:49 a.m. licensed<br>entered R66's room<br>(artificial opening at<br>confirmed R66 was<br>stated R66 had not<br>recent past becaus<br>uncomfortable for F<br>and did not apply R<br>-8:03 a.m. the nurs<br>room and immediat<br>station. R66 remain<br>her hands and arms<br>splints observed.<br>-8:20 a.m. R66 rem<br>same position with<br>and her hands reste<br>position. No hand s<br>hands and splints w<br>room.<br>-9:47 a.m. R66 rem<br>bed, no hand splints<br>present in R66's roo<br>On 10/19/16, at 10:<br>had not worn hand<br>wear the splints "at<br>aware when R66 la<br>indicated she thoug | d position with fingers bent<br>ted away from her body. Splint<br>oserved on either of R66's<br>int devices were not observed<br>practical nurse (LPN)-A<br>in to provide her trachea<br>t windpipe) site care. She<br>not wearing hand splints and<br>been wearing them in the<br>e she thought the splints were<br>R66. LPN-A exited R66's room<br>66's hand splints.<br>Be consultant walked in R66's<br>rely walked down to the nurses<br>hed on her back in bed, with<br>s in the same positron, no<br>hained lying in bed in the<br>R66's arms bent at her elbows<br>ed on her chest in the same<br>plints were observed on R66's<br>vere not observed in R66's<br>mained in the same position in<br>s were observed on R66 or | F                 | 279 |  |           |                                     |

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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | E CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING            |     |  | 10/:      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER  |   |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |           |                                     |
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| F 279                    | Continued From pa  | ge 28   | F 2                | 279 |  |           |                                     |
|                          | (NA)-E confirmed F<br>hand splints, and st<br>the last time R66 ha<br>provided a copy of t<br>confirmed the care<br>wear hand splints. S<br>aware R66 was to w<br>LPN-A exited R66's<br>hand splints.<br>On 10/19/16, at 10:<br>not aware of how R | 33 am nursing assistant<br>866 did not routinely wear<br>ated she could not remember<br>ad worn her splints. NA-E<br>the a NA care sheet and<br>sheet directed for R66 to<br>She stated she had not been<br>wear hand splints. NA-A and<br>room and did not apply her<br>40 a.m. NA-D stated she was<br>66's care plan directed her to<br>stated she was not aware if |                    |     |  |           |                                     |
|                          | wear them.<br>On 10/19/16, at 12:<br>her recliner in her re<br>on her chest, right h   | ts or if R66 was supposed to<br>10 p.m. R66 was seated in<br>oom with both hands resting<br>hand in fist, left hand curled in<br>id not have hand splints on  |                    |     |  |           |                                     |
|                          | interview, NA-B star<br>receive range of mo  | 30 a.m., during follow up<br>ted R66 presently did not<br>otion services or presently was<br>orative nursing program.   |                    |     |  |           |                                     |
|                          | interview, NA-D sta<br>her hands and was<br>stiffness had gotten<br>not aware if R66 wa<br>received range of m<br>reviewed the therap<br>assistant reference<br>and stated she felt  | 9:36 a.m., during follow up<br>ted R66 did not routinely use<br>not aware if R66's hand<br>worse. She stated she was<br>as on a restorative program or<br>notion services. NA-D<br>by referral in the nursing<br>book at the nursing station<br>R66's therapy screening was<br>6 did not need range of  |                    |     |  |           |                                     |

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| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | • •               |     | LE CONSTRUCTION   | (X3) DAT | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING           |     |   | 10/2     | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   |          |                                     |
| FRAZEE                   | CARE CENTER   |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |          |                                     |
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| F 279                    | motion services and<br>since the screen was<br>stated she was sure<br>motion when they d<br>On 10/20/16, at 9:4<br>nursing stated she<br>had been disconting<br>she questioned if the<br>indicated she felt R<br>contracted than whe<br>On 10/20/16, at 10:<br>(OT)-A stated R66 I<br>time of admission, a<br>aware if R66 had co<br>confirmed R66's the<br>2/18/16, and indicat<br>2/18/16, was compl<br>the style of splint fo<br>stated a comprehen<br>contractures had not<br>the facility did not h<br>consult. She stated<br>baseline for her cor<br>not include measure<br>stated the ROM and<br>recommended for F<br>contracture and dis<br>OT-A stated the fac<br>providing ROM serve<br>applying R66's splir<br>had a book of recor<br>programs at the nur-<br>was unable to move<br>independently. She<br>fingers were tighter | <ul> <li>d did not need to wear splints as old (February 2016) She</li> <li>a R66 got enough range of ressed her.</li> <li>5 a.m. assistant director of was not aware if R66's splints ued in the past and indicated the splints bothered R66 and 66 was not anymore en she was admitted.</li> <li>03 a.m. occupational therapist had worn hand splints at the and indicated she was not anymore eter after the facility changed the therapy screen on eted after the facility changed r R66 per family request. She haive assessment of R66's ot been completed because ave a physician order for a she was not aware of R66's ot tractures as the screen did ements of limitations and</li> </ul> | F                 | 279 |   |          |                                     |

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|                          |   | AND HUMAN SERVICES  |                   |     |   | FORM  | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|-------------------|-----|---|---|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     |   | (X3) DATI                                     | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING           | i   |   | 10/   | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   | <u>,                                     </u> |                                     |
| FRAZEE                   | CARE CENTER   |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |   |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE  | (X5)<br>COMPLETION<br>DATE          |
| F 279                    | limitations were with<br>she felt R66's hand<br>high tone. She conf<br>splints were recomm<br>high tone. She state<br>wear the splints all<br>off every 2 hours th<br>12/31/15, and shou<br>services since 1/12<br>At approximately 10<br>room and OT-A ask<br>splints. NA-B looke<br>locations and found<br>underneath blanket<br>R66 should have be<br>according to the scl<br>functional decline. If<br>the hand splints in a<br>sure why R66 had r<br>On 10/20/16, at 10:<br>R66's care plan did<br>program or ROM th<br>confirmed R66's ca<br>services were not o<br>R66 had never use<br>R66's ROM, "Was<br>On 10/20/16, at 10:<br>therapy assistant (0<br>stated their usual p<br>ROM program for r<br>therapy screen and<br>recommended ROM<br>manager (CM.) She<br>the plan she was ex<br>program with NAs a | hin normal limits. She stated<br>s weren't contracted but had<br>firmed the ROM and the<br>mended treatments for R66's<br>ed she would expect R66 to<br>night and alternating on and<br>roughout the day since<br>ld have received ROM<br>/16.<br>0:10 a.m., NA-B entered R66's<br>ked her to locate R66's hand<br>d in R66's bedroom in various<br>I them on R66's wheelchair<br>is and equipment. OT-A stated<br>een wearing her hand splints<br>hedule to prevent further<br>NA-B stated R66 had not worn<br>awhile, and stated she was not<br>not been wearing them.<br>35 a.m. LPN-A stated she felt<br>not include a restorative<br>hat she knew of. She<br>re plan and stated that ROM<br>on R66's care plan. She stated<br>d hand splints, and she felt<br>about the same."<br>37 a.m. certified occupational<br>COTA)<br>rocess for implementing a<br>esidents was to complete a | F                 | 279 |   |   |                                     |

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|                          |   | AND HUMAN SERVICES   |                   |     |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|-------------------|-----|--|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,               |     | PLE CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299   | B. WING           |     |  | 10/:      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                   | 5   | STREET ADDRESS, CITY, STATE, ZIP CODE  |           |                                     |
| FRAZEE                   | CARE CENTER   |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 279                    | ROM provided. She<br>documentation that<br>for R66 in her medi<br>She confirmed R66<br>services since 1/12<br>explain why she net<br>On 10/20/16, at 10:<br>R66's stiffness had<br>were more stiff now<br>was more stiff wher<br>they really had to m<br>put her shirts on.<br>On 10/20/16, at 11:<br>elbow ROM while F<br>physically picked up<br>manipulated both a<br>right elbow lacked 2<br>R66 was a little tigh<br>movements, and co<br>with movement. Sh<br>pain and grimaced<br>and R66's left elbow<br>extension.<br>On 10/20/2016 at 1<br>sometimes R66 wa<br>extremities, and sta<br>more depending on<br>her.<br>On 10/21/16, at 10:<br>totally dependent on<br>stated she was uns<br>program , but stated<br>stated she knew R6<br>than her left arm. S | ge 31<br>e confirmed there was no<br>ROM services were provided<br>cal record or in the NA Book.<br>should have received ROM<br>/16, and stated she could not<br>ver received ROM services.<br>40 a.m. NA-B stated she felt<br>gotten worse and her arms<br>v. She stated she noticed R66<br>in they dressed her, and stated<br>hanipulate her arms when they<br>45 a.m. OT evaluated R66's<br>R66 was awake in her bed. OT<br>o R66's right arm and after she<br>rms, she confirmed R66's<br>25% extension. She confirmed<br>it with initial right side<br>onfirmed R66 grimaced in pain<br>he confirmed R66 also had<br>with movement of her left arm,<br>v lacked about 10% for<br>2:00 p.m. NA-D stated<br>s a little more stiff in her upper<br>aff had to manipulate her arms<br>in the shirt they were putting on<br>14 a.m. NA-A stated R66 was<br>in staff for all of her cares. She<br>ure if R66 was on a ROM<br>d she felt R66 should be. She<br>56's right arm was more stiff<br>he stated R66 just started<br>is to both hands today and | F                 | 279 | J  |           |                                     |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                   |     |   | FORM     | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|-------------------|-----|---|----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,               |     |   | (X3) DAT | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING           |     |   | 10/2     | 24/2016                             |
| NAME OF F                | ROVIDER OR SUPPLIER  |   |                   |     | STREET ADDRESS, CITY, STATE, ZIP CODE   |          |                                     |
| FRAZEE                   | CARE CENTER  |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>YMUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE     | (X5)<br>COMPLETION<br>DATE          |
| F 279                    | splints until today.<br>On 10/21/16, at 2:1<br>her back in bed with<br>right hand in a fist, I<br>splints were observ<br>8.5 X 11" white piece<br>instructions and har<br>was observed poste<br>across from her red<br>show preferences.<br>On 10/21/16, at 2:5<br>pathologist (SLP) st<br>with R66 on commu<br>assessed her ability<br>in the past. SLP rep<br>assessment of R66<br>SLP held "Yes and<br>chest. SLP instructe<br>answered her quest<br>motion hand toward<br>use her eyes to lool<br>questions. R66 was<br>assessment at all. F | ge 32<br>er seen R66 wear see hand<br>6 p.m. R66 was observed on<br>n both arms resting on chest,<br>left hand in a "C" shape. No<br>ed on either of R66's hands. A<br>ce of paper with both typed<br>nd-written notes, dated 8/3/16,<br>ed on R66's bedroom wall<br>liner and identified R66's TV<br>5 p.m. speech language<br>tated she had been working<br>unication techniques and<br>v to use her hands and elbows<br>beated her functional<br>. R66 was reclined in bed and<br>No" flash cards above R66's<br>ed R66 to point at the card that<br>tions. R66 unable to point or<br>d cards. SLP instructed R66 to<br>k at either card to answer her<br>a unable to participate in the<br>R66 began crying and SLP<br>. SLP confirmed R66 had 0%<br>ere R66 responded correctly to | F                 | 279 |   |          |                                     |
|                          | On 10/24/16, at 9:5<br>she was not aware<br>and stated she did in<br>TV remote or use it<br>On 10/24/16, at 10:<br>might be able to use  | ns during a past assessment.<br>0 a.m. NA-B stated at present,<br>if R66 could use her call light ,<br>not know if R66 could hold a<br>14 a.m. NA-D stated R66<br>e her call light or TV remote if<br>hand, but wasn't sure.  |                   |     |   |          |                                     |
|                          |  |   |                   |     |   |          |                                     |

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|                          |   | AND HUMAN SERVICES   |                   |     |   | FORM     | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|-------------------|-----|---|----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     | PLE CONSTRUCTION  | (X3) DAT | E SURVEY<br>IPLETED                 |
|                          |   | 245299   | B. WING           | i   |   | 10/      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                   | 5   | STREET ADDRESS, CITY, STATE, ZIP CODE   | •        |                                     |
| FRAZEE                   | CARE CENTER   |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRON<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETION<br>DATE          |
| F 279                    | On 10/24/16, at 10:<br>(RN-A) stated R66<br>impairment and wa<br>all cares. She state<br>on a ROM program<br>today, or had declin<br>extremities. She state<br>ROM and wore her<br>therapy recommend<br>was not on R66's ca<br>On 10/24/16, at 10:<br>(CM)-A stated R66<br>impairment, and wa<br>cares. She indicate<br>contractures on adr<br>remember where the<br>side of R66's body<br>remembered talking<br>past about R66's ca<br>and stated she told<br>remote in her room<br>CM-A stated R66 we<br>since 1/12/16, and<br>and off during the de<br>stated she expected<br>according to the scl<br>services from the N<br>no documentation i<br>the NA book that Re<br>services were not o<br>On 10/24/16, at 12<br>while she was awak<br>COTA picked up R6<br>and put her call light | <ul> <li>38 a.m. registered nurse<br/>had severe cognitive<br/>s totally dependent on staff for<br/>d she was unaware if R66 was<br/>a, wore her arm splints before<br/>hed in ROM to her upper<br/>ated R66 should have received<br/>arm splints according to the<br/>dations and confirmed ROM<br/>are plan.</li> <li>53 a.m. clinical manager<br/>had severe cognitive<br/>as dependent on staff for<br/>d she thought R66 had<br/>mission, but stated she did not<br/>he contractures were, or which<br/>was affected. CM-A stated she<br/>g to the physician in the distant<br/>ontractures after admission<br/>him she saw R66 use her TV</li> <li>v</li> <li>vas supposed to get ROM<br/>was to wear hand splints on<br/>lay, and keep on all night. She<br/>d R66 to wear her hand splints<br/>hedule and receive ROM<br/>IA's. She confirmed there was<br/>n R66's medical record or in<br/>66 had ever received ROM</li> </ul> | F                 | 279 |   |          |                                     |

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|                          |  | AND HUMAN SERVICES   |                    |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|--------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                |     |   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299   | B. WING            | i   |   | 10/2      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                    | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   | ·         |                                     |
| FRAZEE                   | CARE CENTER  |  |                    |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 279                    | fingers were very w<br>didn't move and the<br>picked up R66's left<br>call light between R<br>and fingers did not<br>were very weak and<br>hand and R66 could<br>light. COTA also ev<br>TV remote. COTA a<br>remote in R66's right<br>R66's arm by her el<br>the TV remote at al<br>COTA lifted R66's left<br>put the remote betw<br>remote slipped in R<br>the ceiling. R66 was<br>towards her TV or a<br>left hand and finger<br>R66 declined in her<br>On 10/24/16, at 12:<br>(AD) confirmed action<br>in R66's room at the<br>listed TV shows R6<br>at the time the sign<br>could hold and use<br>channel surf on the<br>shows she liked to the<br>On 10/24/16, at 1:4<br>stated she felt if R6<br>remote or call light<br>it was evidence of a<br>stated the failure to<br>not a new concern<br>brought her concern | veak and her fingers and hand<br>e call light fell on her lap. COTA<br>t arm by the elbow, placed her<br>166's fingers. R66's left hand<br>move. R66 hand and fingers<br>d call light just sat loose in her<br>d not grasp or activate her call<br>valuated R66 for holding her<br>attempted to place R66's TV<br>ht hand while she supported<br>lbow. R66 was unable to hold<br>I with her right hand or fingers.<br>eft arm up by the elbow and<br>veen R66's left fingers. The TV<br>166's hand and pointed up to<br>s unable to hold the remote<br>activate the remote with her<br>rs. She stated she was sure<br>r upper extreme ROM. | F2                 | 279 |   |           |                                     |

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|                          |   | AND HUMAN SERVICES  |                    |     |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|--------------------|-----|--|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                |     |  | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING            |     |  | 10/2      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |                    | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  |           |                                     |
| FRAZEE                   | CARE CENTER   |   |                    |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 279                    | Continued From pa   | .ge 35  | F 2                | 279 |  |           |                                     |
| F 280<br>SS=E            | stated when R66 fir<br>use her TV remote,<br>call light, and write I<br>She stated when R6<br>facility R66 could al<br>arms in the arm hol<br>stated R66 could no<br>and indicated she fe<br>cried. She stated R6<br>affected by her brai<br>visited R66 over the<br>noticed staff were m<br>both hands. and sta<br>of been using the ha<br>time." FM-A stated<br>any exercises with I<br>and stated she didn<br>stated R66 received<br>admission to this fa<br>asked facility staff w<br>exercises and state<br>they felt her brain w<br>them to do that.<br>Review of facility po<br>dated 4/1/08 identifi<br>assessed on admis<br>such as ROM. If a F<br>identified need, a pl<br>meet resident need<br>identified residents<br>highest level of fund<br>483.20(d)(3), 483.1 | 25 p.m. family member (FM)-A<br>rst got to the facility she could<br>, change the channels, use her<br>her name and the word Mom.<br>66 was first admitted to the<br>lso pull her covers up, put her<br>les of her night gown. FM-A<br>o longer do any of those things<br>elt R66 was sad and frequently<br>166's right side was most<br>in injury. She stated she had<br>e previous weekend and<br>now putting the hand splints on<br>ated she felt the facility should<br>and splints for R66 " the whole<br>I she had never seen staff do<br>R66 for her hands and arms,<br>n't know if they ever had. She<br>d ROM all the time before<br>acility. She stated she had<br>why R66 did not get ROM<br>ed she had been told by staff<br>vas not working enough for<br>policy, Restorative Program,<br>fied residents would be<br>ssion for a restorative program<br>ROM program was an<br>lan would be individualized to<br>as and goals. The policy further<br>would be supported and their<br>ctioning maintained.<br>0(k)(2) RIGHT TO<br>NNING CARE-REVISE CP | F2                 | 280 |  |           | 12/14/16                            |
| 00-L                     |   | ne right, unless adjudged   |                    |     |  |           |                                     |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                    |     | FORM   | ): 12/15/2016<br>APPROVED<br>). 0938-0391 |
|--------------------------|---|--|--------------------|-----|--|---|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | LE CONSTRUCTION (X3) DA  | TE SURVEY<br>MPLETED                      |
|                          |   | 245299   | B. WING            | i   | 10   | /24/2016                                  |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                    | 5   | STREET ADDRESS, CITY, STATE, ZIP CODE  |   |
| FRAZEE                   | CARE CENTER   |  |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE                |
| F 280                    | incapacitated under<br>participate in planni<br>changes in care and<br>A comprehensive co-<br>within 7 days after to<br>comprehensive asso<br>interdisciplinary tea<br>physician, a registe<br>for the resident, and<br>disciplines as deter<br>and, to the extent p<br>the resident, the resi<br>legal representative                          | the laws of the State, to ng care and treatment or   | F2                 | 280 |  |   |
|                          | by:<br>Based on observat<br>review the facility fa<br>for 1 of 3 residents(<br>staff to provide all le<br>the facility failed to<br>ambulation for 3 of<br>reviewed for ambula<br>Findings include:<br>R66's admission Mi<br>1/11/16 identified R<br>included traumatic I<br>and diabetes. The N<br>severe cognitive im<br>dependent of staff f | NT is not met as evidenced<br>ion, interview and record<br>iled to revise the plan of care<br>R66) who was dependent on<br>eisure activities. In addition,<br>revise the care plan for<br>4 residents (R29, R46, R38)<br>ation services. |                    |     | <ul> <li>F 280</li> <li>1. R66 s care plan was updated to include focus on R66 s activities of interest, and 1:1 visits.</li> <li>R29 is on a restorative nursing ambulation program and is being walked by staff.</li> <li>R 46 is on a restorative nursing ambulation program and is being walked by staff.</li> <li>R 46 is on a restorative nursing ambulation program and is being walked by staff.</li> <li>R 38 was evaluated by Physical Therapy on 10-31-16 and is currently being treated by Physical Therapy.</li> <li>2. All residents dependent of staff for activities participation and need assistance from staff with ambulation</li> </ul> |   |

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| TATEMENT                 | OF DEFICIENCIES   | K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:   |                    |     | LE CONSTRUCTION  | (X3) DATE                                      | 0938-039<br>SURVEY<br>PLETED |
|--------------------------|---|--|--------------------|-----|--|--|------------------------------|
|                          |   | 245299   | B. WING            |     |  | 10/  | 04/0010                      |
|                          | PROVIDER OR SUPPLIER  | 245235   | D. Milla           |     | TREET ADDRESS, CITY, STATE, ZIP CODE   | 10/2   | 24/2016                      |
|                          | CARE CENTER   |  |                    | 2   | FRAZEE, MN 56544   |  |                              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | ) BE   | (X5)<br>COMPLETIO<br>DATE    |
| F 280                    | Continued From pa   | -  | F 2                | 280 |  | thic   |                              |
|                          | transfers and locomotion off the unit. The MDS<br>identified R66 enjoyed listening to music, being<br>around animals such as pets, keeping up with the<br>news, doing things with groups of people,<br>participating in favorite activities and spending<br>time outdoors.<br>R66's Care Area Assessment (CAA), dated<br>1/11/16 identified R66 suffered from a traumatic<br>brain injury, was unable to speak and make<br>needs known and was dependent on staff for all |  |                    |     | <ul> <li>have the potential to be affected in area. Care plans reviewed and up as needed.</li> <li>3. Mandatory education provided who develop comprehensive care planning was provided on Novemb and 17, 2016 providing education of procedure titled, Care Plans-Comprehensive with a focus</li> </ul>   | dated<br>to staff<br>er 16<br>on the           |                              |
|                          | needs known and w<br>her ADL. The CAA<br>people with her eye<br>or no questions and<br>it was on.<br>R66's care plan dat<br>a big fan of duck D<br>the Kardashians. R   |  |                    |     | care planning for residents depend<br>staff for activities and need for a<br>restorative nursing ambulation prog<br>A licensed nurse to monitor restora<br>nursing program progress through<br>monthly review of residents receivi<br>restorative care, ADL score, and de<br>in ADL score, and from Casper rep   | ent on<br>gram.<br>ttive<br>a<br>ng<br>ecline  |                              |
|                          | directed activity sta<br>room to inform all s<br>Dynasty and Keepi<br>activity staff were to<br>and activity staff were<br>(people, Us Weekly<br>during 1:1 visits an<br>enjoy story time. Re<br>R66 required a mere<br>her up and into her   | bk at times. R66's care plan<br>ff had posted a sign in her<br>staff that she enjoys Duck<br>ing up with the Kardashians,<br>o complete 4 1:1 visits a week,<br>buld provide gossip magazines<br>y, Star) and would read to her<br>d would see if she was up to<br>66's care plan further directed<br>chanical lift and 2 staff to get<br>wheelchair, and R66 would be<br>er destinations as desired and |                    |     | <ul> <li>4. An audit was developed to more activities and restorative nursing carplanning including the monitoring or resident participation and resident progress in nursing restorative RO splint programs. The audit will be completed by the DON or designed weekly X 4 weeks, then monthly X months. Audit findings will be provide the QA committee monthly x 3 more with follow-up to committee recommendations.</li> <li>5. Deficient practice will be correct.</li> </ul> | are<br>f<br>M and<br>e<br>2<br>ided to<br>1ths |                              |
|                          | Assessment dated staff indicated they activities to let her   | Therapeutic Programs<br>1/4/16, identified activities<br>would try to bring her to<br>observe and be around people,<br>was in bed a lot. The   |                    |     | December 14, 2016  |  |                              |

|                          |  | AND HUMAN SERVICES   |                     |    |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|---------------------|----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |    | CONSTRUCTION  | (X3) DATI | E SURVEY<br>PLETED                  |
|                          |  | 245299   | B. WING _           |    |   | 10/       | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                     | ST | REET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER  |  |                     |    | 9 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG |    | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | included cards and<br>large group program<br>group activities succ<br>programing would be<br>enjoyed watching the<br>Review of R66's acc<br>dated 7/26/16, iden<br>involvement was fa<br>passive, R66 was u<br>a meaningful way.<br>watched TV on a da<br>watched movies. The<br>sometimes watch the<br>would rather watch<br>visits by staff each<br>family visited once poutside.<br>Review of activities<br>10/11/16, identified<br>was fair, participation<br>R66 was unable to<br>meaningful way. The<br>also watches movies<br>player. The note fur<br>4, 1:1 visits by active<br>would sometimes ra-<br>indicated family visi-<br>wheeled her around<br>weather was nice. The<br>R66's activity plan w<br>goal for the last 3 m<br>were effective. and<br>recommended for F<br>Review of the faciliti | r identified R66's past interests<br>games and plan included<br>ms and entertainment, small<br>h as manicures, 1:1<br>be needed, and R66 also<br>he birds and TV.<br>tivities quarterly progress note<br>tified R66's activity<br>ir and participation was<br>unable to structure her time in<br>The note identified R66<br>aily basis, and sometimes<br>he note indicated R66 would<br>he birds, but staff felt R66<br>TV and R66 would have 4, 1:1<br>week. The note also indicated<br>per week and took her<br>quarterly progress note dated<br>R66's activity involvement<br>on level remained passive and<br>structure her time in a<br>he note indicated R66 loved TV<br>es on her personal DVD<br>rther identified R66 would have<br>rity staff each week and they<br>ead her a book. The note also<br>ited once per week and<br>d or took her outside if the<br>The progress note identified<br>was appropriate, had met her<br>nonths, activity interventions<br>no changes were<br>R66's activity program. | F 28                | 30 |   |           |                                     |
|                          |  | 6 to 10/16 identified 4-5  |                     |    |   |           |                                     |

Facility ID: 00730

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING       (X3) DATE SURVEY<br>COMPLETED         NAME OF PROVIDER OR SUPPLIER       245299       B. WING       10/24/2016         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE<br>219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544       10/24/2016         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       (X5)  |           |  | AND HUMAN SERVICES  |          |     |  | FORM   | 12/15/2016<br>APPROVED<br>0938-0391 |
|---|-----------|--|---|----------|-----|--|--|-------------------------------------|
| NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       FRAZEE CARE CENTER     INTEGENT OF DEFICIENCES       PARTER     PROVIDER OR SUPPLIER       PREFIX     REGULATORY OR LSC IDENTIFYING INFORMATION       F 280     Continued From page 39       activities per week which R66 had special interest<br>in such as music, Bingo, movies, outside walks<br>and manicures.     F 280       Review of R66's Resident Activity Attendance<br>Chart forms from 41/116 to 10/17/16 revealed<br>R66 consistently watched TV and family visited.<br>However, the attendance charts did not include<br>consistent 111 visits, and did not consistently<br>include attendance at either large or small group<br>acclivities or activities out of room       -4/16, 6 out of 16 opportunities of 1:1 visits from<br>staff for the month, 1 mail reading, 1 glider, and 4<br>unable.       -7/16, 5 out of 18 opportunities of 1:1 visits from<br>staff for the month, 1 mail reading, 1 glider, and 4<br>unable.       -7/16, 7 out of 18 opportunities of 1:1 visits from<br>staff for the month, 1 mail reading, 1 glider<br>and 3 unable       -8/16, 7 out of 18 opportunities of 1:1 visits from<br>staff for the month, 1 mail reading, 1 glider<br>and 3 unable   | STATEMENT | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA   |          |     | E CONSTRUCTION   | (X3) DATE                                    | E SURVEY                            |
| PRAZEE CARE CENTER     219 WEST MAPLE AVENUE, PO BOX 96<br>PRAZEE, INN 56541       OWID<br>PREFX<br>TAG     SUMMARY STATEMENT OF DEFICIENCIES<br>LEACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATIONY OR LSC DENTIFYING INFORMATION     ID<br>PREFX<br>TAG     PROVIDER'S FLAN OF CORRECTION<br>(EACH OFFREENCE IN TOTING APPROPRIATE<br>DEFICIENCY)     OWIMETTION<br>(EACH OFFREENCE)     OWIMETTION<br>(EACH OFFREENCE)     OWIMETTION<br>(EACH OFFREENCE)     OWIMETTION<br>(EACH OFFREENCE)     OWIMETTION<br>(EACH OFFREENCE)     OWIMETTION<br>(EACH OFFREENCE)     DEFICIENCY)     DEFICIENCY     DEFICIENCY     DEFICIENCY     DEFICIENCY     DEFICIENCY     DEFICIENCY     DEFICIENCY     DIATE     DOMET     DOMET     DOMET     DOMET     DEFICIENCY     DEFICIENCY     DIATE     DEFICIENCY     DIATE  |           |  | 245299  | B. WING  |     |  | 10/:   | 24/2016                             |
| FRAZEE CARE CENTER     FRAZEE, NN 56544       (24) ID<br>PREFIX<br>TAG     SUMMARY STATEMENT OF DEFICIENCIES<br>IEACH DEFICIENCY MUST BE PRECEDED BY FULL<br>RECOUNTORY ON LSC.DENTIFYING INFORMATION)     ID<br>PREFIX<br>PREFIX     PROVIDERS PLANOF CORRECTIVE<br>(CROSS-REFERENCE) TO THE APPROPRIATE<br>OCROSS-REFERENCE) TO THE APPROPRIATE<br>DEFICIENCY     Commentation<br>(25),<br>CROSS-REFERENCE) TO THE APPROPRIATE<br>DEFICIENCY     Commentation<br>(26),<br>CROSS-REFERENCE) TO COMMENTATION<br>(26),<br>CROSS-REFERENCE) TO COMMENTATION<br>(26),<br>CROSS-REFERENCE) TO COMMENTATION<br>(26),<br>CROSS-REFERENCE) TO COMMENTATION (26),<br>CROSS-REFERENCE) TO COMMENTATION<br>(26),<br>CROSS-REFERENCE) TO COMMENTATION<br>(26),<br>CROSS-REFERENCE) TO COMMENTATION<br>(26),<br>CROSS-REFERENCE) TO COMMENTATION (26),<br>CROSS-REFERENCE) TO COMMENTATION<br>(26),<br>CROSS-REFERENCE) TO COMMENTATION (26),<br>CROSS-REFERENCE) TO COMMENTATION<br>(26),<br>CROSS-REFERENCE,<br>CROSSS, CROSSS, CROSSS, CROSSS, CROSSS, CROSSS, CROSSS, CROSSS | NAME OF F | PROVIDER OR SUPPLIER   |   | <u> </u> | S   | TREET ADDRESS, CITY, STATE, ZIP CODE                             | <u>,                                    </u> |                                     |
| PIÈERT<br>TAG       IEACH DEFICIENCY MUST BE PRECEDB DY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       PRÊFIX<br>TAG       IEACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE       Commentation<br>DEFICIENCY)         F 280       Continued From page 39<br>activities per week which R66 had special interest<br>in such as music, Bingo, movies, outside walks<br>and manicures.       F 280       F 280         Review of R66's Resident Activity Attendance<br>Chart forms from 4/1/16 to 10/17/16 revealed<br>R66 consistently watched TV and family visited.<br>However, the attendance to there large or small group<br>acclivities. The monthly documentation as<br>follows:       F 280         -4/16, 6 out of 16 opportunities of 1:1 visits from<br>staff for the month, and 3 unable and 1 refused.<br>No other documentation of large or small group<br>activities room, 1 mail reading, and 2 cleaning<br>glasses.       -6/16, 9 out of 16 opportunities for 1:1 visits from<br>staff for the month, 1 mail reading, and 2 cleaning<br>glasses.       -6/16, 5 out 18 opportunities for 1:1 visits from<br>staff for the month, 1 mail reading, 1 glider, and 4<br>unable.         -7/16, 5 of ut 18 opportunities for 1:1 visits from<br>staff for the month, 1 special event, 1 bird<br>watching, 2 cleaning glasses, 2 outside, 1 glider<br>and 3 unable       -8/16, 7 out of 18 opportunities for 1:1 visits for<br>the month, 1 bird watching, 1 wheeling, 1 outside,<br>1 cleaning glasses, and 1 unable   | FRAZEE    | CARE CENTER  |   |          |     |  |  |                                     |
| <ul> <li>activities per week which R66 had special interest<br/>in such as music, Bingo, movies, outside walks<br/>and manicures.</li> <li>Review of R66's Resident Activity Attendance<br/>Chart forms from 41/16 to 10/17/16 revealed<br/>R66 consistently watched TV and family visited.<br/>However, the attendance charts did not include<br/>consistent 1:1 visits, and did not consistently<br/>include attendance at either large or small group<br/>acclivities. The monthly documentation as<br/>follows:</li> <li>-4/16, 6 out of 16 opportunities of 1:1 visits from<br/>staff for the month, and 3 unable and 1 refused.<br/>No other documentation of large or small group<br/>activities or activities out of room</li> <li>-5/16, 7 out of 18 opportunities for 1:1 visits from<br/>staff for the month, 1 in family lounge, 1 in<br/>activities room, 1 mail reading, and 2 cleaning<br/>glasses.</li> <li>-6/16, 9 out of 16 opportunities of 1:1 visits from<br/>staff for the month, 1 mail reading, 1 glider, and 4<br/>unable.</li> <li>-7/16, 5 of out 18 opportunities for 1:1 visits from<br/>staff for the month, 1 special event, 1 bird<br/>watching, 2 cleaning glasses, 2 outside, 1 glider<br/>and 3 unable</li> <li>-8/16, 7 out of 18 opportunities for 1:1 visits from<br/>staff for the month, 1 special event, 1 bird<br/>watching, 2 cleaning glasses, 2 outside, 1 glider<br/>and 3 unable</li> <li>-8/16, 7 out of 18 opportunities for 1:1 visits for</li> </ul>  | PRÉFIX    | (EACH DEFICIENCY   | Y MUST BE PRECEDED BY FULL  | PREFI    | x   | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP | ) BE   | COMPLETION                          |
| the month, 1 outside, 1 cleaning glasses, and 1<br>unable   | F 280     | activities per week y<br>in such as music, B<br>and manicures.<br>Review of R66's Re<br>Chart forms from 4/<br>R66 consistently wa<br>However, the attend<br>consistent 1:1 visits<br>include attendance<br>acclivities. The mo<br>follows:<br>-4/16, 6 out of 16 op<br>staff for the month,<br>No other document<br>activities or activitie<br>-5/16, 7 out of 18 op<br>staff for the month,<br>activities room, 1 m<br>glasses.<br>-6/16, 9 out of 16 op<br>staff for the month,<br>unable.<br>-7/16, 5 of out 18 op<br>staff for the month,<br>watching, 2 cleaning<br>and 3 unable<br>-8/16, 7 out of 18 op<br>the month, 1 outsid | which R66 had special interest<br>Bingo, movies, outside walks<br>esident Activity Attendance<br>/1/16 to 10/17/16 revealed<br>atched TV and family visited.<br>dance charts did not include<br>s, and did not consistently<br>at either large or small group<br>onthly documentation as<br>pportunities of 1:1 visits from<br>and 3 unable and 1 refused.<br>tation of large or small group<br>es out of room<br>pportunities for 1:1 visits from<br>1 in family lounge, 1 in<br>hail reading, and 2 cleaning<br>pportunities of 1:1 visits from<br>1 mail reading,1 glider, and 4<br>poportunities for 1:1 visits from<br>1 special event, 1 bird<br>g glasses, 2 outside, 1 glider<br>pportunities for 1:1 visits for<br>ratching, 1 wheeling, 1 outside,<br>and 1 unable<br>pportunities for 1:1 visits for | F 2      | :80 |  |  |                                     |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                     |    |   | FORM      | APPROVED<br>0938-0391      |
|--------------------------|--|--|---------------------|----|---|-----------|----------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` '                 |    | E CONSTRUCTION  | (X3) DATE | E SURVEY<br>PLETED         |
|                          |  | 245299   | B. WING             |    |   | 10/2      | 24/2016                    |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                     |    | TREET ADDRESS, CITY, STATE, ZIP CODE  |           |                            |
| FRAZEE                   | CARE CENTER  |  |                     |    | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI><br>TAG | <  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE |
| F 280                    | Continued From pa  | ge 40  | F 2                 | 80 |   |           |                            |
|                          |  | ut of 13 opportunities for 1:1<br>mily lounge, 2 cleaning  |                     |    |   |           |                            |
|                          | to 10:03 a.m. R66's<br>and her bedroom de<br>observed on her ba<br>hospital gown. R66<br>position with no me<br>and 3 minutes. R66<br>calendar posted on<br>the foot of her bed,<br>sign was posted on<br>recliner and identifie<br>-R66 was to be cha<br>-No more Kardashia<br>-Family Feud on ch<br>-Wheel of fortune<br>-Jeopardy 5:00 p.m<br>-Judge Judy 9:00 a<br>-get movie going ea<br>On 10/19/16, at 10:<br>were in R66's room<br>her recliner. LPN-A<br>going to watch on T<br>those Kardashian g<br>R66 a hard time ab<br>you never now wha | nged during check ups<br>ans'!<br>annel 11:00 a.m.<br>   |                     |    |   |           |                            |
|                          | seated in her recline<br>type program was c  | 10 p.m. R66 was dressed and<br>er, in front of the TV. A political<br>on TV and R66 eyes were<br>he TV and out her bedroom |                     |    |   |           |                            |

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|                          |  | AND HUMAN SERVICES  |                     |    | 0   | FORM<br>MB NO. | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|---------------------|----|---|----------------|-------------------------------------|
|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 |    |   |                | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING _           |    |   | 10/2           | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                     |    | TREET ADDRESS, CITY, STATE, ZIP CODE  |                |                                     |
| FRAZEE                   | CARE CENTER  |   |                     |    | 9 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |                |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG |    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE             | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | dressed in a hospita<br>and her eyes were<br>On 10/21/16, at 10:<br>nurse (LPN-A) state<br>on staff for ADLs. S<br>was after R66 got u<br>TV in her recliner.<br>On 10/24/16, at 10:<br>stated R66 spent he<br>get 1:1 visits. She s<br>open curtains, and<br>the TV shows she li<br>stated she didn't kn<br>of her room, and sta<br>sit at the nurses de<br>and missed 1:1 visit<br>and asleep. She sta<br>provide 1:1 visits or<br>it was hard to provid<br>R66 required so mu<br>get up. She stated s<br>in her chair when fa<br>tried to get her out to<br>difficult.<br>On 10/24/16, at 10:<br>(CM-A) stated staff<br>recliner and she was<br>because they were<br>bed or her Broda ch<br>the time. She confir<br>and stated she und<br>time with her in her<br>On 10/24/16, at 12: | 22 a.m. R66 was in her bed<br>al gown. R66's TV was off,<br>focused on the ceiling.<br>224 a.m. licensed practical<br>ed R66 was totally dependent<br>she stated the usual routine<br>up, she spent her day watching<br>208 a.m. activities aide (AA-A)<br>er day watching TV and would<br>stated during 1:1 visits they<br>sit with her talk to her about<br>iked, or put a movie on. She<br>now how often R66 came out<br>ated sometimes they had her<br>sk. She stated R66 slept a lot,<br>its because she was in bed<br>ated activity staff tried to<br>n an attempt basis. She stated<br>de activities for R66 because<br>uch care, and was difficult to<br>she felt R66 was probably up<br>amily visited, and staff had<br>to story time but it was too<br>253 a.m. clinical manager<br>would get her up in her<br>atched the Kardashians'<br>on a lot, otherwise R66 was in<br>hair in her room the majority of<br>rmed R66's current care plan<br>lerstood activities staff spent | F 28                | 30 |   |                |                                     |

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|                          |   | AND HUMAN SERVICES   |                     |    |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|---------------------|----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |    | E CONSTRUCTION  | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299   | B. WING _           |    |   | 10/2      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                     |    | REET ADDRESS, CITY, STATE, ZIP CODE   | -         |                                     |
| FRAZEE                   | CARE CENTER   |  |                     |    | 9 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | ,  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | and stated R6 also<br>her room. AD indica<br>had wanted to bring<br>Adventure activity, y<br>during the week, bu<br>attend because she<br>stated R66 used to<br>staff struggled with<br>her wheelchair to at<br>she would like R66<br>it was such a hassle<br>her wheelchair, and<br>or recliner. AD conf<br>stated her care plar<br>portable DVD playe<br>activity records and<br>TV. She confirmed<br>R66's care plan had<br>current information. | iff what TV shows R66 liked<br>had a portable DVD player in<br>ated in the past activities staff<br>g R66 to the Afternoon<br>which was scheduled daily<br>ut struggled to get R66 to<br>e was not in her chair. She<br>get her nails done but activity<br>finding staff to get her up in<br>ttend the activity. She stated<br>to attend music programs but<br>e to find staff to get her up in<br>d R66 was usually in her bed<br>firmed R66's care plan and<br>n could be updated. She<br>n was TV focused and the<br>er also. AD confirmed R66's<br>I stated R66 mostly watched<br>the sign posted in room and<br>d not been updated with | F 28                | 30 |   |           |                                     |
|                          | identified R29 had o  | ary form dated 9/16/16,<br>diagnoses which included<br>malaise, and psychosis.   |                     |    |   |           |                                     |

Facility ID: 00730

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                    |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|--------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | LE CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING            |     |   | 10/:      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |           |                                     |
| FRAZEE                   | CARE CENTER  |   |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | R29's admission M<br>7/14/16, identified F<br>impairment, and rec<br>for bed mobility, tra<br>the unit, dressing a<br>identified ambulatio<br>the assessment per<br>R29's admission C/<br>R29 had dementia,<br>memory problems,<br>appeared related to<br>status related to fall<br>R29's current care f<br>revealed R29 had a<br>walker with assist of<br>ambulation, toileting<br>R29's care plan dire<br>wheeled walker and<br>On 10/19/2016, at<br>her wheelchair, at a<br>propelled herself wi<br>room towards her re<br>On 10/19/2016, at<br>her wheelchair with<br>asked staff direction<br>continued to self pro<br>On 10/19/2016, at<br>nurse (LPN)-C amb<br>desk with a front wh<br>around R29's waist<br>On 10/24/2016, at<br>wheelchair in the ha<br>The facility form title | <ul> <li>linimum Data Set (MDS) dated R29 had severe cognitive quired extensive assistance nsfer, locomotion on and off of and hygiene. The MDS in did not occur for R29 during riod.</li> <li>AA dated 7/14/16, identified both short term and long term and had poor balance which o decreased weight bearing I prior to admission.</li> <li>plan revised 10/14/16, an unsteady gait, used a of one and assist with g, and mobility as needed.</li> <li>ected assist of one with front d wheelchair for ambulation.</li> <li>8:46 a.m. R29 was seated in a table in the dining room. R29 th her feet, from the dining oom.</li> <li>9:02 a.m. R29 self propelled her feet in the hall. R29 ns to her room and then opel down the hall.</li> <li>10:30 a.m. licensed practical pulated R29 past the nurses neeled walker and a gait belt .</li> <li>9:57 a.m. R29 propelled her</li> </ul> | F 2                | 280 |   |           |                                     |

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|                          |  | AND HUMAN SERVICES   |                   |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|-------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | T OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     |   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299   | B. WING           | )   |   | 10/2      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                   | Ę   | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER  |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | to nursing from phy<br>receive the following<br>ambulate twice daily<br>walker), gait belt, ar<br>x (times) 1. Pt has a<br>therapy. Pt may req<br>upright posture and<br>R29's progress note<br>through 10/23/16, th<br>received therapy for<br>not note that reside<br>nursing staff to amb<br>day, nor was there of<br>received ambulation<br>R29 did not have a<br>the nursing assistan<br>On 10/21/16, at 11::<br>assistant (PTA) stat<br>with residents ambu<br>programs being cor<br>stated felt there was<br>the facility to comple<br>maintenance progras<br>stated residents suc<br>receive their ambula<br>On 10/24/2016, at<br>R29 was not on a w<br>indicated R29 would<br>walk with her in her<br>On 10/24/2016, at 1<br>R29 was not schedi<br>ambulation program | <ul> <li>vsical therapy directed R29</li> <li>vg: "Recommend Pt (patient)</li> <li>rg: "state and serious concerns ulation and maintenance mpleted consistently. PTA s not enough nursing staff in lete ambulation and ams on a routine basis. PTA ch as R29 did not routinely ation programs.</li> <li>10:14 a.m. NA-I indicated valking program. NA-I d self transfer and staff would room to the bathroom.</li> <li>10:16 a.m. (NA)-E indicated luled on a list for an</li> </ul> | F2                | 280 |   |           |                                     |

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|                          |   | AND HUMAN SERVICES  |                    |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|--------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                |     | E CONSTRUCTION  | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING            |     |   | 10/;      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |           |                                     |
| FRAZEE                   | CARE CENTER   |   |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | from therapy servic<br>ambulation or lower<br>to be completed by<br>to maintain the prog<br>therapy. PTA-G ver<br>therapy in August of<br>currently walking tw<br>PTA-G indicated an<br>would not be enoug<br>walking program.<br>On 10/24/16, at 10:<br>(CM)-B indicated R<br>program for one sta<br>hallway with use of<br>was unaware how of<br>verified R29's Resid<br>Interdepartmental C<br>to nursing from phy<br>following: "Recomm<br>twice daily with fww<br>belt, and CGA (care<br>has ambulated up t<br>require verbal cues<br>and take larger step<br>have a form which of<br>program in the NA grou<br>current care plan an<br>R29 was to receive<br>two times a day with<br>OM-B indicated with<br>observations of R25<br>was unaware if R25 | n therapy were discontinued<br>es and then continue with a<br>r extremity exercise program<br>the nursing assistants in order<br>gress which was made in<br>ified R29 was discharged from<br>f 2016, and should be<br>to times a day up to 150 feet.<br>nbulation into the bathroom<br>gh steps to be considered a<br>52 a.m. the clinical manager<br>29 had an ambulation<br>aff to walk the full length of the<br>a gait belt and a walker. CM-B<br>often R29 ambulated. CM-B | F2                 | 280 |   |           |                                     |

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| DEPART    | FORM                             | APPROVED  |               |     |  |                                       |            |  |
|-----------|----------------------------------|---|---------------|-----|--|---------------------------------------|------------|--|
|           | CARENCIES                        | & MEDICAID SERVICES   |               | тір | LE CONSTRUCTION  | OMB NO. 0938-0391<br>(X3) DATE SURVEY |            |  |
| -         | OF DEFICIENCIES<br>OF CORRECTION | IDENTIFICATION NUMBER:  |               |     |  |                                       | IPLETED    |  |
|           |                                  |   | _             |     |  |                                       |            |  |
|           |                                  | 245299  | B. WING _     |     |  | 10/                                   | 24/2016    |  |
| NAME OF F | PROVIDER OR SUPPLIER             |   |               |     | STREET ADDRESS, CITY, STATE, ZIP CODE                          |                                       |            |  |
| FRAZEE    | CARE CENTER                      |   |               |     | P19 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544           |                                       |            |  |
| (X4) ID   | SUMMARY STA                      | TEMENT OF DEFICIENCIES  | ID            |     | PROVIDER'S PLAN OF CORRECTI                                    |                                       | (X5)       |  |
| PRÉFIX    | (EACH DEFICIENCY                 | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)       | PREFIX<br>TAG | x   | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO | D BE                                  | COMPLETION |  |
| TAG       |                                  |   | TAG           |     | DEFICIENCY)  |                                       |            |  |
|           |                                  |   |               |     |  |                                       |            |  |
| F 280     | Continued From pa                | .ge 46  | F 2           | 80  |  |                                       |            |  |
|           | On $10/24/2016$ at $^{\circ}$    | 11:00 p.m. R46 was laying on                                    |               |     |  |                                       |            |  |
|           |                                  | her right side, covered with two                                |               |     |  |                                       |            |  |
|           | small blankets, the              | call light was secured to the                                   |               |     |  |                                       |            |  |
|           |                                  | o the side of the bed, and a proximately 3 feet from the        |               |     |  |                                       |            |  |
|           | bed in which R46 la              |   |               |     |  |                                       |            |  |
|           |                                  | -   |               |     |  |                                       |            |  |
|           |                                  | rders dated 9/20/16, identified<br>I muscle weakness, syncope   |               |     |  |                                       |            |  |
|           | and collapse.                    | muscle weakness, syncope  |               |     |  |                                       |            |  |
|           | •                                |   |               |     |  |                                       |            |  |
|           |                                  | nimum Data Set (MDS) dated<br>R46 had intact cognition, and     |               |     |  |                                       |            |  |
|           |                                  | assistance for transfer,  |               |     |  |                                       |            |  |
|           |                                  | off of the unit, dressing and                                   |               |     |  |                                       |            |  |
|           |                                  | ssistance for bed mobility and<br>The MDS identified ambulation |               |     |  |                                       |            |  |
|           |                                  | 46 during the assessment  |               |     |  |                                       |            |  |
|           | period.                          | Ū   |               |     |  |                                       |            |  |
|           | B46's Care Area As               | ssessment (CAAS) dated  |               |     |  |                                       |            |  |
|           |                                  | Cognitive Patterns- intact.                                     |               |     |  |                                       |            |  |
|           | Functional status: A             | Activities of daily living status-                              |               |     |  |                                       |            |  |
|           |                                  | of one staff for transfers, of staff to ambulate in room,       |               |     |  |                                       |            |  |
|           | ambulation in corric             | ,   |               |     |  |                                       |            |  |
|           |                                  |   |               |     |  |                                       |            |  |
|           |                                  | ed Resident Referral,<br>Communication dated 11/6/15,           |               |     |  |                                       |            |  |
|           |                                  | vsical therapy directed R46                                     |               |     |  |                                       |            |  |
|           | receive the following            | g: "Please ambulate Pt  |               |     |  |                                       |            |  |
|           |                                  | regular walker), transfer belt,<br>( (times) daily. Pt. amb.    |               |     |  |                                       |            |  |
|           |                                  | 0' any ? (questions) call."                                     |               |     |  |                                       |            |  |
|           | . , .                            |   |               |     |  |                                       |            |  |
|           |                                  | plan revised 8/22/16, revieled dy gait and weakness, SBA        |               |     |  |                                       |            |  |
|           |                                  | one for transfer and with                                       |               |     |  |                                       |            |  |

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PRINTED: 12/15/2016

|                          |   | AND HUMAN SERVICES  |                   |     |  | FORM     | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|-------------------|-----|--|----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,               |     | LE CONSTRUCTION  | (X3) DAT | E SURVEY<br>IPLETED                 |
|                          |   | 245299  | B. WING           |     |  | 10/      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER  | •   |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  | -        |                                     |
| FRAZEE                   | CARE CENTER   |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | Continued From pa walker.   | ge 47   | F 2               | 280 |  |          |                                     |
|                          | through 10/1/16, di   | es were reviewed 4/3/16,<br>id not note that R46 had<br>n services with floor staff.  |                   |     |  |          |                                     |
|                          |   | ambulation program sheet in<br>nt maintenance book.   |                   |     |  |          |                                     |
|                          | R29 was not sched ambulation program  | 10:16 a.m. (NA)-E indicated<br>uled on a list for an<br>n. NA-E stated R29 could pivot<br>couple steps but not walk any   |                   |     |  |          |                                     |
|                          | assistant (PTA)-G in<br>reached their goal i<br>from therapy servic<br>ambulation or lower<br>to be completed by<br>to maintain the prog<br>therapy. PTA-G ver<br>from therapy and s<br>times a day up to 2<br>tolerated. PTA-G in<br>to be walking with F<br>program should cor<br>a decline, hospitaliz<br>if a decline were to<br>be re-screened. PT | 10:32 a.m. physical therapy<br>indicated residnets who had<br>in therapy were discontinued<br>es and then continued with a<br>r extremity exercise program<br>the nursing assistants in order<br>gress which was made in<br>ified R46 had been discharged<br>should be currently walking two<br>00 feet or as far as R46<br>dicated she would expect staff<br>R46 in the hall and the<br>ntinue unless the resident had<br>eation or pain. PTA-G indicated<br>occur the resident should then<br>A-G indicated ambulation into<br>d not be enough steps to be<br>ng program. |                   |     |  |          |                                     |
|                          | (CM)-B indicated sh<br>ambulate. CM-B in<br>therapy was received  | 52 a.m. the clinical manager<br>ne had never seen R46<br>dicated when a referral from<br>ed for an ambulation program<br>rogram it would be written on a  |                   |     |  |          |                                     |

Facility ID: 00730

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|                          |  | AND HUMAN SERVICES   |                   |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|-------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | • •               |     | PLE CONSTRUCTION  | (X3) DATE | E SURVEY<br>IPLETED                 |
|                          |  | 245299   | B. WING           | i   |   | 10/:      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                   | ٤   | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER  |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | form for the nursing<br>maintenance book.<br>Referral, Interdepar<br>11/6/15, to nursing<br>the following: "Pleas<br>RW (regular walker<br>(assist) 2 X (times)<br>to 200' any ? (quest<br>did not have a form<br>program in the NA r<br>review of R46's cha<br>ambulation program<br>months of Decembo<br>July 2016, but no fu<br>documentation was<br>R46's ambulation p<br>being performed.<br>On 10/24/16, at 11:<br>nursing staff did not<br>had not asked her t<br>walking with the use<br>PTA-G, R46 stated,<br>in a while, I can fee<br>approximately 8 fee<br>stop a while to rest<br>minutes, R46 contir<br>to her room. R46 w<br>reached her room.<br>On 10/24/16, at 11:<br>with R46 identified s<br>walk more; howeve<br>were very busy and<br>assistance and tool<br>On 10/24/16, at 2:0<br>(PA)-A indicated sho | age 48<br>g assistants(NA) in the NA<br>CM-B verified R46's Resident<br>rtmental Communication dated<br>from physical therapy directed<br>se ambulate Pt (patient) with<br>c), transfer belt, and 1 A<br>daily. Pt. amb. (ambulate) up<br>tions) call." CM-B verified R46<br>which directed the ambulation<br>maintenance book. With<br>art, CM-B verified the<br>n had been in place for the<br>er 2015, April, May, June and<br>urther ambulation program<br>a found. The CM-B verified<br>rogram was not currently<br>11 a.m. R46 verified the<br>t walk with her in the hall and<br>to walk with them. While<br>e of a walker, gait belt and<br>," I can feel I have not walked<br>d it in my arms." R46 walked<br>et, stopped and requested to<br>her arms. After resting a few<br>nued to walk with PTA-G back<br>ras breathing heavily when she<br>24 a.m. a follow up interview<br>she was aware she should<br>or, believed the facility staff<br>I she required a lot of<br>k a lot of the staffs time.<br>00 p.m. physician assistant<br>e would expect facility staff to<br>e plans and to initiate | F2                | 280 |   |           |                                     |

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|                          |  | AND HUMAN SERVICES  |                   |     |   | FORM     | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|-------------------|-----|---|----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     | E CONSTRUCTION  | (X3) DAT | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING           |     |   | 10/2     | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   | -   |                   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |          |                                     |
| FRAZEE                   | CARE CENTER  |   |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) BE     | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | prevent resident fur<br>in the residnets qua<br>not providing recom<br>is not uncommon h<br>R38's significant ch<br>(MDS) 9/26/16, ider<br>cognitive impairmer<br>included degenerat<br>and back pain. The<br>independent in bed | king or exercise programs to<br>nctional decline and a decline<br>ality of life. PA-A stated, " Sadly<br>nmended restorative exercises                      | F2                | 280 |   |          |                                     |
|                          | turning around and walking and R38 die   | activity did not occur for<br>facing opposite direction while<br>d not walk.<br>ea Assessment (CAA) dated   |                   |     |   |          |                                     |
|                          | 9/26/16, indicated F performance and w   | R38 had improved ADL<br>would be addressed on care<br>not address R38's ambulation.   |                   |     |   |          |                                     |
|                          | R38 was not steady<br>human assistance f<br>and facing opposite  | IDS dated 5/24/16, identified<br>y, only able to stabilize with<br>for walking and turning around<br>direction while walking. The<br>ambulated with limited |                   |     |   |          |                                     |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                   |     |   | FORM     | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|-------------------|-----|---|----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     |   | (X3) DAT | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING           |     |   | 10/2     | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   |          |                                     |
| FRAZEE                   | CARE CENTER  |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE     | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | Continued From pa assistance from sta  | -   | Fź                | 280 |   |          |                                     |
|                          | required assistance<br>and transfer. The C<br>receiving therapies  | ed 5/24/16, identified R38<br>e from staff to safely ambulate<br>AA revealed R38 was<br>and her goal was to return to<br>opes of returning home.  |                   |     |   |          |                                     |
|                          |  | AA dated 5/24/16, identified<br>cooperative with therapies in<br>e.   |                   |     |   |          |                                     |
|                          | indicated she was f<br>and contact guard a<br>also indicated R38<br>assist to transfer wi<br>wheeled self indepe | plan updated 6/10/16,<br>ully ambulatory with a walker<br>assistance. R38's care plan<br>was receiving therapy and<br>th one and gait belt, and R38<br>endently in wheelchair. R38's<br>entify any updates past |                   |     |   |          |                                     |
|                          | dated 10/17/16, list<br>included R38 was a<br>toileting and ADL's,<br>therapy for walking.                       | Care Plan Group C form,<br>ed various interventions which<br>assist of one for transfers,<br>and listed R38 received<br>The form did not list any<br>for R38's ambulation.                                      |                   |     |   |          |                                     |
|                          | the facility hallway,<br>propelling herself to<br>feet. R38 propelled  | 6 p.m. R38 was observed in<br>seated in a wheelchair,<br>the activity room with both<br>herself up to a squared table,<br>wspaper and began to read   |                   |     |   |          |                                     |
|                          |  | 8 p.m. R38 indicated she had<br>the bathroom and slid herself   |                   |     |   |          |                                     |

Facility ID: 00730

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|                          |  | AND HUMAN SERVICES  |  |     |   | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |  |  |
|--------------------------|--|---|--|-----|---|-------------------------------|-------------------------------------|--|--|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |  |     |   | (X3) DATE SURVEY<br>COMPLETED |                                     |  |  |
|                          |  | 245299  | B. WING  | i   |   | 10/;                          | 24/2016                             |  |  |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |  | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                                     |  |  |
| FRAZEE                   | CARE CENTER  |   | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544 |     |   |                               |                                     |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                                   |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE                          | (X5)<br>COMPLETION<br>DATE          |  |  |
| F 280                    | to the toilet seat to it<br>was able to comple<br>liked to be as indep<br>proceeded to proper<br>utilizing both feet to<br>activity. At 3:08 p.m<br>wheelchair in the ac<br>participating in Bing<br>ambulate at any tim<br>On 10/20/16, at 1:5<br>(NA)-F stated R38 it<br>and was able to pro-<br>destinations. NA-F<br>with all of her person<br>maintain her indepen<br>not think R38 was a<br>assisted R38 to am<br>nursing assistants w<br>residents who were<br>and stated she did it<br>ambulation program<br>On 10/20/16, at 2:3<br>not assisted R38 withe<br>past. NA-B state<br>units were responsi<br>programs, after the<br>determined by occu<br>therapies (PT). NA-<br>both PT and OT up<br>months and indicate<br>been placed on the<br>stated she felt R38<br>could R38 ambulate<br>unit often times cou | use the toilet. She stated she<br>the most cares for herself and<br>bendent as possible. R38<br>el herself out of her room,<br>the activity room to attend an<br>h. R38 was seated in her<br>ctivity room actively<br>go. R38 was not observed to<br>he during observations.<br>7 p.m. nursing assistant<br>used a wheelchair for mobility<br>opel herself to and from<br>stated R38 was independent<br>onal cares and liked to<br>endence. NA-F stated she did<br>able to walk and had never<br>abulate. NA-F stated the<br>were responsible to ambulate<br>on an ambulation program<br>not think R38 was on an<br>n in the facility.<br>90 p.m. NA-B stated she had<br>ith ambulation at any time in<br>ed the NA on the individual<br>ible for residents walking | F 2  | 280 |   |                               |                                     |  |  |

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|                          |  | AND HUMAN SERVICES   |                    |     |   | FORM      | 12/15/2016<br>APPROVED          |
|--------------------------|--|--|--------------------|-----|---|-----------|---------------------------------|
| STATEMENT                | RS FOR MEDICARE  | & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | LE CONSTRUCTION   | (X3) DATE | 0938-0391<br>E SURVEY<br>PLETED |
|                          |  | 245299   | B. WING            |     | ·····   | 10/2      | 24/2016                         |
| NAME OF                  | PROVIDER OR SUPPLIER   | <u> </u>   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  | -         |                                 |
| FRAZEE                   | CARE CENTER  |  |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |           |                                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE      |
| F 280                    | On 10/20/16, at 3:1<br>(LPN)-B stated the<br>responsible to amb<br>ambulation program<br>she was unsure if F<br>program at present<br>clinical record, conf<br>PT and OT dated 7<br>to be assisted with<br>walker and one-per<br>LPN-B stated she of<br>assisted to ambulat<br>On 10/21/16, at 10:<br>(RN)-A stated she w<br>ambulation program<br>seen R38 ambulate<br>On 10/21/16, at 11:<br>assistant (PTA) state<br>physical and occup<br>admission to the fac<br>stated R38 was dis-<br>in July 2016, with a<br>be placed on an am<br>staff. PTA stated R3<br>one assist and a fro<br>feet consistently, w<br>PTA stated she had<br>residents' ambulatio<br>being completed co<br>there was not enou<br>to complete ambula<br>programs on a rout<br>On 10/21/16, at 11:<br>no longer able to wa<br>move about the fac | 8 p.m. licensed practical nurse<br>NAs on the units were<br>vulate with residents who had<br>ns in the facility. LPN-B stated<br>R38 was on an ambulation<br>and after review of R38's<br>firmed R38 had a referral from<br>78/16, which directed R38 was<br>ambulation twice daily with a<br>rson assistance up to 40 feet.<br>did not think R38 had been<br>te since therapy ended.<br>35 a.m. registered nurse<br>was unaware if R38 was on an<br>n and indicated she had not<br>e with staff in the past.<br>20 a.m. physical therapy<br>ted R38 had received both<br>rational therapy upon<br>cility in May of 2016. PTA<br>continued from both therapies<br>referral to nursing for R38 to<br>nbulation program with nursing<br>38 was able to ambulate with<br>ont wheeled walker up to 40<br>hen PT and OT were stopped.<br>d serious concerns with<br>on and maintenance programs<br>onsistently. PTA stated felt<br>ugh nursing staff in the facility<br>ation and maintenance | F 2                | 280 |   |           |                                 |

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|                          |  | AND HUMAN SERVICES   |                     |                                 |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|---------------------|---------------------------------|---|-----------|-------------------------------------|
| STATEMEN                 | T OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 | PLE CONSTRUCTION                | N   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299   | B. WING _           |                                 |   | 10/2      | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                     |                                 | CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER  |  |                     | 219 WEST MAPLE<br>FRAZEE, MN 56 | AVENUE, PO BOX 96<br>0544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CO                        | DER'S PLAN OF CORRECTION<br>DRRECTIVE ACTION SHOULD<br>ERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | had worked with the<br>stated nursing staff<br>ambulation since the<br>months ago. R38 si<br>which affected her a<br>had some "treatme<br>again with help.<br>On 10/21/16, at 11:<br>room, and looked in<br>locations in her roo<br>R38 no longer had<br>stated she would ex<br>available so nursing<br>PTA left R38's room<br>wheeled walker and<br>R38. PTA applied a<br>torso and cued R38<br>up to the walker wh<br>gait belt. R38 was of<br>from the wheelchain<br>R38's knees remain<br>80 degree angle, w<br>or straighten her km<br>R38 twice more and<br>stand erect or straig<br>she could not stand<br>stood up for a long<br>remember the last t<br>Was in July, 2016. F<br>the ability to fully sta<br>On 10/21/16, at 11:<br>interview, PTA state<br>from therapy, R38 h | age 53<br>erapy for her walking. R38<br>had not assisted with her<br>herapy had stopped several<br>tated she had bad knees<br>ability to walk, but felt if she<br>nts" she would be able to walk<br>36 a.m. PTA entered R38's<br>in her closet and various<br>m for her walker. PTA stated<br>a walker in her room and<br>expect R38 to have a walker<br>g staff could assist her to walk.<br>In briefly, returned with a front<br>d placed the walker in front of<br>a transfer belt around R38's<br>8 to stand from her wheelchair<br>tile PTA pulled upwards on the<br>only able to lift her buttocks<br>r seat approximately 7 inches.<br>hed bent at approximately an<br>as unable to stand fully erect<br>tees. PTA attempted to stand<br>d R38 continued to not able to<br>ghten her knees. R38 stated<br>d up all of the way and had not<br>time. R38 stated she could not<br>time she had used a walker.<br>en the last time she had<br>sponded, "with you." PTA<br>ime she had worked with R38<br>PTA confirmed R38 had lost<br>and and to ambulate.<br>44 a.m. during a follow up<br>ed when R38 was discharged<br>had been ambulating about<br>n minimal assist of one and a | F 28                |                                 |   |           |                                     |

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|                          |  | AND HUMAN SERVICES  |                   |     |  | FORM     | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|-------------------|-----|--|----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     | E CONSTRUCTION   | (X3) DAT | E SURVEY<br>IPLETED                 |
|                          |  | 245299  | B. WING           |     |  | 10/      | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |          |                                     |
| FRAZEE                   | CARE CENTER  |   |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | front wheeled walke<br>referred to an ambu<br>and she would have<br>assistance with wal<br>daily. PTA stated sh<br>problem with the far<br>ambulation/mainter<br>concerns and state<br>enough NAs to com<br>ambulation/mainter<br>Review of R38's ho<br>dated 5/17/16, iden<br>weakness and falls<br>revealed R38 was h<br>walking. The summ<br>sent to the facility for<br>extremity weakness<br>Review of R38's ph<br>8/2/16, revealed R38<br>(MD) had seen her<br>revealed R38 had p<br>was ambulating usi<br>revealed R38 had p<br>was ambulating usi<br>revealed R38's dau<br>had exhibited regre<br>ended.<br>Review of R38's ph<br>10/6/16, revealed R<br>another practitioner<br>a wheelchair for lon<br>and OT during the s<br>that time due to incl<br>determined to be a<br>Review of a facility<br>Interdepartmental C | er. PTA stated R38 was<br>ulation maintenance program<br>e expected R38 to receive<br>king with nursing staff twice<br>he felt the facility had a huge<br>cility's<br>hance program due to staffing<br>d she felt there were not<br>hplete resident<br>hance programs.<br>spital discharge summary<br>tified R38 had been treated for<br>at home. The summary<br>having difficulty standing and<br>hary further revealed R38 was<br>or acute rehab due to lower<br>s.<br>ysician progress note dated<br>38's primary medical doctor<br>at the clinic. The note also<br>blateau in therapy, however,<br>ng a walker. The note further<br>ghter had concerns that R38<br>ssion after therapy was<br>ysician progress note dated<br>for had established care with<br>the note revealed R38 used<br>to distances, had received PT<br>spring and summer, and at<br>reased care needs R38 was | F                 | 280 |  |          |                                     |

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|                          |  | AND HUMAN SERVICES   |                    |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | E CONSTRUCTION  | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299   | B. WING            |     |   | 10/2      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |           |                                     |
| FRAZEE                   | CARE CENTER  |  |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | a ambulation progra<br>daily with front walk<br>40 feet. The form a<br>complained of left k<br>any questions to ca<br>Review of R38's me<br>record lacked furthe<br>ambulation status of<br>documentation of fa<br>worksheets.<br>Nursing progress m<br>5/17/16, to 10/18/16<br>On 5/17/16, R38 wa<br>required one assists<br>On 6/10/16, the not<br>with therapy.<br>On 6/11/16, R38 qu<br>when she would be<br>On 8/4/16, R38 req<br>R38's nursing progra<br>documentation of R<br>in R38's ambulation<br>On 10/21/16, at 1:3<br>nursing (ADON) co<br>ambulation/mainter<br>been implemented<br>R38's referral for ar<br>program directed st<br>a front wheeled wal<br>ADON stated she w | am to include ambulation twice<br>ker and one assistance up to<br>lso identified R38 has<br>knee pain and if nursing had<br>ll.<br>edical record revealed the<br>er documentation of R38's<br>or progress and lacked<br>acility forms maintenance ADL<br>otes were reviewed from<br>6, revealed the following:<br>as full weight bearing and<br>ance with ADL's.<br>the indicated R38 was working<br>testioned nursing staff on<br>able to return home.<br>uired one assist with ADL's.<br>ress notes lacked any<br>R38's ambulation and decline<br>in status. | F 2                | 280 |   |           |                                     |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|---------------------|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 | TIPLE CONSTRUCTION  | (X3) DATI | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING _           |   | 10/2      | 24/2016                             |
| NAME OF F                | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER   |   |                     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>YMUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE      | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | stated she had und<br>had been assisting<br>stated she was not<br>ambulate. NM-A st<br>R38's ambulation/m<br>been started.<br>A facility policy titled<br>4/1/08 identified res<br>admission for a res  | ine her ambulation.<br>7 a.m. nurse manager (NM)-A<br>erstood the nursing assistants<br>R38 with ambulation. NM-A<br>aware R38 could not longer<br>ated she was not sure why<br>naintenance program had not<br>d, Restorative Program, dated<br>idents would be assessed on<br>torative program such as | F 28                | 80  |           |                                     |
| F 282<br>SS=E            | identified need, a pl<br>meet resident need<br>identified residents<br>highest level of fund<br>Review of facility po<br>Plans-Comprehens<br>facility would revise<br>care plan to meet th<br>psychosocial needs<br>comprehensive ass<br>483.20(k)(3)(ii) SEF<br>PERSONS/PER CA<br>The services provide<br>must be provided b<br>accordance with ea<br>care.<br>This REQUIREMEN<br>by:<br>Based on observat | plicy, Care<br>ive, dated 4/1/08 identified the<br>the resident's comprehensive<br>he resident's mental and<br>a as identified by<br>essment.<br>RVICES BY QUALIFIED<br>ARE PLAN<br>led or arranged by the facility<br>y qualified persons in<br>ch resident's written plan of                          | F 28                | F 282 Services provided by qualif   | ied       | 12/14/16                            |
|                          |   | iled to ensure resident care  |                     | person/per care plan  |           |                                     |

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## **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245299 **B** WING 10/24/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE CARE CENTER FRAZEE, MN 56544 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 57 F 282 plan interventions were implemented for bathing 1. R 61 is being bathed according to her preferences for 1 of 3 residents (R61) reviewed preference; R61 s bath schedule and for choices, ambulation programs were care plan have been updated. implemented and routinely followed for 1 of 4 Resident R44 continues on a restorative residents (R44) reviewed for ambulation. In ambulation program. addition the facility failed to ensure resident care R 18 will be reassessed through a 3 day plan interventions were implemented for Bowel and Bladder Assessment to assess assessed repostitioning, personal cares needs for incontinence patterns and assessed for 1 of 1 resident (R18) reveiwed for urinary through a tissue tolerance test; R18 s incontinence and for repositioning for 2 of 2 care plans will be updated to include a residents (R18, R66) at risk for development of turning and repositioning program in accordance with assessment findings. pressure ulcers. . R66 will be assessed for tissue tolerance with update to turning and repositioning care plan according to tissue tolerance Findings include: test findinas. **Bathing Preferences:** R 66 has been re-evaluated by therapy; therapy recommendations for ROM and Review of R61's current care plan revised splinting of upper extremities is being 1/27/16, revealed R61 required assistance of one followed by nursing staff. with bathing. Review of nursing assistant care sheet provided by the facility, dated 10/17/16, directed staff to 2. All resident have the potential to be at assist R61 with a bath 3 times a week, Monday, risk. A list of residents with a BIMS score Wednesday and Fridays. of 12 or greater will be generated and each resident will be interviewed for bath preference including timing and On 10/19/16, at 1:26 p.m. R61 stated she had not received her bath on Monday 10/17/16, due to not frequency. All residents needing enough staff on the floor. R61 stated she had assistance with ambulation and have had been told the staff would try to help her with a fall in the past 30 days will be reviewed bathing on 10/18/16, though due to not enough for the need for a restorative ambulation staff on the floor, she had not received assistance program and care plans will be updated with a bath. R61 stated the nursing assistants accordingly. A list of residents coded on (NA) do not have enough time during the day to the MDS as having a current pressure give baths, so she had changed to before bed. ulcer will assessed for appropriate turning R61 stated she was scheduled to have 3 baths a and repositioning interventions and care week, Monday, Wednesday and Fridays and was plans updated. A list of residents currently still not able to get 3 baths a week due to not wearing splints will be generated and care enough staff on the floor. R61 stated it had been plans updated as needed. Residents who

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 12/15/2016 FORM APPROVED

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245299 **B** WING 10/24/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE CARE CENTER FRAZEE, MN 56544 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 58 F 282 "months" since she had received 3 baths a week, have incontinence will be check for proper and indicated she understood it was due to the incontinence care and care plans updated lack of nursing staff. as needed. On 10/20/16, at 1:52 a.m. NA-F stated she 3. Mandatory nursing staff education understood R61 was supposed to receive 2 baths was provided on November 16 and 17. a week in the evenings and was not sure if R61 2016 on the procedure titled, Restorative received her baths routinely. Nursing: Goals and Needs Assessment with a focus on the need for the facility to On 10/21/16, at 11:02 a.m. ADON indicated she provide restorative nursing in the form of had met with R61 on 10/20/16 and confirmed R61 Turning and Repositioning, ROM, Splinting, and ambulation; restorative had not been routinely receiving her 3 baths a week as care planned. nursing documentation will be on the Maintenance Therapy Flowsheet . On 10/21/16, at 1:37 p.m. during a follow up Residents totally incont. of bowel or interview. ADON stated she felt staff were unable bladder need to be checked and changed to routinely complete the number of baths based every two hours or according to their on residents preference, such as R61, due to tissue tolerance assessment and care staffing shortages. plan. 4. An audit was developed to monitor On 10/24/16, at 9:31 a.m. nurse manager (NM)-A resident bathing choices through stated she was unaware R61's baths were not observation and chart review. Care plans getting done 3 times a week. She stated R61's will be updated to include bathing care plan should be followed. preference and frequency. Audit to be observational monitoring of staff Ambulation Review of R44's current care plan updated performing restorative nursing programs 9/25/15, revealed R44 was independent with including ambulation, ROM, and splitting mobility in a wheelchair and required assistance and care plans have been updated. A with ambulation with use of a walker. R44's care (PIP) performance improvement project plan directed staff to offer to walk with R44 to all for restorative nursing programs and care meals. planning has been started and all current residents receiving restorative interventions will be reviewed for Review of Aide Care Plan Group C form, dated 10/17/16. listed various interventions which progress. All other residents will be included R44 was assist one for ADL's and review for change in ADL score or decline directed staff to assist R44 with ambulation twice in ADL s monthly. All residents on daily to 200 feet, with a rear wheeled walker and restorative programs will be reviewed monthly and determine if the residents transfer belt.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00730

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|                          |  | AND HUMAN SERVICES   |                     |    |  | FORM  | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|---------------------|----|--|---|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |    | E CONSTRUCTION   | (X3) DATE   | E SURVEY<br>PLETED                  |
|                          |  | 245299   | B. WING _           |    |  | 10/:  | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                     | ST | TREET ADDRESS, CITY, STATE, ZIP CODE   |   |                                     |
| FRAZEE                   | CARE CENTER  |  |                     |    | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |   |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE  | (X5)<br>COMPLETION<br>DATE          |
|                          | Continued From pa<br>On 10/19/16, at 8:1<br>standard wheelchai<br>dining room and wh<br>table. R44 verbalize<br>obtained her food a<br>a.m. R44 had eater<br>time propelled hers<br>Review of a facility<br>Worksheet from Ap<br>identified R44's was<br>twice a day (BID) lo<br>with a walker and tr<br>also indicated R44's<br>ambulate up to 200<br>revealed the followi<br>- Review of R44's A<br>R44 had received h<br>of 31 days in the an<br>in the pm hours.<br>-Review of R44's M<br>identified R44 had r<br>program 13 out of 3<br>out of 31 in the pm.<br>-Review of R44's Ju<br>R44 had received h | SC IDENTIFYING INFORMATION)<br>age 59<br>6 a.m. R44 was seated in a<br>ir, propelling herself into the<br>neeled herself up to a circular<br>ed her breakfast order,<br>and ate independently. At 8:34<br>n 100% of her meal and at that<br>belf out of the dining room.<br>form titled Maintenance ADL<br>oril 2016, to October 2016,<br>s on an ambulation program<br>ong distances in the hallways<br>ransfer belt. The worksheet<br>was to be assisted to<br>0 feet (ft.) R44's worksheets<br>ing:<br>April 2016, worksheet identified<br>her ambulation program 16 out<br>n hours and 25 out of 31 days |                     |    | CROSS-REFERENCED TO THE APPROP   | errals<br>o<br>v staff.<br>be<br>r timely<br>ts that<br>sments<br>rith<br>pdated<br>iving<br>e will<br>n<br>audited<br>ation<br>cy of<br>eted by<br>weeks,<br>ndings<br>s to the<br>nmittee |                                     |
|                          | R44 had received h<br>of 30 days in the an<br>pm.  | uly 2016, worksheet identified<br>her ambulation program 7 out<br>n and 12 out of 30 days in the<br>ugust 2016, worksheet  |                     |    |  |   |                                     |

|                          |  | AND HUMAN SERVICES  |                    |     |  | FORM     | : 12/15/2016<br>APPROVED<br>. 0938-0391 |
|--------------------------|--|---|--------------------|-----|--|----------|---|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     |  | (X3) DAT | E SURVEY<br>IPLETED                     |
|                          |  | 245299  | B. WING            |     |  | 10/      | 24/2016                                 |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                    | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  | -        |   |
| FRAZEE                   | CARE CENTER  |   |                    |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |          |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE    | (X5)<br>COMPLETION<br>DATE              |
| F 282                    | identified R44 had r<br>program 8 out of 31<br>-Review of R44's S<br>identified R44 had r<br>program 11 days ou<br>out of 30 in the pm.<br>-Review of R44's O<br>identified R44 had r<br>program 2 days out<br>days out of 17 in the<br>Review of an Occup<br>assessment dated 3<br>discharged from the<br>placed on the nursin<br>program) and was t<br>wheeled walker with<br>On 10/20/16, at 1:5<br>(NA)-F stated R44 y<br>cares on her own. N<br>assistance to ambu<br>on an ambulation p<br>am and in the pm. 1<br>when R44 was not<br>not enough nursing<br>On 10/20/16, at 2:3<br>required limited ass<br>and ambulation. NA<br>ambulation program<br>residents ambulatio<br>were not getting do<br>enough staff and th | <ul> <li>received her ambulation<br/>I days in the am and pm.</li> <li>eptember 2016, worksheet<br/>received her ambulation<br/>ut of 30 in the am and 8 days</li> <li>ectober 2016, worksheet<br/>received her ambulation<br/>t of 17 in the the am and 0<br/>e pm.</li> <li>pational Therapy (OT)<br/>3/12/15, revealed R44 was<br/>erapy services and had been<br/>ng gait list (ambulation<br/>to ambulate with a front<br/>h stand by assistant<br/>was able to complete most<br/>NA-F stated R44 required<br/>late in the hallways and was<br/>rogram for twice a day in the<br/>NA-F stated there were days<br/>assisted to ambulate due to<br/>staff on the floor.</li> <li>4 p.m. NA-B stated R44<br/>sistance with ADL's of dressing<br/>A-B stated R44 was on an<br/>n for twice a day. NA-B stated<br/>on/maintenance programs<br/>ne as they should due to not<br/>is included R44.</li> </ul> | F2                 | 282 |  |          |   |
|                          | On 10/20/16, at 3:2  | 4 p.m. licensed practical nurse   |                    |     |  |          |   |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                    |     |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|--------------------|-----|--|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | PLE CONSTRUCTION   | (X3) DATI | E SURVEY<br>IPLETED                 |
|                          |  | 245299   | B. WING            |     |  | 10/:      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                    |     | STREET ADDRESS, CITY, STATE, ZIP CODE  |           |                                     |
| FRAZEE                   | CARE CENTER  |  |                    |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>YMUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE      | (X5)<br>COMPLETION<br>DATE          |
| F 282                    | (LPN)-B stated R44<br>program for twice a<br>stated R44 liked to<br>was not assisted wi<br>enough staff on the<br>On 10/21/16, at 10:<br>on a walking progra<br>walk twice a day. R<br>to 3 times a day and<br>was walked once a<br>told her they were to<br>not receive her amb<br>that had been happ<br>several months. R4<br>around the entire bl<br>perimeter around th<br>time would get a bit<br>like she should. R44<br>was not as steady of<br>R44 stated she fear<br>to walk if she did no<br>program of twice a<br>On 10/21/16, at 10:<br>(RN)-A confirmed F<br>program twice daily<br>walker and gait belt<br>R44 was routinely r<br>program and stated<br>answer the question<br>On 10/21/16, at 10:<br>therapy assistant (O<br>been referred to nu<br>program last year a | <ul> <li>was on a ambulation</li> <li>day in the am and pm. LPN-B</li> <li>walk and felt the times R44</li> <li>th ambulation was due to not floor.</li> <li>08 a.m. R44 stated she was am which she was supposed to 44 stated she used to walk up d stated she was lucky if she day. R44 stated the staff had oo busy on the days she did bulation program. R44 stated ening routinely for the last 44 stated she was able to walk lock (200 feet square the nursing station,) but at the swinded due to not walking 4 stated she felt as though she on her legs as she used to be. The she would lose her ability of continue with her ambulation day.</li> <li>18 a.m. registered nurse R44 was on an ambulation to 200 feet with assist of one, the ceiving her ambulation and and the ambulation of the ambulatice of the ambulation of the ambulation of the ambul</li></ul> | F 2                | 282 |  |           |                                     |

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|               |  | AND HUMAN SERVICES   |              |      |  | FORM | APPROVED            |
|---------------|--|--|--------------|------|--|------|---------------------|
|               |  |  | (X2) MUL     | TIPL |  |      | 0938-0391<br>SURVEY |
| AND PLAN C    | FCORRECTION                              | DENTIFICATION NUMBER:  |              |      |  |      | PLETED              |
|               |  | 245299   | B. WING      |      |  | 10/3 | 24/2016             |
| NAME OF F     | PROVIDER OR SUPPLIER                     |  | ſ            | S    | TREET ADDRESS, CITY, STATE, ZIP CODE   | 10/1 |                     |
| FRAZEE        | CARE CENTER                              |  |              |      | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544                               |      |                     |
| (X4) ID       | SUMMARY STA                              | TEMENT OF DEFICIENCIES   | ID           | -    | PROVIDER'S PLAN OF CORRECTION  | ٨    | (X5)                |
| PREFIX<br>TAG |  | / MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)      | PREFI<br>TAG |      | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) |      | COMPLETION<br>DATE  |
| F 282         | Continued From po                        | ao 62  |              | 000  |  |      |                     |
| 1 202         | Continued From pa<br>On 10/21/16. at 11: | 13 a.m. assistant director of                                  | F 2          | 282  |  |      |                     |
|               | nursing (ADON) co                        | nfirmed R44 was not  |              |      |  |      |                     |
|               |  | ng her ambulation program.<br>expected staff to routinely      |              |      |  |      |                     |
|               | complete ambulation                      | on/maintenance programs for                                    |              |      |  |      |                     |
|               | resident.                                |  |              |      |  |      |                     |
|               |  |  |              |      |  |      |                     |
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|               |  |  |              |      |  |      |                     |
|               |  |  |              |      |  |      |                     |
|               | Repositioning/perso                      | onal cares:  |              |      |  |      |                     |
|               |  | rrent care plan last updated                                   |              |      |  |      |                     |
|               |  | 18 had severe cognitive loss, municate her needs and was       |              |      |  |      |                     |
|               | totally dependent or                     | n staff for toileting,   |              |      |  |      |                     |
|               |  | and was frequently<br>I and bladder and wore an                |              |      |  |      |                     |
|               | incontinent brief . T                    | he care plan listed  |              |      |  |      |                     |
|               |  | included to assist R18 to turn<br>y 2 hours and prn, keep skin |              |      |  |      |                     |

Facility ID: 00730

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|                          |  | AND HUMAN SERVICES  |                   |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|-------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,               |     | LE CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING           | i   |   | 10/2      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER  |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 282                    | and change R18 ew<br>with repositioning.<br>On 10/19/16, from 7<br>continuous observa<br>following:<br>On 10/19/16, at 7:0<br>gel cushioned whee<br>room. R18's bed wa<br>were balled into a b<br>was hung forward in<br>her eyes were close<br>-at 7:38 a.m. the ca<br>by R18's roommate<br>the room to assist F<br>housekeeping staff<br>made R18's bed wh<br>the wheelchair. At 7<br>staff member whee<br>R18 had remained<br>head was in a chin<br>Housekeeping staff<br>dining room and pla<br>around her neck, at<br>face with the clothir<br>-at 7:56 a.m. R18 re<br>wheelchair in the di<br>(DA)brought R18 he<br>plate on the table in<br>At that time nursing<br>approached R18, p<br>and verbally promp<br>opened her eyes ar | a gel cushion in the<br>re plan directed staff check<br>very 2 hours for incontinence<br>7:03 a.m. to 10:39 a.m.,<br>ations of R18 revealed the<br>33 a.m. R18 was seated in a<br>elchair, fully dressed in her<br>as stripped of its linens which<br>bundle on her bed. R18's head<br>in a chin to chest position and<br>ed.<br>all light to R18's room was on<br>a, staff were observed to enter<br>R18's roommate. At that time,<br>entered R18's room and<br>hile she remained seated in<br>7:41 a.m. the housekeeping<br>led R18 to the dining room.<br>with her eyes closed and her<br>to chest position.<br>5 wheeled R18 to a table in the<br>aced a clothing protector<br>t that time R18 covered her<br>ng protector.<br>emained seated in the<br>ning room. A dietary aid<br>er breakfast plate, left the<br>n front of her and walked away. | F2                | 282 |   |           |                                     |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                   |     |  | FORM | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|-------------------|-----|--|------|-------------------------------------|
|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | • •               |     | LE CONSTRUCTION  |      | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING           |     |  | 10/2 | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |   |                   |     | STREET ADDRESS, CITY, STATE, ZIP CODE  |      |                                     |
| FRAZEE                   | CARE CENTER   |   |                   |     | PARENT MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |      |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE   | (X5)<br>COMPLETION<br>DATE          |
| F 282                    | R18 ate 100% of he<br>independently while<br>R18 remained seat<br>table<br>-at 8:46 a.m. R18 re<br>wheelchair at the di<br>attempt to leave fro<br>completed her mea<br>juice and water in fr<br>attempt to reach for<br>spoon, and would re<br>the lipped edge of h<br>her spoon.<br>-at 9:01 a.m. R18 re<br>wheelchair in the di<br>attempts to leave th<br>R18 and asked how<br>respond, NA-H wall<br>repeatedly run her so<br>of the plate, while s<br>spoon. R18 had ma<br>fluids.<br>-at 9:18 a.m. R18 re<br>wheelchair in the di<br>spoon on the table,<br>Shortly after R18's<br>chin to chest positio<br>assist R18 with rep<br>-at 9:30 a.m. R18 re<br>wheelchair in the di<br>her eyes, looked ar<br>protector and cover | er breakfast foods<br>e seated in the wheelchair.<br>ed in the wheelchair at the<br>emained seated in her<br>ning room table, had made no<br>m the table. R18 had<br>I, had a glass of milk orange<br>ront of her though made no<br>r them. R18 held onto her<br>epeatedly run the spoon over<br>her plate, periodically licking<br>emained seated in her<br>ning room, having made no<br>he table. NA-H approached<br>wher day was, R18 did not<br>ked away. R18 continued to<br>spoon around the lipped edge<br>he periodically licked her<br>ade no attempts to drink her<br>emained seated in her<br>ning room. R18 had set the<br>and had closed her eyes.<br>head dropped forward in a<br>on. No staff had offered to | F                 | 282 |  |      |                                     |

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|                          |   | AND HUMAN SERVICES  |                   |     |   | FORM     | : 12/15/2016<br>APPROVED<br>. 0938-0391 |
|--------------------------|---|---|-------------------|-----|---|----------|---|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     | PLE CONSTRUCTION  | (X3) DAT | E SURVEY<br>IPLETED                     |
|                          |   | 245299  | B. WING           | i   |   | 10/      | 24/2016                                 |
| NAME OF I                | PROVIDER OR SUPPLIER  |   | -                 | 5   | STREET ADDRESS, CITY, STATE, ZIP CODE   |          |   |
| FRAZEE                   | CARE CENTER   |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |          |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETION<br>DATE              |
| F 282                    | face covered with th<br>-at 9:37 a.m. NA-D<br>awoke R18 and offe<br>awake, removed the<br>face and allowed N.<br>juice. R18 drank 50<br>handed R18 her gla<br>independently drant<br>seated in her wheel<br>room. NA-D was no<br>assistance with care<br>needs.<br>-at 9:42 a.m. NA-H<br>her to drink her rem<br>remained seated in<br>removed the clothin<br>R18 then took her s<br>it, in a cradling posi<br>-at 9:50 a.m. NA-H<br>room while seated i<br>to her room and ha<br>NA-H attached the<br>and left R18's room<br>offer R18 with any co<br>or toileting.<br>-at 10:01 a.m. NA-E<br>R18's room, did not<br>-at 10:09 a.m. NA-<br>hallway from R18's<br>R18's room and im<br>the hallway.<br>-at 10:39 a.m. assis | entered the dining room,<br>ered R18 her fluids. R18<br>e clothing protector from her<br>A-D to assist her to drink her<br>1% of her juice. NA-D then<br>ass of water and R18<br>k the water. NA-D left R18<br>lchair and exited the dining<br>ot observed to offer R18<br>es, repositioning or toileting<br>approached R18 and assisted<br>naining fluids, while R18<br>her wheelchair. NA-H<br>ng protector from R18's neck,<br>shirt and covered her face with | F                 | 282 |   |          |   |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                   |     |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|-------------------|-----|--|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     | E CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING           |     |  | 10/:      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                   |     | TREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER   |   |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 282                    | her wheelchair for a<br>minutes. At that tim<br>required assistance<br>checking and chang<br>confirmed R18 was<br>ADON went to R18<br>assistance from oth<br>talkie.<br>-at 10:39 a.m. NA-E<br>asked R18 to use th<br>gait belt across R18<br>assisted R18 to use th<br>gait belt across R18<br>assisted R18 to sta<br>ambulate to the bat<br>slacks and incontin-<br>amount of urine in h<br>amount of bowel. A<br>buttocks surface wh<br>had deep blush pinl<br>surrounding her per<br>blanchable. NA-E a<br>complete toileting n<br>back in her wheelch<br>R18 had remained<br>of 3 hours and 36 n<br>staff were observed<br>repositioning.<br>On 10/19/16, at 10:<br>thought R18 was la<br>a.m. and had stated<br>helping others with<br>repositioning and to<br>R18 was supposed<br>checked and chang<br>needed. NA-E stated | an observed 3 hours and 36<br>e the ADON confirmed R18<br>e with repositioning and<br>ging every 2 hours. ADON<br>at risk for skin breakdown.<br>'s room while requesting<br>her nursing staff via walkies<br>E entered R18's room and<br>he bathroom. NA-E donned a<br>8's torso, NA-E and ADON<br>nd from the wheelchair,<br>hroom and removed R18's<br>ent brief. R18 had a moderate<br>her brief as well as a small<br>DON confirmed R18's entire<br>hich had contact with the brief<br>k creases and was moist<br>ri-rectal area, though was<br>and ADON assisted R18 to<br>eeds and assisted R18 to sit | F2                | 282 |  |           |                                     |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                     |   |                                 | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|---------------------|---|---------------------------------|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION G  |                                 | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299   | B. WING _           |   |                                 | 10/2      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STAT  |                                 |           |                                     |
| FRAZEE                   | CARE CENTER  |  |                     | 219 WEST MAPLE AVENUE,<br>FRAZEE, MN 56544                        | PO BOX 96                       |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                        | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN<br>(EACH CORRECTIVE<br>CROSS-REFERENCED<br>DEFICI | ACTION SHOULD<br>TO THE APPROPE | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 282                    | Continued From pa  | ge 67  | F 28                | 2   |                                 |           |                                     |
|                          | needs must be anti-<br>dependent on 2 sta<br>repositioning and to<br>required routine ever<br>toileting. NA-B state<br>red at times, but co<br>areas on R18's butt<br>On 10/20/16, at 3:2<br>(LPN)-B stated R18<br>staff of for all of her<br>was at risk for skin<br>incontinence and in<br>On 10/21/16, at 1:3<br>interview ADON sta<br>to routinely reposition<br>timely manner, such<br>shortages. ADON s<br>able to fill in for sick<br>when the facility we<br>schedule. | 8 p.m. licensed practical nurse<br>was totally dependent on<br>needs. LPN-B stated R18<br>breakdown due to |                     |   |                                 |           |                                     |
|                          | Hand splints   |  |                     |   |                                 |           |                                     |

|                          |   | AND HUMAN SERVICES   |                     |    |   | FORM     | APPROVED<br>. 0938-0391    |
|--------------------------|---|--|---------------------|----|---|----------|----------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |    |   | (X3) DAT | E SURVEY<br>IPLETED        |
|                          |   | 245299   | B. WING _           |    |   | 10/      | 24/2016                    |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                     | S  | STREET ADDRESS, CITY, STATE, ZIP CODE   |          |                            |
| FRAZEE                   | CARE CENTER   |  |                     |    | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |          |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | <  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROV<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETION<br>DATE |
| F 282                    | Continued From pa   | lge 68   | F 2                 | 82 |   |          |                            |
|                          | aphasic (non verba<br>and was unable to r<br>care plan also ident<br>splints for 2 hours of<br>day, and was to we<br>care plan failed to it<br>and did not identify | ted 2/18/16, identified R66 was<br>I) due to traumatic brain injury,<br>make her needs known. R66's<br>tified R66 was to wear hand<br>on and 2 hours off during the<br>ear the splints all night. R66's<br>dentify R66 had contractures,<br>a ROM or a restorative<br>r R66 to prevent further |                     |    |   |          |                            |
|                          | 10/17/16, identified<br>with cares and was<br>off every 2 hours du<br>on all night. The Aic<br>R66 had contractur   | Care Plan, Group B dated<br>R66 required total assistance<br>to wear hand splints on and<br>uring the day and leave them<br>de Care Plan did not identify<br>res or that she required a ROM<br>ng program to prevent further   |                     |    |   |          |                            |
|                          | a.m. were conducte<br>-At 7:00 a.m., R66<br>back in bed, with he<br>arms were bent at t<br>in a fist position on<br>was in a "C" shaped                             | was observed lying on her<br>er eyes closed. Both R66's<br>the elbow, her right hand was<br>her chest, and her left hand<br>d position with fingers bent   |                     |    |   |          |                            |
|                          | devices were not of<br>hands, and the split<br>in her room.<br>-7:49 a.m. licensed<br>entered R66's room<br>(artificial opening at<br>confirmed R66 was             | ted away from her body. Splint<br>bserved on either of R66's<br>nt devices were not observed<br>practical nurse (LPN)-A<br>n to provide her trachea<br>t windpipe) site care. She<br>not wearing hand splints and<br>been wearing them in the  |                     |    |   |          |                            |

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|                          |  | AND HUMAN SERVICES  |                    |     |  | FORM     | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|--------------------|-----|--|----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | E CONSTRUCTION   | (X3) DAT | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING            |     |  | 10/      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |          |                                     |
| FRAZEE                   | CARE CENTER  |   |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETION<br>DATE          |
| F 282                    | recent past becaus<br>uncomfortable for F<br>and did not apply R<br>-8:03 a.m. the nurs<br>room and immediat<br>station. R66 remain<br>her hands and arms<br>splints observed.<br>-8:20 a.m. R66 rem<br>same position with<br>and her hands reste<br>position. No hand s<br>hands and splints w<br>room.<br>-9:47 a.m. R66 rem<br>bed, no hand splints<br>present in R66's roo<br>On 10/19/16, at 10:<br>had not worn hand<br>wear the splints "at<br>aware when R66 la<br>indicated she thoug<br>past. LPN-A left roo<br>splints to R66.<br>On 10/19/16, at 10:<br>(NA)-E confirmed F<br>hand splints, and st<br>the last time R66 ha<br>provided a copy of t<br>confirmed the care<br>wear hand splints. S<br>aware R66 was to w | e she thought the splints were<br>R66. LPN-A exited R66's room<br>66's hand splints.<br>se consultant walked in R66's<br>tely walked down to the nurses<br>hed on her back in bed, with<br>s in the same positron, no<br>nained lying in bed in the<br>R66's arms bent at her elbows<br>ed on her chest in the same<br>plints were observed on R66's<br>were not observed in R66's<br>hained in the same position in<br>s were observed on R66 or | F 2                | 282 |  |          |                                     |

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|                          |  | AND HUMAN SERVICES  |                    |     |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|--------------------|-----|--|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                |     | E CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING            |     |  | 10/2      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER  |   |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 282                    | Continued From pa  | ige 70  | F 2                | 282 |  |           |                                     |
|                          | not aware of how R care for R66. She s   | 40 a.m. NA-D stated she was<br>66's care plan directed her to<br>stated she was not aware if<br>hts or if R66 was supposed to   |                    |     |  |           |                                     |
|                          | her recliner in her ro<br>on her chest, right h  | 10 p.m. R66 was seated in<br>oom with both hands resting<br>hand in fist, left hand curled in<br>id not have hand splints on  |                    |     |  |           |                                     |
|                          | interview, NA-B star<br>receive range of mo  | 30 a.m., during follow up<br>ted R66 presently did not<br>otion services or presently was<br>orative nursing program.   |                    |     |  |           |                                     |
|                          | nursing stated she<br>had been disconting<br>she questioned if th<br>indicated she felt R  | 5 a.m. assistant director of<br>was not aware if R66's splints<br>ued in the past and indicated<br>he splints bothered R66 and<br>66 was not anymore<br>en she was admitted.  |                    |     |  |           |                                     |
|                          | (RN-A) stated R66<br>impairment and wa<br>all cares. She state<br>on a ROM program<br>today, or had declir<br>extremities. She sta<br>ROM and wore her | 38 a.m. registered nurse<br>had severe cognitive<br>s totally dependent on staff for<br>d she was unaware if R66 was<br>wore her arm splints before<br>hed in ROM to her upper<br>ated R66 should have received<br>arm splints according to the<br>dations and confirmed ROM<br>are plan. |                    |     |  |           |                                     |
|                          | PRESSURE ULCE  | R   |                    |     |  |           |                                     |
|                          | R66's care plan dat  | ted 2/18/16, identified R66 was   |                    |     |  |           |                                     |

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|                          |   | AND HUMAN SERVICES   |                   |     |  | FORM     | : 12/15/2016<br>APPROVED<br>. 0938-0391 |
|--------------------------|---|--|-------------------|-----|--|----------|---|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     |  | (X3) DAT | E SURVEY<br>IPLETED                     |
|                          |   | 245299   | B. WING           | i   |  | 10/      | 24/2016                                 |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  | •        |   |
| FRAZEE                   | CARE CENTER   |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |          |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETION<br>DATE              |
| F 282                    | fragile skin, not beir<br>immobile and was to<br>plan also identified<br>the bed or wear she<br>feet, and was to be<br>according to her tur<br>care plan further ide<br>and was to be check<br>hours.<br>Review of the Aide<br>10/17/16, identified<br>with cares, was to be<br>every 2 hours, and<br>or wear sheepskin I<br>On 10/19/16, at 7:0<br>dark, and her door<br>dressed in a hospita<br>her back in bed. Re<br>and her body was of<br>legs were straight, a<br>on her mattress. Sh<br>boots. R66's sheep<br>be piled up on R66'<br>7:19 a.m. R66 was<br>bed, her eyes were<br>loud mouth breathin<br>the mattress and was<br>boots. At 7:39 a.m.<br>in her bed with her<br>continued to be dire<br>wearing her sheeps | and pressure ulcers related to<br>any pressure ulcers related to<br>any able to turn herself, was<br>bed and chair bound. The care<br>R66 was to suspend heels off<br>eepskin boots to protect her<br>turned and repositioned<br>rning and positioning plan. The<br>entified R66 was incontinent<br>ked and changed every 2<br>Care Plan, Group B, dated<br>R66 required total assistance<br>be turned and repositioned<br>was to float heels off the bed<br>boots.<br>D0 a.m. R66's bedroom was<br>was fully open. R66 was<br>al gown, and was asleep on<br>66's arms rested on her chest<br>covered with a blanket. R66's<br>and her heels rested directly<br>he was not wearing sheep skin<br>skin boots were observed to<br>s dresser across the room. At<br>in the same position in her<br>now open, continued with<br>ng and heels rested directly on<br>as not wearing her sheep skin<br>R66 was in the same position<br>eyes closed. R66's heels<br>ectly on her bed and was not | F                 | 282 |  |          |   |
|                          | entered R66's room  | a. LPN-A stated R66's heels<br>d and she was not wearing   |                   |     |  |          |   |

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|                          |   | AND HUMAN SERVICES  |                   |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|-------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     | E CONSTRUCTION  | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING           |     |   | 10/:      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |           |                                     |
| FRAZEE                   | CARE CENTER   |   |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE          |
| F 282                    | sheep skin boots. I<br>heels were, "kind of<br>her mattress. LPN-<br>to approximately or<br>however it did not li<br>LPN-A laid R66's he<br>immediately left the<br>At 8:03 a.m. the reg<br>walked in to R66's no<br>out, towards the nu<br>remained in the sar<br>asleep. R66 remain<br>heels floated, or sh<br>a.m.<br>At 10:03 a.m. LPN<br>developing pressur<br>think R66 had press<br>stated R66 sometin<br>and sometimes the<br>bed. LPN-A stated I<br>pressure mattress a<br>repositioned and ch<br>hours. LPN-A confin<br>been repositioned v<br>that morning. At 10<br>observation (3 hour<br>confirmed both R66<br>and R66 had not we<br>heels and bottom w<br>R66's room and as<br>morning cares.<br>At 10:33 a.m. NA-E<br>last time R66 was r<br>was supposed to b<br>checked and chang | LPN-A stated she felt R66's<br>f," floated by the bubbles in<br>A then pulled a flat pillow down<br>he inch under R66's calves<br>ft R66's heels off the mattress.<br>eels directly on the bed, and | F                 | 282 |   |           |                                     |

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|                          |  | AND HUMAN SERVICES  |                     |  | FORM      | : 12/15/2016<br>APPROVED<br>: 0938-0391 |
|--------------------------|--|---|---------------------|--|-----------|---|
| STATEMENT                | FOF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 | PLE CONSTRUCTION<br>G  | (X3) DATE | E SURVEY<br>IPLETED                     |
|                          |  | 245299  | B. WING             |  | 10/:      | 24/2016                                 |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |           |   |
| FRAZEE                   | CARE CENTER  |   |                     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |           |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE      | (X5)<br>COMPLETION<br>DATE              |
| F 282                    | see when she reportaking care of R66 f<br>felt R66 was was at<br>ulcers, but she didn<br>problems. NA-E sta<br>bed because R66 h<br>and had an air bed.<br>didn't wear her sheet<br>her current care she<br>sheepskin boots. N<br>room after R66 was<br>floated by a pillow of<br>On 10/19/16, at 10:<br>didn't know if R66 w<br>pressure ulcers, or<br>her to do for R66's<br>special mattress, ar<br>would be at risk. NA<br>R66 had a history o<br>aware of any sheep<br>stated she did not r<br>and stated she thou<br>been repositioned w<br>by the night staff.<br>On 10/19/16, at 12:<br>recliner in front of h<br>heels floated on a p<br>sheep skin boots. F<br>the foot rest of her n<br>On 10/19/16, at 1:1<br>back, legs straight of<br>directly on her bed. | sitioned R66 as they were<br>for the day. NA-E stated she<br>trisk for developing pressure<br>of think R66 had any skin<br>ated R66 heels could be on the<br>had no breakdown at this time<br>. NA-E further stated R66<br>ep skin boots. NA-E confirmed<br>eet did not direct the use of<br>A-E and LPN-A left R66's<br>is in her recliner with her heels<br>on the footrest of the recliner.<br>40 a.m. NA-D stated she<br>was at risk for developing<br>what R66's care plan directed<br>skin. She stated R66 had a<br>nd stated she assumed R66<br>A-D stated she didn't know if<br>of pressure ulcers and wasn't<br>o skin boots for R66. NA-D<br>eposition R66 this morning,<br>ught the last time R66 had<br>was at approximately 630 a.m. | F 28                |  |           |   |

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| CENTER                   |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA  | (X2) MUI          | TIPI |   | FORM.<br>MB NO. | 12/15/2016<br>APPROVED<br>0938-0391<br>E SURVEY |
|--------------------------|---|---|-------------------|------|---|-----------------|---|
|                          | OF CORRECTION   | IDENTIFICATION NUMBER:  | . ,               |      |   |                 | PLETED  |
|                          |   | 245299  | B. WING           |      |   | 10/:            | 24/2016   |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |                   | S    | STREET ADDRESS, CITY, STATE, ZIP CODE   |                 |   |
| FRAZEE                   | CARE CENTER   |   |                   |      | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |                 |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE              | (X5)<br>COMPLETION<br>DATE                      |
| F 282                    | Continued From pa   | ige 74  | F 2               | 282  |   |                 |   |
|                          | totally dependent of<br>she wasn't sure of I<br>she didn't think R66<br>ulcers, and didn't kr<br>ulcers in the past. N<br>rested directly on he<br>wearing sheepskin<br>Aide Care Sheet an<br>had sheepskin boo<br>sheet, but R66's he<br>and R66 was suppo<br>2 hours.<br>On 10/24/16, at 10:<br>(RN)-A stated R66<br>pressure ulcers bed<br>herself. She stated<br>had ever had any s | 4 p.m. NA-B stated R66 was<br>n staff for cares, and stated<br>R66's cognition. She stated<br>5 was at risk for pressure<br>now if R66 had pressure<br>NA-B confirmed R66's heels<br>er bed and she was not<br>boots. NA-B confirmed R66's<br>nd stated she didn't know R66<br>ts as they weren't on her<br>bels were supposed to floated<br>osed to be repositioned every<br>38 a.m. registered nurse<br>was at risk for developing<br>cause she couldn't reposition<br>she didn't remember if R66<br>kin problems. She stated<br>upposed to be floated off of |                   |      |   |                 |   |
|                          | R66 every 2 hours.<br>On 10/24/16, at 10:<br>stated R66 had sev<br>was dependent on a<br>was supposed to be<br>her heels were sup<br>bed, or R66 was to<br>had a history of pre<br>remembered R66 h<br>February from a pro<br>and that's when the<br>implemented floatin<br>confirmed R66's mo<br>directed staff to floating<br>wear sheep skin bo                                      | A's were supposed reposition<br>53 a.m. Unit Manager (UM-A)<br>vere cognitive impairment and<br>staff for cares. She stated R66<br>e repositioned every 2 hours,<br>posed to be floated off of her<br>wear sheepskin boots. R66<br>essure ulcers. She stated she<br>had a blister on her heel in<br>ofo boot or splint she wore,<br>ey discontinued the boot and<br>ng R66's heels. UM-A<br>ost recent care plan which<br>at R66's heels off the bed or<br>bots, and turn and reposition<br>She stated she expected staff                                       |                   |      |   |                 |   |

Facility ID: 00730

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                    |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|--------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                |     | E CONSTRUCTION  | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING            |     |   | 10/2      | 24/2016                             |
| NAME OF F                | ROVIDER OR SUPPLIER   |   |                    |     | TREET ADDRESS, CITY, STATE, ZIP CODE  |           |                                     |
| FRAZEE                   | CARE CENTER   |   |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 282<br>F 309<br>SS=D   | apply sheep skin bo<br>reposition R66 ever<br>ulcers. She stated s<br>needed more educat<br>floating of heels.<br>A facility policy titleo<br>4/1/08, identified res<br>admission and as n<br>program including a<br>identified residents<br>highest level of funct<br>A facility policy titleo<br>Management dated<br>facility's policy to en<br>or bladder incontine<br>treatment and servi<br>functioning. The pol<br>an individual toiletin<br>residents and noted<br>483.25 PROVIDE O<br>HIGHEST WELL BI<br>Each resident must<br>provide the necessa<br>or maintain the high<br>mental, and psycho<br>accordance with the<br>and plan of care.<br>This REQUIREMEN<br>by:<br>Based on observat | <ul> <li>plan and float her heels or pots to R66's feet, and y 2 hours to prevent pressure the felt nursing assistants ation on repositioning and</li> <li>I, Restorative Program, dated sidents would be assessed on eeded for a restorative imbulation. The policy further would be supported and their ctioning maintained.</li> <li>I Bowel and Bladder 4/1/08, revealed it was the sure each resident with bowel ence would receive appropriate ces to maintain normal licy directed staff to develop g schedule for all incontinent I on resident care plans.</li> <li>CARE/SERVICES FOR EING</li> <li>receive and the facility must ary care and services to attain test practicable physical, social well-being, in a comprehensive assessment</li> <li>NT is not met as evidenced ion, interview and document</li> </ul> |                    | 282 | F 309 Provide care and services for   | ЪГ        | 12/14/16                            |
|                          |   | ion, interview and document iled to ensure consistent   |                    |     | F 309 Provide care and services to<br>highest well-being of residents   | )r        |                                     |

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|                          |   | AND HUMAN SERVICES  |  |     |   | FORM   | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|--|-----|---|--|-------------------------------------|
|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |   | (X3) DATE SURVEY<br>COMPLETED  |                                     |
|                          |   | 245299  | B. WING                                | i   |   | 10/2   | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |  | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   | •  |                                     |
| FRAZEE                   | CARE CENTER   |   |  |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |  |                                     |
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| F 309                    | blood sugar checks<br>reviewed who were<br>Findings include:<br>Review of R61's qu<br>(MDS) dated 7/24/1<br>cognitively intact ar<br>included, insulin de<br>heart failure (CHF)<br>identified R61 requ<br>staff with dressing.<br>received insulin inje<br>Review of R61's an<br>(CAA) dated 1/22/1<br>diagnoses of depre<br>grateful for anything<br>was content to stay<br>others. The CAA fu<br>to feel self pity in ge<br>R61 had a diagnos<br>requiring insulin an<br>checked 4 times a<br>related to erratic lev<br>R61 received Lantu<br>insulin accordingly.<br>Review of R61's cu<br>1/27/16, did not add<br>diabetes, blood sug<br>On 10/19/16, at 1:0<br>wheelchair in her ro<br>face (evident by, fu<br>jaw line). R61 state<br>that morning. R61 st | routine medical treatments of<br>a for 1 of 2 resident (R61)<br>insulin dependent.<br>harterly Minimum Data Set<br>16, identified R61 was<br>nd had diagnoses which<br>pendent diabetes, congestive<br>and anxiety. The MDS<br>ired extensive assistance from<br>The MDS also identified R61<br>ections daily.<br>mual Care Area Assessment<br>6, revealed R61 had<br>ession and anxiety, was<br>g that was done for her and<br>r in her room with visits from<br>rther revealed R61 "appeared<br>eneral." The CAA revealed<br>is of diabetes mellitus,<br>d R61's blood sugars were<br>day and as needed (prn)<br>vels. The CAA further revealed<br>us insulin and a sliding scale | F                                      | 309 | <ol> <li>R 61 is having her blood glucos<br/>levels checked according to the<br/>physicians order.</li> <li>All residents with a physician o<br/>routine blood glucose monitoring ha<br/>potential to be affected in this area.<br/>of residents with routine blood gluc<br/>monitoring physician orders will be<br/>generated and to assess each is re<br/>blood glucose monitoring and<br/>documentation according to the<br/>physicians order.</li> <li>Mandatory nursing and activity<br/>education was provided on Novem<br/>and 17, 2016 educating the staff or<br/>procedure titled, Glucometer blood<br/>Testing and Medication Administrat<br/>Record with a focus on the need fo<br/>licensed staff to perform blood gluco<br/>level monitoring per physician orde</li> <li>An audit will be developed to m<br/>physicians orders for blood gluco<br/>monitoring and documentation on t<br/>MAR/TAR according to physician o<br/>The audit will be completed by the<br/>or designee, weekly X 4 weeks, the<br/>monthly X 2 months. Audit findings<br/>provided monthly x 3 months to the<br/>committee with follow-up to commi-<br/>recommendations.</li> <li>Deficient practice will be correct<br/>December 14, 2016</li> </ol> | rder for<br>ave the<br>A list<br>ose<br>eceiving<br>staff<br>ber 16<br>the<br>Sugar<br>ion<br>r<br>sose<br>rs.<br>nonitor<br>se<br>he<br>rders.<br>DON,<br>en<br>s will be<br>e QA<br>ttee |                                     |

Facility ID: 00730

PRINTED: 12/15/2016 FORM APPROVED

| CENTE                    | RS FOR MEDICARE  | AND HUMAN SERVICES   | 1                  |     | 0   | FORM<br>MB NO. | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|--------------------|-----|---|----------------|-------------------------------------|
|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     |   |                | E SURVEY<br>PLETED                  |
|                          |  | 245299   | B. WING            |     |   | 10/2           | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                    |     | TREET ADDRESS, CITY, STATE, ZIP CODE  |                |                                     |
| FRAZEE                   | CARE CENTER  |  |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |                |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE           | (X5)<br>COMPLETION<br>DATE          |
| F 309                    | R61 stated she felt<br>blood sugar checke<br>sleeping all night. F<br>blood sugar a few t<br>had frightened her,<br>time since that had<br>worried for most of<br>whether to sit and c<br>answer her call ligh<br>tray had come arout<br>to eat just in case h<br>the low side. R61 s<br>the nurses to routin<br>sugars. R61 stated<br>during her last care<br>few months ago, ar<br>improvement. R61<br>reassurance that al<br>for blood sugars.<br>Review of R61's cu<br>10/6/16, revealed th<br>- Accu checks (bloc<br>11:30 a.m., 5:00 p.r<br>sugar less than 100<br>pattern, order was<br>- Novolog solution -<br>inject per sliding sc<br>= 1 unit; 201-250 =<br>301-350 = 4 units; 3<br>units, > than 400 ca<br>diabetes, if blood su | it was important to have her<br>ed in the morning after<br>R61 stated she had a very low<br>imes in the morning, stated it<br>though it had been a long<br>occurred. R61 stated she had<br>the morning and did not know<br>ery or see if someone would<br>t. R61 stated her breakfast<br>and 9:15, so she had decided<br>her blood sugar had been on<br>tated she had difficulty getting<br>hely check her morning blood<br>she had voiced her concern<br>e conference which had been a<br>nd had not seen an<br>stated she had been<br>I the nurses knew her routine<br>rrrent physician orders signed<br>he following orders:<br>od sugar checks) 730 a.m.,<br>m., 9:00 p.m. call if blood<br>0 or greater than 300 as a<br>start dated 9/3/14.<br>100 units/ml (insulin aspart)<br>ale: if 0-150 = 0 unit; 151-200<br>2 units; 251-300 = 3 units;<br>351-400 = 5 units; 401-500 = 6<br>all MD, sq 3 times a say for<br>ugar lower than 100 or greater | F3                 | 309 |   |                |                                     |

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|                          |   | AND HUMAN SERVICES   |                     |    |  | FORM     | : 12/15/2016<br>APPROVED<br>: 0938-0391 |
|--------------------------|---|--|---------------------|----|--|----------|---|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |    | E CONSTRUCTION   | (X3) DAT | E SURVEY<br>IPLETED                     |
|                          |   | 245299   | B. WING             |    |  | 10/      | 24/2016                                 |
| NAME OF F                | PROVIDER OR SUPPLIER                        |  |                     | S  | TREET ADDRESS, CITY, STATE, ZIP CODE   | -        |   |
| FRAZEE                   | CARE CENTER                                 |  |                     |    | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |          |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                            | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIZ<br>TAG | x  | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU)<br>CROSS-REFERENCED TO THE APPRC<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETION<br>DATE              |
| F 309                    | Continued From pa for diabetes.             | ge 78  | F 3                 | 09 |  |          |   |
|                          | insulin) inject 22 un                       | nsulin glargine, long acting<br>its subcutaneous (sq) one<br>o diabetes, order was start                                     |                     |    |  |          |   |
|                          |   | nsulin glargine,) inject 8 units<br>ed to diabetes, order was start  |                     |    |  |          |   |
|                          |   | edication administration<br>n August 2016, to October<br>following:  |                     |    |  |          |   |
|                          | sugar results were<br>11:30 a.m. results v  | aled R61's 7:30 a.m. blood<br>blank on 7 out of 31 days<br>vere blank on 8 out of 31 days<br>Its were blank 10 out of 31     |                     |    |  |          |   |
|                          | blood sugar results<br>11:30 a.m. results v | revealed R61's 7:30 a.m.<br>were blank 7 out of 30 days,<br>vere blank 9 out of 30 days,<br>ere blank 8 out of 30 days.      |                     |    |  |          |   |
|                          | sugar results were<br>a.m. results were b   | realed R61' s 7:30 a.m. blood<br>blank 13 out of 21 days, 11:30<br>lank 10 out of 21 days, 5:30<br>lank 7 out of 21 days.    |                     |    |  |          |   |
|                          | sheet dated 9/20/16<br>accu check had not   | form titled, Diabetic Flow<br>6, to 10/20/16, revealed R61's<br>t been completed as<br>ut of the 30 days R61's blood<br>led. |                     |    |  |          |   |
|                          |   | cial service note dated 8/7/16,<br>ruminated" about diagnoses  |                     |    |  |          |   |

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|                          |   | I AND HUMAN SERVICES<br>E & MEDICAID SERVICES   |                    |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|--------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | T OF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                |     |   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING            | i   |   | 10/2      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |                    | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER   |   |                    |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 309                    | and how staff chang<br>regarding the timing<br>revealed R61 had of<br>would tend to focus<br>was provided reass<br>Review of a social s<br>revealed R61 was of<br>chronic melancholy<br>her medical issues<br>exclusion of all else<br>expressed distress<br>change in the buildi<br>The note further rev<br>concerns that a new<br>the routine of seaso<br>medication adminis<br>R61 was given reas<br>worker (SW) that st<br>orientation and carr<br>note revealed R61 f<br>intent to consider the<br>reiterate her worry of<br>note also revealed a<br>her medical concern<br>children.<br>On 10/20/16, at 9:3<br>(LPN)-B stated she<br>supposed to have he<br>times a day. LPN-B<br>brittle diabetic and f<br>have her blood sug<br>LPN-B stated R61 v<br>sugars and felt R61<br>she did not have her<br>routine. | ges had impacted her care<br>g of the med pass. The note<br>chronic temperaments and<br>s on medical conditions and | F3                 | 309 |   |           |                                     |

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| DEPARTMENT OF HEALTH<br>CENTERS FOR MEDICAR  |   |                     |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--|---|---------------------|-----|---|-----------|-------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 |     |   | (X3) DATE | E SURVEY<br>IPLETED                 |
|  | 245299  | B. WING             |     |   | 10/:      | 24/2016                             |
| NAME OF PROVIDER OR SUPPLIER   | 1   | <u> </u>            | ST  | TREET ADDRESS, CITY, STATE, ZIP CODE  | -         |                                     |
| FRAZEE CARE CENTER   |   |                     |     | 9 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |           |                                     |
| PREFIX (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| blood sugars were<br>on a consistent ba<br>expected R61's ph<br>as well as R61's ca<br>On 10/20/16, at 9:<br>Practitioner (CNP)<br>with R61 for 5 yea<br>R61's medical con-<br>stated R61 require<br>as it had been diffi<br>sugars and require<br>sugars. CNP state<br>sugars to be consi<br>basis. CNP stated<br>controlled with me<br>On 10/20/16, at 2::<br>reported to her tha<br>answered, she did<br>blood sugars were<br>NA-B stated she fe<br>she reported her co-<br>she had reported fe<br>a month ago.<br>On 10/21/16, at 11<br>interview, ADON co-<br>August, September<br>amount" of blanks<br>blood sugar results<br>say for sure R61's<br>checked on those<br>not documented si<br>On 10/24/16, at 9:<br>stated she was un | tated she was not aware R61's<br>e not being routinely monitored<br>asis. The ADON stated she<br>hysician orders to be followed<br>are plan.<br>49 a.m. Certified Nurse<br>stated she had been working<br>rs and was very familiar with<br>holitions including diabetes. CNP<br>ed frequent blood sugar testing<br>icult to regulate her blood<br>ed insulin to maintain her blood<br>ed she expected R61's blood<br>istently checked on a routine<br>R61 had anxiety which was |                     | .09 |   |           |                                     |

Facility ID: 00730

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| CENTER<br>STATEMENT<br>AND PLAN C | RS FOR MEDICARE   | AND HUMAN SERVICES  & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245299  TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | . , | S<br>S<br>P<br>F |             | FORM /<br>MB NO.<br>(X3) DATE<br>COMI<br>10/2 | 12/15/2016<br>APPROVED<br>0938-0391<br>E SURVEY<br>PLETED<br>24/2016<br>24/2016 |
|-----------------------------------|---|---|-----|------------------|-------------|---|---|
| F 309                             | R61's blood sugars<br>R61's care plan sho<br>On 10/24/16, at 10:<br>stated R61 was a c<br>focus on her medic<br>R61 had reported to<br>that not all the nurs<br>SW stated she did<br>medications, treatm<br>followed. SW stated<br>times she was afrai<br>working, though did<br>she felt it was just s<br>upsetting R61 and<br>SW stated she had<br>how a nurse was do<br>should tell that nurs<br>stated her usual pra-<br>nurse regarding res<br>medications and tre<br>SW stated R61 ten<br>and felt R61 had ar<br>issue.<br>A facility policy titled<br>April 1, 2008, reveal<br>directed staff to che<br>prior to insulin adm<br>sugars as needed of<br>A facility policy titled<br>1, 2008, revealed a<br>included the right to<br>with reasonable aco<br>needs and preferen-<br>residents right to ch | <ul> <li>a to be routinely checked and build be followed.</li> <li>a.21 a.m. social worker (SW) chronic worrier and tended to al concerns. SW confirmed to her on in July and August es were following her routine. Not check to see if R61's nents or care plan was being d R61 had reported to her at id when new staff were d not probe further. SW stated staff turnover that was R61 was an "anxious person." I told R61 if she did not like oing something that R61 se she was uncomfortable. SW actice would be to talk to the sident concerns with eatments and thought she did. ded to ruminate over things in underlying mental health</li> <li>d Insulin Administration, dated aled a facility policy which eck resident physician orders inistration and to check blood or ordered.</li> <li>d Resident Rights, dated April list of resident rights which or receive services in the facility commodation of individual noes. The policy also revealed noose activities, schedules, nsistent with interests,</li> </ul> | F   | 309              | DEFICIENCY) |   |   |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                   |     | FORM   | 12/15/2016<br>APPROVED<br>0938-0391 |  |
|--------------------------|---|---|-------------------|-----|--|-------------------------------------|--|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     |  | (X3) DATE SURVEY<br>COMPLETED       |  |
|                          |   | 245299  | B. WING           | i   |  | 24/2016                             |  |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |                   |     | TREET ADDRESS, CITY, STATE, ZIP CODE   |                                     |  |
| FRAZEE                   | CARE CENTER   |   |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |                                     |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>YMUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE          |  |
| F 310<br>SS=G            | 483.25(a)(1) ADLS<br>UNAVOIDABLE  | DO NOT DECLINE UNLESS   | F:                | 310 |  | 12/14/16                            |  |
|                          | resident, the facility<br>abilities in activities<br>unless circumstanc<br>condition demonstra<br>unavoidable. This i<br>to bathe, dress, and<br>ambulate; toilet; ead<br>or other functional of<br>This REQUIREMEN<br>by:<br>Based on observat<br>review, the facility fa<br>services to prevent<br>residents (R38) who<br>ambulation. R38 wa<br>with ambulation and<br>decline in ambulation<br>to ambulate resulted<br>Findings include:<br>R38's significant ch<br>(MDS) 9/26/16, ider<br>cognitive impairmer<br>included degenerati<br>and back pain. The<br>independent in bed<br>wheelchair indepen<br>the MDS identified a<br>turning around and<br>walking and R38 dia<br>R38's ADL Care Are | ange Minimum Data Set<br>ntified R38 had moderate<br>nt and had diagnoses which<br>ive joint disease, weakness<br>MDS identified R38 was<br>mobility, transfers and used a<br>dently for locomotion. Further,<br>activity did not occur for<br>facing opposite direction while<br>d not walk. |                   |     | <ul> <li>F 310 ADLS do not decline unless<br/>unavoidable</li> <li>R38 was evaluated by therapy on 10-<br/>31-16 and is currently being treated by<br/>Physical Therapy.</li> <li>All residents that need assistance<br/>from staff with ambulation have the<br/>potential to be affected in this area and<br/>are receiving adequate assistance from<br/>staff with ambulation programs. A list of<br/>residents coded on the MDS as needing<br/>assistance from staff with ambulation and<br/>have fallen in the past 30 days will be<br/>generated and reviewed for the need for<br/>restorative programs. Care plans will be<br/>reviewed and updated as needed. A<br/>Performance improvement plan (PIP) has<br/>been created and meets at least monthly<br/>to review current restorative programs, all<br/>new referrals, and update care plans as<br/>needed.</li> </ul> |                                     |  |
|                          |   | ea Assessment (CAA) dated<br>R38 had improved ADL   |                   |     | 3. Mandatory nursing staff education   |                                     |  |

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| TATEMENT                 | OF DEFICIENCIES  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | · · /               | PLE CONSTRUCTION   | · · /  | E SURVEY<br>PLETED        |
|--------------------------|--|--|---------------------|--|--|---------------------------|
|                          |  | 245299   | B. WING _           |  | 10/24/2016   |                           |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP   |  |                           |
| FRAZEE                   | CARE CENTER  |  |                     | 219 WEST MAPLE AVENUE, PO BO<br>FRAZEE, MN 56544   | OX 96  |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CC<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI<br>DEFICIENCY)  | N SHOULD BE<br>E APPROPRIATE   | (X5)<br>COMPLETIC<br>DATE |
| F 310                    | performance and w<br>plan. The CAA did<br>R38's admission M<br>R38 was not steady<br>human assistance<br>and facing opposite<br>identified R38 had<br>assistance from sta<br>R38's ADL CAA da<br>required assistance<br>and transfer. The C<br>receiving therapies<br>independence in ho<br>R38's Behavioral C<br>R38's Behavioral C<br>R38's goal was to c<br>order to return hom<br>On 10/18/16, at 1:3<br>the facility hallway,<br>propelling herself to<br>feet. R38 propelled<br>opened the daily ne<br>the paper.<br>On 10/20/16, at 1:3<br>wheeled herself int<br>to the toilet seat to<br>was able to comple<br>liked to be as indep<br>proceeded to prope<br>utilizing both feet to<br>activity. At 3:08 p.m<br>wheelchair in the a | vould be addressed on care<br>not address R38's ambulation.<br>MDS dated 5/24/16, identified<br>y, only able to stabilize with<br>for walking and turning around<br>e direction while walking. The<br>ambulated with limited<br>aff.<br>ted 5/24/16, identified R38<br>e from staff to safely ambulate<br>CAA revealed R38 was<br>and her goal was to return to<br>opes of returning home. | F 31                | <ul> <li>was provided on November 2016 on the procedure title Ambulation Program with a need for residents depender ambulation are being ambulation are being ambulation are being ambulation are being ambulation.</li> <li>An audit was developed restorative nursing ambulation including care planning, padocumentation. A monthly resident restorative prograby a licensed nurse. The acompleted by the DON or oweekly X 4 weeks, then momonths. Audit findings will monthly x 3 months to the with follow-up to committed recommendations.</li> <li>Deficient practice will the December 14, 2016</li> </ul> | d, Restorative<br>a focus on the<br>ent on staff for<br>ulated<br>n/therapy<br>d to monitor<br>tion programs<br>inticipation and<br>review of<br>ms will be done<br>audit will be<br>designee<br>onthly X 2<br>be provided<br>QA committee |                           |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                   |     |   | FORM      | : 12/15/2016<br>APPROVED<br>: 0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | • •               |     | PLE CONSTRUCTION  | (X3) DATE | E SURVEY<br>IPLETED                     |
|                          |  | 245299  | B. WING           |     |   | 10/:      | 24/2016                                 |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |   |
| FRAZEE                   | CARE CENTER  |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE              |
| F 310                    | On 10/20/16, at 1:5<br>(NA)-F stated R38 in<br>and was able to pro-<br>destinations. NA-F<br>with all of her perso-<br>maintain her independ<br>not think R38 was a<br>assisted R38 to am<br>nursing assistants was<br>residents who were<br>and stated she did in<br>ambulation program<br>On 10/20/16, at 2:3<br>not assisted R38 with<br>the past. NA-B state<br>units were responsi-<br>programs, after the<br>determined by occu-<br>therapies (PT). NA-<br>both PT and OT up<br>months and indicate<br>been placed on the<br>stated she felt R38<br>could R38 ambulate<br>unit often times cou-<br>their ambulation pro-<br>NAs on the floor.<br>On 10/20/16, at 3:1<br>(LPN)-B stated the<br>responsible to ambu-<br>ambulation program<br>she was unsure if F<br>program at present<br>clinical record, conf | <ul> <li>a during observations.</li> <li>7 p.m. nursing assistant used a wheelchair for mobility pel herself to and from stated R38 was independent nal cares and liked to endence. NA-F stated she did able to walk and had never bulate. NA-F stated the vere responsible to ambulate on an ambulation program not think R38 was on an in the facility.</li> <li>0 p.m. NA-B stated she had th ambulation at any time in ed the NA on the individual ble for residents walking</li> </ul> | F3                | 310 |   |           |   |

Facility ID: 00730

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|                          |  | AND HUMAN SERVICES  |                    |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|--------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                |     | LE CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING            |     |   | 10/2      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                    |     | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER  |   |                    |     | PRAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 310                    | to be assisted with walker and one-per<br>LPN-B stated she d<br>assisted to ambulat<br>On 10/21/16, at 10:<br>(RN)-A stated she w<br>ambulation program<br>seen R38 ambulate<br>On 10/21/16, at 11::<br>assistant (PTA) state<br>physical and occup<br>admission to the fac<br>stated R38 was disc<br>in July 2016, with a<br>be placed on an am<br>staff. PTA stated R3<br>one assist and a fro<br>feet consistently, wh<br>PTA stated she had<br>residents' ambulatio<br>being completed co<br>there was not enou-<br>to complete ambula<br>programs on a rout<br>On 10/21/16, at 11::<br>no longer able to wa<br>move about the fac<br>walking when she w<br>had worked with the<br>stated nursing staff<br>ambulation since th<br>months ago. R38 st<br>which affected her a | <ul> <li>ambulation twice daily with a son assistance up to 40 feet.</li> <li>did not think R38 had been te since therapy ended.</li> <li>35 a.m. registered nurse was unaware if R38 was on an n and indicated she had not with staff in the past.</li> <li>20 a.m. physical therapy ted R38 had received both ational therapy upon cility in May of 2016. PTA continued from both therapies referral to nursing for R38 to abulation program with nursing 38 was able to ambulate with ont wheeled walker up to 40 hen PT and OT were stopped. I serious concerns with on and maintenance programs onsistently. PTA stated felt gh nursing staff in the facility ation and maintenance</li> </ul> | F                  | 310 |   |           |                                     |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                   |     |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|-------------------|-----|--|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,               |     |  | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299   | B. WING           |     |  | 10/;      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  |           |                                     |
| FRAZEE                   | CARE CENTER   |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 310                    | room, and looked in<br>locations in her room<br>R38 no longer had a<br>stated she would ex-<br>available so nursing<br>PTA left R38's room<br>wheeled walker and<br>R38. PTA applied a<br>torso and cued R38<br>up to the walker wh<br>gait belt. R38 was of<br>from the wheelchain<br>R38's knees remain<br>80 degree angle, wa<br>or straighten her kn<br>R38 twice more and<br>stand erect or straig<br>she could not stand<br>stood up for a long<br>remember the last th<br>PTA asked R38 who<br>walked and R38 res<br>confirmed the last th<br>was in July, 2016. F<br>the ability to fully state<br>from therapy, R38 h<br>40-60 feet daily with<br>front wheeled walker<br>referred to an ambu<br>and she would have<br>assistance with wal<br>daily. PTA stated sh<br>problem with the far<br>ambulation/mainter | 36 a.m. PTA entered R38's<br>a her closet and various<br>m for her walker. PTA stated<br>a walker in her room and<br>kpect R38 to have a walker<br>g staff could assist her to walk.<br>b briefly, returned with a front<br>d placed the walker in front of<br>a transfer belt around R38's<br>8 to stand from her wheelchair<br>ile PTA pulled upwards on the<br>only able to lift her buttocks<br>r seat approximately 7 inches.<br>hed bent at approximately an<br>as unable to stand fully erect<br>ees. PTA attempted to stand<br>d R38 continued to not able to<br>ghten her knees. R38 stated<br>I up all of the way and had not<br>time. R38 stated she could not<br>ime she had used a walker.<br>en the last time she had<br>sponded, "with you." PTA<br>ime she had worked with R38<br>PTA confirmed R38 had lost<br>and and to ambulate.<br>44 a.m. during a follow up<br>ed when R38 was discharged<br>had been ambulating about<br>n minimal assist of one and a<br>er. PTA stated R38 was<br>ulation maintenance program<br>e expected R38 to receive<br>king with nursing staff twice<br>he felt the facility had a huge | F                 | 310 |  |           |                                     |

Facility ID: 00730

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                    |     |   | FORM     | : 12/15/2016<br>APPROVED<br>. 0938-0391 |
|--------------------------|---|--|--------------------|-----|---|----------|---|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | LE CONSTRUCTION   | (X3) DAT | E SURVEY<br>IPLETED                     |
|                          |   | 245299   | B. WING            |     |   | 10/      | 24/2016                                 |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  | -        |   |
| FRAZEE                   | CARE CENTER   |  |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |          |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRC<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETION<br>DATE              |
| F 310                    | dated 5/17/16, iden<br>weakness and falls<br>revealed R38 was h<br>walking. The summ<br>sent to the facility for<br>extremity weakness<br>Review of R38's ph<br>8/2/16, revealed R3<br>(MD) had seen her<br>revealed R38 had p<br>was ambulating usi<br>revealed R38's dau<br>had exhibited regre<br>ended.<br>Review of R38's ph<br>10/6/16, revealed R<br>another practitioner<br>a wheelchair for lon<br>and OT during the s<br>that time due to incu-<br>determined to be a<br>R38's current care p<br>indicated she was f<br>and contact guard a<br>also indicated R38 | spital discharge summary<br>tified R38 had been treated for<br>at home. The summary<br>having difficulty standing and<br>hary further revealed R38 was<br>or acute rehab due to lower<br>s.<br>ysician progress note dated<br>38's primary medical doctor<br>at the clinic. The note also<br>olateau in therapy, however,<br>ng a walker. The note further<br>ghter had concerns that R38<br>ssion after therapy was<br>ysician progress note dated<br>tashad established care with<br>the note revealed R38 used<br>ig distances, had received PT<br>spring and summer, and at<br>reased care needs R38 was | F3                 | 310 |   |          |   |
|                          | care plan did not id<br>6/10/16.  | endently in wheelchair. R38's<br>entify any updates past<br>Care Plan Group C form,  |                    |     |   |          |   |

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|                          |  | AND HUMAN SERVICES   |                    |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | LE CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299   | B. WING            |     |   | 10/2      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                    |     | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER  |  |                    |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | х   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 310                    | dated 10/17/16, lister<br>included R38 was a<br>toileting and ADL's,<br>therapy for walking,<br>other interventions<br>Review of a facility<br>Interdepartmental O<br>revealed therapy ha<br>a ambulation progra<br>daily with front walk<br>40 feet. The form a<br>complained of left k<br>any questions to ca<br>Review of R38's me<br>record lacked furthe<br>ambulation status of<br>documentation of fa<br>worksheets.<br>Nursing progress m<br>5/17/16, to 10/18/16<br>On 5/17/16, R38 wa<br>required one assist<br>On 6/10/16, the not<br>with therapy.<br>On 6/11/16, R38 qu<br>when she would be<br>On 8/4/16, R38 req<br>R38's nursing program | ed various interventions which<br>assist of one for transfers,<br>and listed R38 received<br>. The form did not list any<br>for R38's ambulation.<br>form titled, Resident Referral<br>Communication dated 7/8/16,<br>ad referred R38 to nursing for<br>am to include ambulation twice<br>eer and one assistance up to<br>lso identified R38 has<br>snee pain and if nursing had<br>II.<br>edical record revealed the<br>er documentation of R38's<br>or progress and lacked<br>acility forms maintenance ADL<br>otes were reviewed from<br>5, revealed the following:<br>as full weight bearing and<br>ance with ADL's.<br>re indicated R38 was working<br>testioned nursing staff on<br>able to return home.<br>uired one assist with ADL's. | F3                 | 310 |   |           |                                     |

|                          |  | AND HUMAN SERVICES  |                   |     |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|-------------------|-----|--|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ` '               |     | LE CONSTRUCTION  | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING           | i   |  | 10/2      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  |           |                                     |
| FRAZEE                   | CARE CENTER  |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG | IX  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 310                    | nursing (ADON) co<br>ambulation/mainter<br>been implemented<br>nurse managers we<br>therapy referrals for<br>programs were star<br>referred. ADON sta<br>responsible to initia<br>Maintenance Activit<br>worksheet which we<br>type of assistance w<br>needed and the free<br>program. ADON co<br>ambulation mainter<br>ambulate with R38<br>to 40 feet twice dail<br>expect R38's ambu<br>implemented to ma<br>decline her ambula<br>facility's ambulation<br>not getting done du<br>stated she felt the N<br>complete all resider<br>On 10/24/16, at 9:2<br>stated she had und<br>had been assisting<br>stated she was not<br>ambulate. NM-A st<br>R38's ambulation/m<br>been started.<br>On 10/24/16, at 9:5<br>Practice Registered<br>Practitioner (NP)-A<br>established care wi | 7 p.m. the assistant director of<br>nfirmed R38's<br>nance program had never<br>in July. ADON stated the<br>ere responsible to ensure<br>r ambulation/maintenance<br>ted once a resident was<br>ted the nurse manager was<br>te a facility form titled,<br>cy of Daily Living (ADL)<br>ould direct the NA on what<br>with ADL the individual resident<br>quency of the maintenance<br>nfirmed R38's referral for<br>nance program directed staff to<br>with a front wheeled walker up<br>y. ADON stated she would<br>lation program to be<br>intain and prevent further<br>tion. ADON stated she felt the<br>l/maintenance program was<br>e to staffing concerns and<br>NA did not have the time to<br>nts programs, including R38.<br>7 a.m. nurse manager (NM)-A<br>erstood the nursing assistants<br>R38 with ambulation. NM-A<br>aware R38 could not longer<br>ated she was not sure why<br>naintenance program had not |                   | 310 |  |           |                                     |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                   |     | FORM  | ): 12/15/2016<br>/ APPROVED<br>). 0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     | E CONSTRUCTION (X3) DA  | TE SURVEY<br>MPLETED                        |
|                          |  | 245299  | B. WING           |     | 10  | /24/2016                                    |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                   |     | TREET ADDRESS, CITY, STATE, ZIP CODE  |   |
| FRAZEE                   | CARE CENTER  |   |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | (X5)<br>COMPLETION<br>DATE                  |
| F 310<br>F 311<br>SS=D   | ambulation/mainten<br>would have expected<br>ambulation per the<br>R38's previous prim<br>R38 in August and n<br>on R38's loss of am<br>A message was left<br>physician, but the p<br>during survey.<br>A facility policy titled<br>4/1/08 identified residents<br>admission for a resident and<br>identified need, a pl<br>meet resident need<br>identified residents<br>highest level of fund<br>483.25(a)(2) TREAT<br>IMPROVE/MAINTA<br>A resident is given the<br>services to maintain<br>specified in paragration<br>by:<br>Based on observator<br>review, the facility fat<br>assistance with ambulation and the<br>post of the present the present the present<br>assistance with ambulation and the present<br>assistance wi | ance programs and she<br>ed R38 to be assisted with<br>therapy referral. NP-A stated<br>hary physician had last seen<br>may have more to comment<br>abulation.<br>for R38's previous primary<br>hysician did not call back<br>d, Restorative Program, dated<br>idents would be assessed on<br>torative program such as<br>bulation program was an<br>an would be individualized to<br>s and goals. The policy further<br>would be supported and their<br>ctioning maintained.<br>TMENT/SERVICES TO<br>IN ADLS<br>he appropriate treatment and<br>nor improve his or her abilities<br>uph (a)(1) of this section.<br>NT is not met as evidenced<br>ion, interview and document<br>ailed to ensure consistent<br>pulation was provided as<br>hysical therapy (PT) for 3 of 4<br>9, R46 ) who required |                   | 310 | F 311 Treatment/services to<br>improve/maintain ADLS<br>1. R44, R29, and R46 will continue on<br>restorative programs according to therapy<br>recommendations.<br>2. All residents that need ambulation<br>assistance from staff have the potential to<br>be affected in this area. A list of residents | )   |

Event ID:LSCM11

Facility ID: 00730

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|                          |  | AND HUMAN SERVICES   |                    |     |   | FORM  | 12/15/2016<br>APPROVED<br>0938-0391 |  |
|--------------------------|--|--|--------------------|-----|---|---|-------------------------------------|--|
| STATEMENT                | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | E CONSTRUCTION  | (X3) DATE   | E SURVEY<br>PLETED                  |  |
|                          |  | 245299   | B. WING            |     |   | 10/24/2016  |                                     |  |
| NAME OF                  | NAME OF PROVIDER OR SUPPLIER   |  |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |   |                                     |  |
| FRAZEE                   | CARE CENTER  |  |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96   |   |                                     |  |
|                          |  |  |                    | F   | RAZEE, MN 56544   |   |                                     |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | BE  | (X5)<br>COMPLETION<br>DATE          |  |
| F 311                    | (MDS) dated 7/31/-<br>cognitively intact ar<br>included generalized<br>disorder and anxiet<br>required limited ass<br>corridors and was i<br>mobility and walkin<br>further identified R4<br>wheelchair for mob<br>was steady at all tir<br>walking and when to<br>opposite direction.<br>Review of R44's ac<br>Functional/Rehabilit<br>Assessment dated<br>required assistance<br>unable to ambulate<br>related to an unstea<br>R44 ambulated with<br>walker and a gait b<br>Review of R44's Fa<br>identified R44 had<br>rising from a seated<br>ambulation and am<br>Review of R44's cu<br>9/25/15, revealed F<br>mobility in a wheeld<br>with ambulation wit<br>plan directed staff t<br>meals.<br>Review of Aide Car<br>10/17/16, listed var | arterly Minimum Data Set<br>16, identified R44 was<br>and had diagnoses which<br>ed osteoarthritis, depressive<br>ty. The MDS identified R44<br>sistance to ambulate in the<br>ndependent in transfers, bed<br>g in her room. The MDS<br>44 used a walker and a<br>sility. The MDS revealed R44<br>mes during transitions, while<br>surning around and facing the<br>extivity of daily living (ADL)<br>itation Potential Care Area<br>1/29/16, identified R44<br>e with some ADL's and was<br>any distance independently<br>ady gait. The CAA identified<br>h one nursing assistant (NA) a | F                  | 311 | <ul> <li>coded on the MDS as needing am assistance from staff and have fall the past 30 days will be generated reviewed to ensure they are not aff by this deficient practice. Docume form and Care plans updated as not set of the procedure titled, Rest Ambulation Program with a focus of need for residents dependent on set ambulation to be on an ambulation program.</li> <li>An audit has been developed the monitor restorative nursing ambulation programs including care planning, participation and documentation; and including a monthly review of ambulation programs by a licensed nurse. The will be completed by the DON or dweekly X 4 weeks, then monthly X months. Audit findings will be provided the follow-up to committee recommendations.</li> <li>Deficient practice will be correct December 14, 2016</li> </ul> | en in<br>and<br>ected<br>ntation<br>eeded.<br>tion<br>I 17,<br>prative<br>on the<br>taff for<br>0<br>ulation<br>e audit<br>esignee<br>2<br>ided<br>mittee |                                     |  |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                     |  | FORM     | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|---------------------|--|----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION<br>G  | (X3) DAT | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING             |  | 10/2     | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |          |                                     |
| FRAZEE                   | CARE CENTER   |   |                     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETION<br>DATE          |
| F 311                    | directed staff to ass<br>daily to 200 feet, wi<br>transfer belt.<br>On 10/19/16, at 8:1<br>standard wheelchai<br>dining room and wh<br>table. R44 verbalize<br>obtained her food a<br>a.m. R44 had eater<br>time propelled hers<br>Review of a facility<br>Worksheet from Ap<br>identified R44's was<br>twice a day (BID) lo<br>with a walker and tr<br>also indicated R44<br>ambulate up to 200<br>revealed the followi<br>- Review of R44's A<br>R44 had received h<br>of 31 days in the an<br>in the pm hours.<br>-Review of R44's M<br>identified R44 had r | 6 a.m. R44 was seated in a<br>r, propelling herself into the<br>neeled herself up to a circular<br>ed her breakfast order,<br>and ate independently. At 8:34<br>n 100% of her meal and at that<br>elf out of the dining room.<br>form titled Maintenance ADL<br>ril 2016, to October 2016,<br>s on an ambulation program<br>ang distances in the hallways<br>ansfer belt. The worksheet<br>was to be assisted to<br>feet (ft.) R44's worksheets | F 31                | 1  |          |                                     |
|                          | R44 had received h<br>of 30 days in the an<br>pm.<br>-Review of R44's Ju<br>R44 had received h  | une 2016, worksheet identified<br>her ambulation program 8 out<br>n and 24 out of 30 days in the<br>uly 2016, worksheet identified<br>her ambulation program 7 out<br>n and 12 out of 30 days in the  |                     |  |          |                                     |

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|                          |  | AND HUMAN SERVICES  |                    |   |   | FORM      | APPROVED<br>0938-0391      |
|--------------------------|--|---|--------------------|---|---|-----------|----------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |   |   | (X3) DATE | E SURVEY<br>IPLETED        |
|                          |  | 245299  | B. WING            |   |   | 10/:      | 24/2016                    |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                    | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                            |
| FRAZEE                   | CARE CENTER  |   |                    |   | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |   | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE |
|                          | Continued From pa<br>pm.<br>-Review of R44's A<br>identified R44 had n<br>program 8 out of 31<br>-Review of R44's S<br>identified R44 had n<br>program 11 days out<br>out of 30 in the pm.<br>-Review of R44's O<br>identified R44 had n<br>program 2 days out<br>days out of 17 in the<br>Review of an Occup<br>assessment dated<br>discharged from the<br>placed on the nursi<br>program) and was f<br>wheeled walker with<br>A request for R44's ca<br>from 2/9/16 to 8/16. | sc IDENTIFYING INFORMATION)<br>age 93<br>ugust 2016, worksheet<br>received her ambulation<br>1 days in the am and pm.<br>eptember 2016, worksheet<br>received her ambulation<br>ut of 30 in the am and 8 days<br>b<br>cotober 2016, worksheet<br>received her ambulation<br>t of 17 in the the am and 0<br>e pm.<br>pational Therapy (OT)<br>3/12/15, revealed R44 was<br>erapy services and had been<br>ng gait list (ambulation<br>to ambulate with a front<br>h stand by assistance.<br>ambulation/maintenance<br>om OT was requested, the | TAG                |   | DEFICIENCY)   | RATE      | DATE                       |
|                          | -5/12/16, R44 recei<br>ambulation in am a<br>contact guard assis<br>-2/9/16, revealed R  | ved assistance with<br>nd hs(hour of sleep) with<br>stance of one staff.<br>44 received frequent<br>and by assistance of one staff.   |                    |   |   |           |                            |

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|--------------------------|--|--|--------------------|-----|---|----------|-------------------------------------|
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|                          |  | 245299   | B. WING            |     |   | 10/3     | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |          |                                     |
| FRAZEE                   | CARE CENTER  |  |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | x   | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE     | (X5)<br>COMPLETION<br>DATE          |
| F 311                    | Continued From pa  | ige 94   | F3                 | 811 |   |          |                                     |
|                          |  | rsing progress notes from<br>, revealed the following:   |                    |     |   |          |                                     |
|                          | -5/14/16, revealed I<br>staff.   | R44 ambulated in the hall with   |                    |     |   |          |                                     |
|                          | -10/15/16, revealed with staff.  | I R44 ambulated in the hall  |                    |     |   |          |                                     |
|                          |  | ntatio of R44's ambulation<br>lation status was found in<br>ress.  |                    |     |   |          |                                     |
|                          | (NA)-F stated R44 cares on her own. N<br>assistance to ambu<br>on an ambulation p<br>am and in the pm. I       | 9 p.m. nursing assistant<br>was able to complete most<br>NA-F stated R44 required<br>ulate in the hallways and was<br>rogram for twice a day in the<br>NA-F stated there were days<br>assisted to ambulate due to<br>u staff on the floor. |                    |     |   |          |                                     |
|                          | required limited ass<br>and ambulation. NA<br>ambulation program<br>residents ambulation                       | 4 p.m. NA-B stated R44<br>sistance with ADL's of dressing<br>A-B stated R44 was on an<br>n for twice a day. NA-B stated<br>on/maintenance programs<br>ne as they should due to not<br>is included R44.                                     |                    |     |   |          |                                     |
|                          | (LPN)-B stated R44<br>program for twice a<br>stated R44 liked to<br>was not assisted wi<br>enough staff on the |  |                    |     |   |          |                                     |
|                          | On 10/21/16, at 10:  | :08 a.m. R44 stated she was  |                    |     |   |          |                                     |

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|                          |   | AND HUMAN SERVICES   |                   |     |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|-------------------|-----|--|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     | E CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299   | B. WING           |     |  | 10/2      | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER   |  |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 311                    | on a walking progra<br>walk twice a day. R<br>to 3 times a day and<br>was walked once a<br>told her they were to<br>not receive her amb<br>that had been happ<br>several months. Ra<br>around the entire bl<br>perimeter around th<br>time would get a bit<br>like she should. R4<br>was not as steady of<br>R44 stated she feat<br>to walk if she did no<br>program of twice a<br>therapy assess her<br>R44 stated she felt<br>working so hard and<br>burden and request<br>On 10/21/16, at 10:<br>(RN)-A confirmed F<br>program twice daily<br>walker and gait belt<br>R44 was routinely r<br>program and stated<br>answer the question<br>On 10/21/16, at 10:<br>therapy assistant (O<br>been referred to nu<br>program last year a<br>daily to 200 feet wit<br>walker. OTA stated<br>maintain her ability<br>program was consis | am which she was supposed to<br>44 stated she used to walk up<br>d stated she was lucky if she<br>day. R44 stated the staff had<br>oo busy on the days she did<br>bulation program. R44 stated<br>being routinely for the last<br>44 stated she was able to walk<br>lock (200 feet square<br>he nursing station,) but at the<br>t winded due to not walking<br>4 stated she felt as though she<br>on her legs as she used to be.<br>red she would lose her ability<br>of continue with her ambulation<br>day. R44 agreed to having<br>ability to walk at that time.<br>bad the nursing staff was<br>d did not want to add to their<br>t to be walked.<br>18 a.m. registered nurse<br>R44 was on an ambulation<br>to 200 feet with assist of one,<br>t. RN-A did not comment if<br>eceiving her ambulation<br>d R44 would be best person to | F                 | 311 |  |           |                                     |

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|                          |   | AND HUMAN SERVICES   |                   |     |  | FORM | 12/15/2016<br>APPROVED<br>0938-0391 |
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|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     | E CONSTRUCTION   |      | E SURVEY<br>PLETED                  |
|                          |   | 245299   | B. WING           |     |  | 10/; | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |      |                                     |
| FRAZEE                   | CARE CENTER   |  |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |      |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE | (X5)<br>COMPLETION<br>DATE          |
| F 311                    | nursing staff. COTA<br>responsible for corr<br>ambulation/mainter<br>busy to consistently<br>program. COTA sta<br>wished they were a<br>programs though w<br>enough staff.<br>On 10/21/16, at 10:<br>assistant (PTA) ass<br>hallway with a gait t<br>assistance. R44 ha<br>steps. R44 stated s<br>and stated that had<br>she walked. R44 a<br>and sat down with of<br>At that time R44 sta<br>short on air when s<br>getting walked as fa<br>proceeded to remov<br>PTA for the walk.<br>On 10/21/16, at 10:<br>R44's ability to amb<br>as when she had la<br>as she was aware f<br>recent and likely du<br>her ambulation prog<br>noticed residents w<br>their ambulation/ma<br>not enough staff. P'<br>residents on mainter<br>them referred back<br>to a decline. PTA st<br>not enough staff to<br>residents programs<br>were responsible for | A stated the NA's were<br>ppleting residents<br>ance programs and were too<br>y complete each residents<br>ted NA's had verbalized they<br>ble to complete residents<br>rere unable to due to not<br>46 a.m. physical therapy<br>sisted R44 to ambulate in the<br>belt, walker and contact guard<br>d a steady gait and even<br>the was getting, "short on air,"<br>I been happening lately when<br>mbulated to her wheelchair<br>contact guard assist from PTA.<br>ated she never used to get<br>he walked and she was not<br>ar as she used to. R44 then<br>ve her gait belt and thanked<br>50 a.m. PTA stated she felt<br>bulate the distance the same<br>ast seen her. PTA stated as far<br>R44's shortness of breath was<br>te to not consistently receiving<br>gram. PTA stated she had<br>rere not consistently receiving<br>aintenance programs due to<br>TA stated she had placed<br>enance programs and has had<br>to therapy for treatment due<br>tated she felt this was due to<br>consistently carry out<br>a. PTA stated the facility NA's | F                 | 311 |  |      |                                     |

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|--------------------------|---|---|--------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     |   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING            |     |   | 10/:      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |   | ·                  | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |           |                                     |
| FRAZEE                   | CARE CENTER   |   |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 311                    | stated she had void<br>residents ambulation<br>nursing and admini-<br>medicare meeting a<br>ago. PTA stated the<br>was the staff were g<br>On 10/21/16, at 11:<br>nursing (ADON) co<br>consistently receivin<br>ADON stated she e<br>complete ambulation<br>resident. ADON state<br>ambulation/mainter<br>done due to staffing<br>the NA's did not have<br>residents programs<br>she did not feel R44 | Ugh NA'S on the floor. PTA<br>eed her concerns about<br>on/maintenance programs to<br>stration during the weekly<br>as recently as a month or so<br>e response she had received<br>going to "talk" to the NA's.<br>13 a.m. assistant director of<br>nfirmed R44 was not<br>ng her ambulation program.<br>expected staff to routinely<br>on/maintenance programs for<br>the she felt the facility's<br>nance program was not getting<br>g concerns and stated she felt<br>we the time to complete all<br>s, including R44. ADON stated<br>4 had lost any ability to<br>d ask R44 how often she | F3                 | 311 |   |           |                                     |
|                          | as directed by phys<br>nursing assistant gr<br>nursing assistance<br>for residents).<br>R29's Order Summ  | eceiving ambulation services<br>ical therapy and per the<br>roup sheet (a reference<br>used regarding specific care<br>ary form dated 9/16/16,<br>diagnoses which included  |                    |     |   |           |                                     |
|                          | muscle weakness,<br>R29's admission N   | malaise, and psychosis.<br>Iinimum Data Set (MDS) dated<br>R29 had severe cognitive   |                    |     |   |           |                                     |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                   |     |   | FOR     | D: 12/15/2016<br>MAPPROVED<br>D. 0938-0391 |
|--------------------------|--|--|-------------------|-----|---|---------|--|
| STATEMEN                 | T OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     | LE CONSTRUCTION   | (X3) DA | TE SURVEY                                  |
|                          |  | 245299   | B. WING           | i   |   | 10      | )/24/2016                                  |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   | •       |  |
| FRAZEE                   | CARE CENTER  |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>YMUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE  | (X5)<br>COMPLETION<br>DATE                 |
| F 311                    | impairment, and red<br>for bed mobility, tra<br>the unit, dressing a<br>identified ambulatio<br>the assessment per<br>R29's admission C/<br>R29 had dementia,<br>memory problems,<br>appeared related to<br>status related to fal<br>R29's current care<br>revealed R29 had a<br>walker with assist of<br>ambulation, toileting<br>R29's care plan dire<br>wheeled walker and<br>On 10/19/2016, at<br>her wheelchair, at a<br>propelled herself with<br>asked staff direction<br>continued to self pr<br>On 10/19/2016, at<br>nurse (LPN)-C amb<br>desk with a front wh<br>around R29's waist<br>On 10/24/2016, at<br>wheelchair in the ha<br>The facility form title<br>Interdepartmental C | quired extensive assistance<br>nsfer, locomotion on and off of<br>and hygiene. The MDS<br>n did not occur for R29 during<br>riod.<br>AA dated 7/14/16, identified<br>both short term and long term<br>and had poor balance which<br>decreased weight bearing<br>prior to admission.<br>plan revised 10/14/16,<br>in unsteady gait, used a<br>of one and assist with<br>g, and mobility as needed.<br>ected assist of one with front<br>d wheelchair for ambulation.<br>8:46 a.m. R29 was seated in<br>a table in the dining room. R29<br>th her feet, from the dining<br>pom.<br>9:02 a.m. R29 self propelled<br>her feet in the hall. R29<br>ns to her room and then<br>opel down the hall.<br>10:30 a.m. licensed practical<br>pulated R29 past the nurses<br>neeled walker and a gait belt<br>9:57 a.m. R29 propelled her | F                 | 311 |   |         |  |

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|                          |  | AND HUMAN SERVICES   |                   |     |  | FORM   | : 12/15/2016<br>APPROVED<br>: 0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` '               |     | PLE CONSTRUCTION   | (X3) DAT                                     | E SURVEY<br>IPLETED                     |
|                          |  | 245299   | B. WING           | i   |  | 10/  | 24/2016                                 |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                   | ;   | STREET ADDRESS, CITY, STATE, ZIP CODE  | <u>.                                    </u> |   |
| FRAZEE                   | CARE CENTER  |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE   | (X5)<br>COMPLETION<br>DATE              |
| F 311                    | ambulate twice dail<br>walker), gait belt, an<br>x (times) 1. Pt has a<br>therapy. Pt may rec<br>upright posture and<br>R29's progress not<br>through 10/23/16, th<br>received therapy fo<br>not note that reside<br>nursing staff to amb<br>day, nor was there<br>received ambulation<br>R29 did not have a<br>the nursing assistan<br>On 10/21/16, at 11:<br>assistant (PTA) stat<br>with residents ambu<br>programs being cor<br>stated felt there was<br>the facility to compl<br>maintenance progra<br>stated residents suc<br>receive their ambul<br>On 10/24/2016, at<br>R29 was not on a w<br>indicated R29 would<br>walk with her in her<br>On 10/24/2016, at<br>R29 was not sched<br>ambulation program<br>On 10/24/2016, at<br>assistant (PTA)-G in | y with fww (front wheeled<br>nd CGA (contact guard assist)<br>ambulated up to 150' in<br>quire verbal cues to maintain<br>I take larger steps."<br>es were reviewed 6/30/16,<br>he notes identified R29 had<br>r strengthening; however did<br>ont had received the referral for<br>bulate resident two times a<br>documentation that R29 had<br>n services with floor staff.<br>ambulation program sheet in<br>nt maintenance book.<br>20 a.m. physical therapy<br>ted she had serious concerns<br>ulation and maintenance<br>mpleted consistently. PTA<br>s not enough nursing staff in<br>ete ambulation and<br>ams on a routine basis. PTA<br>ch as R29 did not routinely<br>ation programs.<br>10:14 a.m. NA-I indicated<br>valking program. NA-I<br>d self transfer and staff would<br>room to the bathroom. | F                 | 311 |  |  |   |

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|                          |   | AND HUMAN SERVICES  |                   |     |  | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |
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| STATEMENT                | T OF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | • •               |     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |   | 245299  | B. WING           | i   |  | 10/;                          | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |   |                   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                                     |
| FRAZEE                   | CARE CENTER   |   |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |
| F 311                    | from therapy servic<br>ambulation or lower<br>to be completed by<br>to maintain the prog<br>therapy. PTA-G ver<br>therapy in August o<br>currently walking tw<br>PTA-G indicated an<br>would not be enoug<br>walking program.<br>On 10/24/16, at 10:<br>(CM)-B indicated R<br>program for one sta<br>hallway with use of<br>was unaware how overified R29's Resid<br>Interdepartmental C<br>to nursing from phy<br>following: "Recomm<br>twice daily with fww<br>belt, and CGA (care<br>has ambulated up t<br>require verbal cues<br>and take larger step<br>have a form which overified the NA grou-<br>current care plan an<br>R29 was to receive<br>two times a day with<br>CM-B indicated with<br>observations of R29<br>was unaware if R29<br>ambulation program<br>feet.<br>On 10/24/16, at 11: | es and then continue with a<br>r extremity exercise program<br>the nursing assistants in order<br>gress which was made in<br>ified R29 was discharged from<br>f 2016, and should be<br>to times a day up to 150 feet.<br>Inbulation into the bathroom<br>gh steps to be considered a<br>52 a.m. the clinical manager<br>29 had an ambulation<br>aff to walk the full length of the<br>a gait belt and a walker. CM-B<br>often R29 ambulated. CM-B | F                 | 311 |  |                               |                                     |

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|                          |  | AND HUMAN SERVICES  |                     |    |   | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |    | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245299  | B. WING             |    |   | 10/:                          | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                     | S  | TREET ADDRESS, CITY, STATE, ZIP CODE  | •                             |                                     |
| FRAZEE                   | CARE CENTER  |   |                     |    | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG | ×  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |
| F 311                    | stand from the whe<br>length of the hall from<br>her room. PTA-G in<br>and had remained a<br>ambulation as when<br>from physical thera<br>R46<br>R46 was not receive<br>directed by physica<br>On 10/24/2016, at 1<br>top of her bed on h<br>small blankets, the<br>grab bar attached to<br>wheel chair was ap<br>bed in which R46 la<br>R46's physicians or<br>diagnoses included<br>and collapse.<br>R46's quarterly Mir<br>8/11/16, identified F<br>required extensive<br>locomotion on and<br>toilet use, limited as<br>personal hygiene. T<br>did not occur for R4<br>period.<br>R46's Care Area As<br>11/9/15, included: C<br>Functional status: A<br>limited assistance of<br>ambulation in corrior | A pelchair and ambulate 1/2 the<br>benchair and ambulate 1/2 the<br>benchair and ambulate 1/2 the<br>benchair and ambulate 1/2 the<br>benchair and her back to<br>addicated R29 had not declined<br>at the functioning level with<br>in she had been discharged<br>py services. | F 3                 | 11 |   |                               |                                     |

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|                          |  | AND HUMAN SERVICES  |                   |     |   | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245299  | B. WING           |     |   | 10/2                          | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                                     |
| FRAZEE                   | CARE CENTER  |   |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |
| F 311                    | Interdepartmental C<br>to nursing from phy<br>receive the following<br>(patient) with RW (r<br>and 1 A (assist) 2 X<br>(ambulate) up to 20<br>R46's current care r<br>R46 had an unstead<br>(stand by assist) of<br>walker.<br>R46's progress note<br>through 10/1/16, di<br>received ambulation<br>R46 did not have a<br>the nursing assistan<br>On 10/24/2016, at 1<br>R29 was not sched<br>ambulation program<br>transfer and take a<br>distance.<br>On 10/24/2016, at<br>assistant (PTA)-G in<br>reached their goal i<br>from therapy servic<br>ambulation or lower<br>to be completed by<br>to maintain the prog<br>therapy. PTA-G ver<br>from therapy and s<br>times a day up to 20<br>tolerated. PTA-G in<br>to be walking with F<br>program should cor | Communication dated 11/6/15,<br>rsical therapy directed R46<br>g: "Please ambulate Pt<br>regular walker), transfer belt,<br>( (times) daily. Pt. amb.<br>00' any ? (questions) call."<br>plan revised 8/22/16, revieled<br>dy gait and weakness, SBA<br>one for transfer and with<br>es were reviewed 4/3/16,<br>id not note that R46 had<br>n services with floor staff.<br>ambulation program sheet in<br>nt maintenance book.<br>10:16 a.m. (NA)-E indicated | F                 | 311 |   |                               |                                     |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                   |     |  | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|-------------------|-----|--|-------------------------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,               |     |  | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245299   | B. WING           |     |  | 10/2                          | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                                     |
| FRAZEE                   | CARE CENTER  |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)            | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |
| F 311                    | if a decline were to<br>be re-screened. PT.<br>the bathroom would<br>considered a walkin<br>On 10/24/16, at 10:<br>(CM)-B indicated sh<br>ambulate. CM-B in<br>therapy was receive<br>or other exercise pr<br>form for the nursing<br>maintenance book.<br>Referral, Interdepar<br>11/6/15, to nursing the<br>following: "Pleas<br>RW (regular walker<br>(assist) 2 X (times))<br>to 200' any ? (quest<br>did not have a form<br>program in the NA r<br>review of R46's cha<br>ambulation program<br>months of Decembor<br>July 2016, but no fu<br>documentation was<br>R46's ambulation p<br>being performed.<br>On 10/24/16, at 11:<br>nursing staff did not<br>had not asked her t<br>walking with the use<br>PTA-G, R46 stated,<br>in a while, I can fee<br>approximately 8 fee<br>stop a while to rest<br>minutes, R46 contir | occur the resident should then<br>A-G indicated ambulation into<br>I not be enough steps to be | F                 | 311 |  |                               |                                     |

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|                          |  | AND HUMAN SERVICES  |                    |     |  | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|--------------------|-----|--|-------------------------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                |     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245299  | B. WING            |     |  | 10/;                          | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                                     |
| FRAZEE                   | CARE CENTER  |   |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |
| F 311                    | Continued From pa  | ige 104   | F3                 | 311 |  |                               |                                     |
|                          | R46's ambulation a<br>stand from bed and<br>the hall. R46 was a<br>from her room towa<br>back to her room. F<br>declined and had re<br>level with ambulatio<br>discharged from ph<br>On 10/24/16, at 11:<br>with R46 identified a<br>walk more; howeve<br>were very busy and<br>assistance and took<br>On 10/24/16, at 2:0<br>(PA)-A indicated shi<br>follow resident care<br>recommended walk<br>prevent resident fur<br>in the residnets qua | <ul> <li>11 a.m. (PTA)-G assessed<br/>ability. PTA-G assisted R46 to<br/>d ambulate out of her room into<br/>ble to ambulate 1/2 of the hall<br/>ard the nurses desk and then<br/>PTA-G indicated R46 had not<br/>emained at the functioning<br/>on as when she had been<br/>hysical therapy services.</li> <li>24 a.m. a follow up interview<br/>she was aware she should<br/>er, believed the facility staff<br/>d she required a lot of<br/>k a lot of the staffs time.</li> <li>90 p.m. physician assistant<br/>e would expect facility staff to<br/>a plans and to initiate<br/>king or exercise programs to<br/>nctional decline and a decline<br/>ality of life. PA-A stated, " Sadly<br/>nmended restorative exercises<br/>ere."</li> </ul> |                    |     |  |                               |                                     |
| F 312<br>SS=D            | 4/1/08, identified re-<br>admission and as n<br>program including a<br>identified residents<br>highest level of func<br>483.25(a)(3) ADL C<br>DEPENDENT RES<br>A resident who is un<br>daily living receives   | d, Restorative Program, dated<br>sidents would be assessed on<br>needed for a restorative<br>ambulation. The policy further<br>would be supported and their<br>ctioning maintained.<br>CARE PROVIDED FOR<br>IDENTS<br>nable to carry out activities of<br>the necessary services to<br>ition, grooming, and personal  | F 3                | 312 |  |                               | 12/14/16                            |

Facility ID: 00730

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   | FORM APPROVED<br>OMB NO. 0938-0391     |  |   |                               |  |  |
|--------------------------|---|---|--|--|---|-------------------------------|--|--|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |   | (X3) DATE SURVEY<br>COMPLETED |  |  |
|                          |   | 245299  | B. WING                                |  | 10/2  | 24/2016                       |  |  |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE  |   |                               |  |  |
| FRAZEE                   | CARE CENTER   |   |  | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |   |                               |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>YMUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)  | BE  | (X5)<br>COMPLETION<br>DATE    |  |  |
| F 312                    | Continued From pa and oral hygiene.   | ge 105  | F 312                                  | 2  |   |                               |  |  |
|                          | by:<br>Based on observat<br>review the facility fa<br>were completed in a<br>residents (R18) rev<br>and on who were of<br>program.<br>Findings include:<br>Review of R18's qu<br>(MDS) dated 7/26/1<br>cognitive impairmer<br>communicate with s<br>included, dementia,<br>MDS identified R18<br>for activities of daily<br>staff for assistance<br>hygiene and toiletin<br>was frequently inco<br>The MDS identified<br>program for bowel of<br>Review of R18's an<br>identified R18 was fa<br>ADL's. The MDS identified<br>incontinent of bowel<br>identified R18 was fabowel or bladder into<br>Review of R18's Co<br>Area Assessment (M | staff and had diagnoses which<br>depression and anxiety. The<br>was totally dependent on staff<br>living (ADL's) and required 2<br>with bed mobility, personal<br>g. The MDS identified R18<br>ntinent of bowel and bladder.<br>R18 was not on a toileting<br>or bladder incontinence.<br>nual MDS dated 4/26/16,<br>totally dependent on staff for<br>entified R18 was frequently<br>I and bladder. The MDS<br>not on a toileting program for<br>continence.<br>ognitive Loss/ Dementia Care<br>CAA) dated 4/26/16, identified |  | <ul> <li>F 312 Assistance with ADLs provided pendent residents</li> <li>1. R18 currently is receiving timeliassistance with toileting. A three das bowel and bladder assessment will completed for R18; R18 is care plabe updated according to assessment findings.</li> <li>2. All residents that require assist with personal cares with urinary incontinence have the potential to baffected in this area. A list of reside that are frequently incontinent will be generated and will be care planned every two hour check and change program. Care plan updated as news provided on November 16 and the procedure titled Activities of Dativing with a focus on the need for toileting and three day bowel and b assessments upon admission, ann or with a change in continence stat</li> <li>4. An audit will be developed to mark through observations and documentation review to ensure residents through observations and documentation review to ensure residents of uncentation review to ensure resident of uncentation review to ensure residen</li></ul> | y<br>ay<br>be<br>an will<br>nt<br>ance<br>pe<br>ents<br>be<br>for an<br>eded.<br>ion<br>17 on<br>tily<br>timely<br>ladder<br>ually,<br>us.<br>ponitor<br>l<br>sidents<br>rine |                               |  |  |
|                          | bowel or bladder ind<br>Review of R18's Co<br>Area Assessment (<br>R18 had cognitive la   | continence.<br>ognitive Loss/ Dementia Care   |  | residents through observations and documentation review to ensure re-  | l<br>sidents<br>rine<br>1 every   |                               |  |  |

Facility ID: 00730

PRINTED: 12/15/2016

|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                     |   | FORM  | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|---------------------|---|---|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |   | (X3) DATE SURVEY<br>COMPLETED                                     |                                     |
|                          |   | 245299  | B. WING             |   | 10/;  | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |   |                                     |
| FRAZEE                   | CARE CENTER   |   |                     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |   |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | BE  | (X5)<br>COMPLETION<br>DATE          |
| F 312                    | The CAA revealed I<br>spite of her inability<br>Communication CA<br>be anticipated by fa<br>Incontinence CAA is<br>incontinent of bowe<br>assistance with all r<br>changed as needed<br>Review of a Bowel<br>Evaluation tool revie<br>had functional urina<br>totally dependent of<br>tool revealed R18 r<br>every 2 hours durin<br>change the 1st and<br>Review of R18's ph<br>10/6/16, revealed R<br>Alzheimer's disease<br>facility staff for her r<br>Review of R18's cu<br>10/7/16, revealed F<br>was unable to comm<br>totally dependent of<br>repositioning needs<br>incontinent of bowe<br>incontinent brief . T<br>check and change<br>incontinence with re<br>On 10/19/16, from 1<br>continuous observa<br>following: | R18's needs were to be met in<br>to make requests. R18's<br>A identified R18's needs must<br>cility staff. Urinary<br>dentified R18 was frequently<br>I and bladder and needed<br>mobility and was toileted or<br>d.<br>and Bladder Functional<br>ewed 7/26/16, revealed R18<br>any incontinence and was<br>in staff for toileting needs. The<br>equired assistance to toilet<br>g the day and to change and<br>3rd rounds during the night.<br>ysician progress note dated<br>ta had severe dementia and<br>e and to be dependent on<br>needs.<br>rrrent care plan last updated<br>ta had severe cognitive loss,<br>municate her needs and was<br>in staff for toileting,<br>and was frequently<br>I and bladder and wore an<br>he care plan directed staff<br>R18 every 2 hours for | F 312               | care planned appropriately. The au<br>be completed by the DON, or desig<br>and monitors the cleanliness of res<br>bed linens on all three shifts. The a<br>will be completed 2-3 per week on<br>three shifts X 4 weeks, the weekly<br>weeks, then monthly X 2 months. I<br>findings will be provided monthly x<br>months to the QA committee with<br>follow-up to committee recommend<br>5. Deficient practice will be correct<br>December 14, 2016 | gnee,<br>sident<br>audit<br>all<br>for 4<br>Audit<br>3<br>dations |                                     |

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|                          |  | AND HUMAN SERVICES  |                   |     |   | FORM                          | : 12/15/2016<br>APPROVED<br>: 0938-0391 |
|--------------------------|--|---|-------------------|-----|---|-------------------------------|---|
| STATEMENT                | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,               |     | PLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |   |
|                          |  | 245299  | B. WING           | i   |   | 10/                           | 24/2016                                 |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   | -                             |   |
| FRAZEE                   | CARE CENTER  |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |                               |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) BE                          | (X5)<br>COMPLETION<br>DATE              |
| F 312                    | gel cushioned whee<br>room. R18's bed wa<br>were balled into a b<br>was hung forward in<br>her eyes were close<br>-at 7:38 a.m. the ca<br>by R18's roommate<br>the room to assist F<br>housekeeping staff<br>made R18's bed wh<br>the wheelchair. At 7<br>staff member whee<br>R18 had remained<br>head was in a chin<br>Housekeeping staff<br>dining room and pla<br>around her neck, at<br>face with the clothin<br>-at 7:56 a.m. R18 ro<br>wheelchair in the di<br>(DA)brought R18 ho<br>plate on the table in<br>At that time nursing<br>approached R18, p<br>and verbally promp<br>opened her eyes ar<br>R18 to begin eating<br>R18 ate 100% of her | elchair, fully dressed in her<br>as stripped of its linens which<br>bundle on her bed. R18's head<br>n a chin to chest position and<br>ed.<br>all light to R18's room was on<br>e, staff were observed to enter<br>R18's roommate. At that time,<br>entered R18's room and<br>hile she remained seated in<br>7:41 a.m. the housekeeping<br>bled R18 to the dining room.<br>with her eyes closed and her<br>to chest position.<br>f wheeled R18 to a table in the<br>aced a clothing protector<br>t that time R18 covered her<br>ng protector.<br>emained seated in the<br>ining room. A dietary aid<br>er breakfast plate, left the<br>n front of her and walked away.<br>g assistant (NA)-G<br>laced a hand on her shoulder<br>ted her to wake up. R18<br>nd NA-G verbally prompted<br>g and handed her a spoon. | F                 | 312 |   |                               |   |
|                          | R18 remained seat<br>table<br>-at 8:46 a.m. R18 re<br>wheelchair at the di<br>attempt to leave fro   | emained seated in her<br>ining room table, had made no<br>om the table. R18 had<br>al, had a glass of milk orange   |                   |     |   |                               |   |

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|                          |  | AND HUMAN SERVICES   |                   |     |   | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,               |     |   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245299   | B. WING           |     |   | 10/2                          | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   | -                             |                                     |
| FRAZEE                   | CARE CENTER  |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |
| F 312                    | juice and water in fr<br>attempt to reach for<br>spoon, and would re<br>the lipped edge of h<br>her spoon.<br>-at 9:01 a.m. R18 re<br>wheelchair in the di<br>attempts to leave th<br>R18 and asked how<br>respond, NA-H wall<br>repeatedly run her so<br>of the plate, while s<br>spoon. R18 had ma<br>fluids.<br>-at 9:18 a.m. R18 re<br>wheelchair in the di<br>spoon on the table,<br>Shortly after R18's<br>chin to chest position<br>assist R18 with repo-<br>-at 9:30 a.m. R18 re<br>wheelchair in the di<br>her eyes, looked ar<br>protector and cover<br>attempt to move aw<br>face covered with th<br>-at 9:37 a.m. NA-D<br>awoke R18 and offe | ront of her though made no<br>r them. R18 held onto her<br>epeatedly run the spoon over<br>her plate, periodically licking<br>emained seated in her<br>ining room, having made no<br>he table. NA-H approached<br>v her day was, R18 did not<br>ked away. R18 continued to<br>spoon around the lipped edge<br>he periodically licked her<br>ade no attempts to drink her<br>emained seated in her<br>ining room. R18 had set the<br>and had closed her eyes.<br>head dropped forward in a<br>on. No staff had offered to | F                 | 312 |   |                               |                                     |
|                          | face and allowed N<br>juice. R18 drank 50<br>handed R18 her gla<br>independently dran  | A-D to assist her to drink her<br>1% of her juice. NA-D then<br>ass of water and R18<br>k the water. NA-D left R18<br>Ichair and exited the dining   |                   |     |   |                               |                                     |

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|                          |   | AND HUMAN SERVICES   |                   |     |  | FORM     | : 12/15/2016<br>APPROVED<br>. 0938-0391 |
|--------------------------|---|--|-------------------|-----|--|----------|---|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     |  | (X3) DAT | TE SURVEY<br>MPLETED                    |
|                          |   | 245299   | B. WING           |     |  | 10       | /24/2016                                |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  |          |   |
| FRAZEE                   | CARE CENTER   |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |          |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE    | (X5)<br>COMPLETION<br>DATE              |
| F 312                    | assistance with car<br>needs.<br>-at 9:42 a.m. NA-H<br>her to drink her rem<br>remained seated in<br>removed the clothin<br>R18 then took her s<br>it, in a cradling posi<br>-at 9:50 a.m. NA-H<br>room while seated it<br>to her room and ha<br>NA-H attached the<br>and left R18's room<br>offer R18 with any c<br>or toileting.<br>-at 10:01 a.m. NA-E<br>R18's room, did not<br>-at 10:09 a.m. NA-<br>hallway from R18's<br>R18's room and imit<br>the hallway.<br>-at 10:39 a.m. assis<br>(ADON) was notifie<br>her wheelchair for a<br>minutes. At that tim<br>required assistance<br>checking and chang<br>confirmed R18 was<br>ADON went to R18 | approached R18 and assisted<br>naining fluids, while R18<br>her wheelchair. NA-H<br>ng protector from R18's neck,<br>shirt and covered her face with | F                 | 312 |  |          |   |
|                          | -at 10:39 a.m. NA-E   | E entered R18's room and   |                   |     |  |          |   |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                    |     |  | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|--------------------|-----|--|-------------------------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245299  | B. WING            |     |  | 10/                           | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                    |     | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                                     |
| FRAZEE                   | CARE CENTER  |   |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETION<br>DATE          |
| F 312                    | asked R18 to use th<br>gait belt across R18<br>assisted R18 to star<br>ambulate to the bat<br>slacks and incontine<br>amount of urine in h<br>amount of bowel. A<br>buttocks surface wh<br>had deep blush pinl<br>surrounding her per<br>blanchable. NA-E a<br>complete toileting n<br>back in her wheelch<br>R18 had remained<br>of 3 hours and 36 m<br>staff were observed<br>repositioning.<br>On 10/19/16, at 10:<br>thought R18 was la<br>a.m. and had stated<br>helping others with<br>repositioning and to<br>R18 was supposed<br>checked and chang<br>needed. NA-E state<br>verbalize hers and s<br>R18's needs.<br>On 10/20/16. at 2:3<br>needs must be antio<br>dependent on 2 star<br>repositioning and to<br>required routine events<br>toileting. NA-B states | he bathroom. NA-E donned a<br>B's torso, NA-E and ADON<br>nd from the wheelchair,<br>hroom and removed R18's<br>ent brief. R18 had a moderate<br>her brief as well as a small<br>DON confirmed R18's entire<br>hich had contact with the brief<br>k creases and was moist<br>ri-rectal area, though was<br>nd ADON assisted R18 to<br>eeds and assisted R18 to<br>eeds and assisted R18 to sit<br>hair.<br>in a seated position for a total<br>hinutes, during that time no<br>to offer R18 assistance with<br>39 a.m. NA-E stated she<br>st repositioned around 6:45<br>d she had been too busy<br>cares to assist R18 with<br>bileting needs. NA-E stated<br>to be repositioned and<br>ged every 2 hours and as<br>ad R18 was not able to<br>staff needed to anticipate<br>6 p.m. NA-B stated R18<br>cipated and was totally<br>ff for her needs, including<br>bileting. NA-B stated R18<br>ery 2 hour repositioning and<br>ed R18's buttocks would get<br>uld not recall any recent open | F                  | 312 |  |                               |                                     |

|   |  |   |  | FORM   | 12/15/2016<br>APPROVED<br>0938-0391  |
|---|--|---|--|--|--|
| OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |   | IPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED  |  |
|   | 245299   | B. WING _   |  | 10/2   | 24/2016  |
| PROVIDER OR SUPPLIER  |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE  |  |  |
| CARE CENTER   |  |   | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |  |  |
| (EACH DEFICIENCY  | Y MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG   | (EACH CORRECTIVE ACTION SHOUL  | ) BE   | (X5)<br>COMPLETION<br>DATE   |
| On 10/20/16, at 3:2<br>(LPN)-B stated R18<br>staff of for all of her<br>was not able to verf<br>needed to anticipate<br>was at risk for skin<br>incontinence and in<br>On 10/21/16, at 1:3<br>interview ADON sta<br>to routinely reposition<br>timely manner, such<br>shortages. ADON sta<br>able to fill in for sick<br>when the facility we<br>schedule.<br>A facility policy titled<br>Management dated<br>facility's policy to er<br>or bladder incontine<br>treatment and servi<br>functioning. The po<br>an individual toiletin | <ul> <li>8 p.m. licensed practical nurse</li> <li>8 was totally dependent on<br/>r needs. LPN-B stated R18<br/>balize her needs and staff<br/>e them. LPN-B stated R18<br/>breakdown due to<br/>nmobility.</li> <li>7 p.m. during a follow up<br/>ated she felt staff were unable<br/>oning and toilet residents in a<br/>h as R18, due to staffing<br/>stated they were not always<br/>c calls and there were times<br/>ere unable to fill holes in the</li> <li>d Bowel and Bladder<br/>4/1/08, revealed it was the<br/>nsure each resident with bowel<br/>ence would receive appropriate<br/>ices to maintain normal<br/>licy directed staff to develop<br/>ng schedule for all incontinent</li> </ul>  | F 31  |  |  |  |
| PREVENT/HEAL P<br>Based on the comp<br>resident, the facility   | RESSURE SORES<br>prehensive assessment of a<br>must ensure that a resident   | F 31  | 14   |  | 12/14/16   |
|   | RS FOR MEDICARE<br>OF DEFICIENCIES<br>OF DEFICIENCIES<br>F CORRECTION<br>PROVIDER OR SUPPLIER<br>CARE CENTER<br>SUMMARY STA<br>(EACH DEFICIENCY<br>REGULATORY OR L<br>Continued From pa<br>On 10/20/16, at 3:2<br>(LPN)-B stated R18<br>staff of for all of her<br>was not able to verl<br>needed to anticipate<br>was at risk for skin<br>incontinence and in<br>On 10/21/16, at 1:3<br>interview ADON stat<br>to routinely reposition<br>timely manner, such<br>shortages. ADON stat<br>to routinely reposition<br>to routinely reposition<br>the schedule.<br>A facility policy timely<br>Management dated<br>facility's policy to error<br>or bladder incontine<br>the schedule.<br>A fasility of the schedule to the sche | IDENTIFICATION NUMBER:         245299         PROVIDER OR SUPPLIER         CARE CENTER         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 111         On 10/20/16, at 3:28 p.m. licensed practical nurse<br>(LPN)-B stated R18 was totally dependent on<br>staff of for all of her needs. LPN-B stated R18<br>was not able to verbalize her needs and staff<br>needed to anticipate them. LPN-B stated R18<br>was at risk for skin breakdown due to<br>incontinence and immobility.         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WING         CARE CENTER       SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       ID<br>PREFIX<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       F 3:         Continued From page 111<br>On 10/20/16, at 3:28 p.m. licensed practical nurse<br>(LPN)-B stated R18 was totally dependent on<br>staff of roall of her needs. LPN-B stated R18<br>was not able to verbalize her needs and staff<br>needed to anticipate them. LPN-B stated R18<br>was at risk for skin breakdown due to<br>incontinence and immobility.       F 3:         On 10/21/16, at 1:37 p.m. during a follow up<br>interview ADON stated she felt staff were unable<br>to routinely repositioning and toilet residents in a<br>timely manner, such as R18, due to staffing<br>shortages. 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F 3:         483.25(c) TREATMENT/SVCS TO<br>PREVENT/HEAL PRESSURE SORES       F 3:         Based on the comprehensive assessment of a<br>resident, the facility must ensure that a resident       F 3: <td>MENT OF HEALTH AND HUMAN SERVICES       O         SFOR MEDICARE &amp; MEDICAID SERVICES       O         OP DEFICIENCIES       (X1) PROVIDERSUPPLERCIA<br/>DENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION<br/>A BUILDING         PROVIDER OR SUPPLER       245299       B         CARE CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE       219 WEST MAPLE AVENUE, PO BOX 96<br/>FRAZEE, IMN 56544         SUMMARY STATEMENT OF DEFICIENCIES<br/>(EACH CORRECTOR ALTONY ON LSC IDENTIFINING INFORMATION)       P       PROVIDER'S PLAN OF CORRECTIO<br/>FRAZEE, IMN 56544         SUMMARY STATEMENT OF DEFICIENCIES<br/>(EACH CORRECTOR ACTION SOLUTION<br/>(FACH CORRECTOR ACTION SOLUTION)       P       PROVIDER'S PLAN OF CORRECTIO<br/>FRAZEE, IMN 56544         Continued From page 111<br/>On 10/20/16, at 3:28 p.m. licensed practical nurse<br/>(LPN)-B stated R18 was totally dependent on<br/>staff of for all of her needs. 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The policy directed staff to develop<br/>an individual tolleting s</td> <td>MENT OF HEALTH AND HUMAN SERVICES     FORM       SF COR MEDICARE &amp; MEDICAID SERVICES     OMB NO.       OF DEFICIENCIES     OMB NO.       OF DEFICIENCIES     OMB NO.       OF ORDERTION     245299       PROVIDER OR SUPPLER     245299       CARE CENTER     STREET ADDRESS, CITY, STATE, ZIP CODE       219 WEST MAPLE AVENUE, PO BOX 96     FRAZEE, MN 56544       TRACH OF DISUPPLER     Image: Compact Number of DEFICIENCIES       Continued From page 111     PREFIX       On 10/20/16, at 3.28 p.m. licensed practical nurse     F 312       Continued From page 111     F 312       On 10/20/16, at 1.37 p.m. during a follow up interview ADON stated they were not always able to with or sick calls and there were times in a timely manner, such as F18, due to stating shortages. 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A facility policy time down due for expression for an expression more times assessment of a resident, the facility were unsure that a resident.</td> | MENT OF HEALTH AND HUMAN SERVICES       O         SFOR MEDICARE & MEDICAID SERVICES       O         OP DEFICIENCIES       (X1) PROVIDERSUPPLERCIA<br>DENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION<br>A BUILDING         PROVIDER OR SUPPLER       245299       B         CARE CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE       219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, IMN 56544         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH CORRECTOR ALTONY ON LSC IDENTIFINING INFORMATION)       P       PROVIDER'S PLAN OF CORRECTIO<br>FRAZEE, IMN 56544         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH CORRECTOR ACTION SOLUTION<br>(FACH CORRECTOR ACTION SOLUTION)       P       PROVIDER'S PLAN OF CORRECTIO<br>FRAZEE, IMN 56544         Continued From page 111<br>On 10/20/16, at 3:28 p.m. licensed practical nurse<br>(LPN)-B stated R18 was totally dependent on<br>staff of for all of her needs. 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Facility ID: 00730

If continuation sheet Page 112 of 184

| DEPARTMENT OF HEALTH AN<br>CENTERS FOR MEDICARE &  |   |                    |     |  | FORM A  | 12/15/2016<br>APPROVED<br>0938-0391 |
|--|---|--------------------|-----|--|---|-------------------------------------|
|  | 1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                |     |  | (X3) DATE   | SURVEY<br>PLETED                    |
|  | 245299  | B. WING            |     |  | 10/2  | 24/2016                             |
| NAME OF PROVIDER OR SUPPLIER   |   |                    | ST  | REET ADDRESS, CITY, STATE, ZIP CODE  |   |                                     |
| FRAZEE CARE CENTER   |   |                    |     | 9 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |   |                                     |
| PREFIX (EACH DEFICIENCY MU   | MENT OF DEFICIENCIES<br>UST BE PRECEDED BY FULL<br>IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY)  | BE  | (X5)<br>COMPLETION<br>DATE          |
| <ul> <li>individual's clinical corthey were unavoidable pressure sores receive services to promote he prevent new sores from this REQUIREMENT by:</li> <li>Based on observation review the facility repositioning program be at risk for pressure (R18, R66) reviewed facility in the facility is the facility in the facility the facility in the facility the facility is the facility the facility is the facility in the facility is the facili</li></ul> | ssure sores unless the<br>ndition demonstrates that<br>e; and a resident having<br>res necessary treatment and<br>ealing, prevent infection and<br>on developing.<br>T is not met as evidenced<br>n, interview and document<br>facility failed to complete<br>or residents on a turn and<br>and who were assessed to<br>e ulcers for 2 of 4 residents<br>for pressure ulcers.<br>terly Minimum Data Set<br>identified R18 had severe<br>was unable to<br>aff and had diagnoses which<br>epression and anxiety. The<br>ras totally dependent on staff<br>ving (ADL's) and required 2<br>th bed mobility. The MDS<br>risk for developing pressure<br>entions in place which<br>educing device for the chair | F 3                | 314 | <ul> <li>F 314 Treatment/Services to preven pressure sores</li> <li>1. R18 and R66 will be assessed ft tissue tolerance; R18 s and R66 s plan for turning and repositioning will updated according to assessment findings.</li> <li>2. All residents with a Braden scorr 15 or less for or with current pressure ulcers have the potential to be affect this area. A list of residents at high (Braden less than 15) for or with preulcers will be generated and reviewet tissue tolerance assessment. Reside at high risk for skin breakdown are I on the CNA pocket worksheet and the care plans are updated to ensure near skin issues to not develop.</li> <li>3. Mandatory nursing staff education was provided on November 16 and 2016 on the procedure titled, Position and Pressure Ulcer Education You Skin with a focus on the need for residents at risk for or with pressure ulcers to be repositioned frequently</li> </ul> | or<br>care<br>ll be<br>e of<br>re<br>ted in<br>risk<br>essure<br>ed for<br>dents<br>isted<br>heir<br>ew<br>on<br>17,<br>oning<br>ur |                                     |

Facility ID: 00730

|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION<br>G  |   | E SURVEY<br>PLETED        |
|--------------------------|---|--|---------------------|--|---|---------------------------|
|                          |   | 245299   | B. WING             |  | 10/   | 24/2016                   |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CO  |   |                           |
| FRAZEE                   | CARE CENTER   |  |                     | 219 WEST MAPLE AVENUE, PO BO<br>FRAZEE, MN 56544   | X 96  |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE /<br>DEFICIENCY)  | SHOULD BE   | (X5)<br>COMPLETIO<br>DATE |
| F 314                    | Area Assessment (<br>R18 had cognitive I<br>was unable to cohe<br>The CAA revealed<br>spite of her inability<br>R18's Communicat<br>needs must be anti<br>Pressure Ulcer CAJ<br>potential for skin br<br>incontinence, decret<br>to make her needs<br>R18 could move ind<br>required staff assis<br>sitting position. The<br>regular schedule of<br>relieving cushion in<br>Review of a Compr<br>dated 7/26/16, reve<br>skin breakdown bas<br>(assessment for pro<br>of 14 and a tissue t<br>revealed interventio<br>included, gel cushio<br>required turning an<br>change every 2 hou<br>Review of R18's ph<br>10/6/16, revealed F<br>routine nursing hon<br>R18 had severe de | am.<br>ognitive Loss/ Dementia Care<br>CAA) dated 4/26/16, identified<br>oss related to dementia and<br>erently verbalize her needs.<br>R18's needs were to be met in<br>to make her needs known.<br>ion CAA identified R18's<br>cipated by facility staff. R18's<br>A identified R18 had a<br>eakdown related to<br>eased mobility and her inability<br>known. The CAA revealed<br>dependently in bed but<br>tance to reposition when in a<br>e CAA identified R18 required a<br>turning and had a pressure<br>wheelchair.<br>ehensive Analysis of Skin form<br>ealed R18 was at high risk for<br>sed on a Braden scale<br>edicting pressure sores) score<br>olerance test. The form<br>ons were put in place which<br>on in wheelchair and R18<br>d repositioning with check and<br>urs and as needed (PRN).<br>eysician progress note dated<br>R18 had been seen for a<br>ne visit. The note revealed<br>mentia and Alzheimer's<br>ependent on facility staff for | F 31                | <ul> <li>4 ulcers. Licensed nurse will of tissue tolerance assessment dependent residents upon a care planning for turning and will be based on individual reassessment findings. Docut turning and repositioning proof on the TAR for nurses to sig completed.</li> <li>4. An observation and chabeen developed to monitor sassessments, appropriate cato prevent/heal impaired skin implementation of intervention turning and repositioning, poseating/mattress pressure renotification and collaboratior and physician (assuring phyare being followed), notificat updating of responsible part daily nurse wound documen MAR/TAR and also the weel review on the wound data coassessment. The audit will by the DON or designee weeks, then monthly X 2 monoths to the QA with follow committee findings.</li> <li>5. Deficient practice will be December 14, 2016</li> </ul> | t for<br>dmission and<br>d repositioning<br>esident<br>mentation of<br>ograms will be<br>n off as<br>rt audit has<br>skin<br>are planning<br>n integrity,<br>ons including<br>ositioning,<br>eduction,<br>n with dietician<br>sician orders<br>ion and<br>ies, and also<br>tation on the<br>kly RN wound<br>oblection<br>be completed<br>ekly X 4<br>onths. Audit<br>nthly x 3<br>y-up to |                           |

|                          |  | AND HUMAN SERVICES   |                   |     |   | FORM     | : 12/15/2016<br>APPROVED<br>. 0938-0391 |
|--------------------------|--|--|-------------------|-----|---|----------|---|
| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     | LE CONSTRUCTION   | (X3) DAT | E SURVEY<br>IPLETED                     |
|                          |  | 245299   | B. WING           | i   |   | 10/      | 24/2016                                 |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   |          |   |
| FRAZEE                   | CARE CENTER  |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |          |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRC<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETION<br>DATE              |
| F 314                    | <ul> <li>was unable to communicative theorem particular dependent or repositioning needs skin breakdown. The interventions which and reposition every clean and dry and a wheelchair.</li> <li>On 10/19/16, from T continuous observation following:</li> <li>At 7:03 a.m. R18 wa a gel cushion, fully bed was stripped of hung forward in a c eyes were closed.</li> <li>At 7:21 a.m. R18 re wheelchair in her reenter R18's room.</li> <li>At 7:38 a.m. the call by R18's roommate the room to assist F housekeeping staff made R18's bed with the wheelchair. At 7 staff member whee R18 remained with was in a chin to che staff wheeled R18 tand placed a clothin At that time R18 co clothing protector.</li> <li>At 7:56 a.m. R18 remained with was remained with remained with remained with remained with remained with remained with was remained with remained with was remained with was remained with remained remained with remained remained with remained with remained r</li></ul> | municate her needs and was<br>n staff for toileting,<br>s and had a potential risk for<br>ne care plan listed<br>included to assist R18 to turn<br>by 2 hours and prn, keep skin | F                 | 314 |   |          |   |

|                          |  | AND HUMAN SERVICES   |                     |   |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |   | E CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299   | B. WING _           |   |  | 10/;      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                     |   | TREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER  |  |                     |   | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG |   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 314                    | (DA)brought R18 he<br>plate on the table in<br>At that time nursing<br>R18, verbally promp<br>handed her a spoor<br>breakfast foods ind<br>seated in the wheel<br>At 8:46 a.m. R18 re<br>wheelchair at the di<br>attempt to leave the<br>At 9:01 a.m. R18 re<br>wheelchair in the di<br>attempts to leave the<br>At 9:18 a.m. R18 re<br>wheelchair in the di<br>eyes. Shortly after F<br>in a chin to chest po<br>assist R18 with repo<br>At 9:30 a.m. R18 re<br>wheelchair in the di<br>eyes, Shortly after F<br>in a chin to chest po<br>assist R18 with repo<br>At 9:30 a.m. R18 re<br>wheelchair in the di<br>her eyes, looked ar<br>protector and cover<br>attempt to move aw<br>face covered with th<br>At 9:37 a.m. NA-D<br>R18 and offered he<br>the clothing protect<br>NA-D to assist her i<br>50% of her juice. N<br>glass of water and i<br>water. NA-D left R1<br>and left the dining r<br>to offer R18 assista | er breakfast plate, left the<br>front of her and walked away.<br>assistant (NA)-G approached<br>pted her to begin eating and<br>n. R18 ate 100% of her<br>ependently. R18 remained<br>lchair at the table.<br>emained seated in her<br>ining room table, and made no<br>table.<br>emained seated in her<br>ning room, having made no<br>ne table.<br>emained seated in her<br>ning room. R18 closed her<br>R18's head dropped forwards<br>osition. No staff offered to | F 31                | 4 |  |           |                                     |

If continuation sheet Page 116 of 184

|                          |  | I AND HUMAN SERVICES<br>E & MEDICAID SERVICES   |                    |     |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|--------------------|-----|--|-----------|-------------------------------------|
| STATEMENT                | T OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | E CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING            |     |  | 10/:      | 24/2016                             |
| NAME OF !                | PROVIDER OR SUPPLIER   |   | <u>.</u>           | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER  |   |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 314                    | Continued From pa  | ige 116   | F 3                | 314 |  |           |                                     |
|                          | At 9:42 a.m. medica<br>R18 and assisted h<br>fluids, while R18 re<br>wheelchair. MR ren<br>from R18's neck, R<br>covered her face w<br>At 9:50 a.m. MR as<br>room in her wheelc<br>and handed R18 a<br>call light to R18's w<br>MR was not observ<br>with any cares, incl<br>At 10:01 a.m. NA-D<br>R18's room, did not<br>At 10:09 a.m. NA-E<br>from R18's room, lo<br>walked away.<br>At 10:39 a.m. the A<br>(ADON) was notifie<br>her wheelchair for a<br>minutes. At that tim<br>required assistance<br>checking and chang<br>time, the ADON con<br>skin breakdown. AD<br>requesting assistant<br>At 10:39 a.m. NA-E<br>asked R18 to use th<br>gait belt around R1<br>assisted R18 to sta<br>ambulate to the bat<br>slacks and incontin | al records (MR) approached<br>her to drink her remaining<br>emained seated in her<br>noved the clothing protector<br>818 then took her shirt and<br>with it, in a cradling position.<br>essisted R18 out of the dining<br>chair, brought her to her room<br>stuffed bear. MR attached the<br>wheelchair and left the room.<br>wed to offer R18 assistance<br>luding repositioning or toileting. |                    |     |  |           |                                     |

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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,               |     | E CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING           |     |  | 10/2      | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |   |                   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER   |   |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 314                    | small amount of sto<br>surface which had of<br>pink creases and w<br>peri-rectal area. NA<br>R18 to complete to<br>back in her wheelch<br>On 10/19/16, at 10:<br>thought R18 was la<br>a.m. and stated she<br>others with cares to<br>and toileting needs.<br>supposed to be rep<br>checked/changed e<br>NA-E stated R18 w<br>needs and staff was<br>On 10/20/16, at 2:3<br>needs must be anti-<br>dependent on 2 sta<br>repositioning and to<br>required routine eve<br>toileting. NA-B state<br>red at times, but co<br>areas on R18's butt<br>On 10/20/16, at 3:2<br>(LPN)-B stated R18<br>staff for all of her ne<br>not able to verbalize<br>to anticipate them.<br>for skin breakdown<br>immobility.<br>On 10/21/16, at 1:3<br>interview the ADON<br>unable to routinely for<br>in a timely manner, | <ul> <li>a) a moist surrounding her had deep was moist surrounding her had been too busy helping basisted and been too busy helping basist R18 with repositioning and assisted R18 was positioned and been too busy helping basist R18 with repositioning and basis basis and basis basis</li></ul> | F                 | 314 |  |           |                                     |

Facility ID: 00730

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                   |     |   | FORM     | : 12/15/2016<br>APPROVED<br>: 0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     | PLE CONSTRUCTION  | (X3) DAT | E SURVEY<br>IPLETED                     |
|                          |   | 245299  | B. WING           |     |   | 10/      | 24/2016                                 |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |                   | 5   | STREET ADDRESS, CITY, STATE, ZIP CODE   | •        |   |
| FRAZEE                   | CARE CENTER   |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |          |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) BE     | (X5)<br>COMPLETION<br>DATE              |
| F 314                    | facility were unable<br>Review of facility po<br>Integrity/Wound Ma<br>determined at risk f<br>receive the proper t<br>included specific ph<br>pressure reliving ec<br>per resident assess<br>R66's Admission M<br>dated 1/11/16, ident<br>cognitive impairmen<br>staff for activities of<br>required 2 or more<br>The MDS further ide<br>which included trau<br>disorder and diabet<br>R66 was at risk for<br>required a pressure<br>and bed, and requir<br>program.<br>R66's quarterly Min<br>7/13/16 identified R<br>impairment, and wa<br>activities of daily live<br>more staff to assist<br>further identified R6<br>included traumatic I<br>and diabetes. The N<br>at risk for developin<br>pressure reducing o<br>and required a turnit<br>R66's Care Area As | ere were times when the<br>to fill holes in the schedule.<br>blicy, Pressure Ulcer/Skin<br>anagement identified residents<br>or loss of skin integrity would<br>creatment/services which<br>hysician ordered treatments,<br>quipment, and repositioning | F                 | 314 |   |          |   |
|                          | brain injury, had a c   | be suffered from a traumatic<br>decreased ability to make<br>and had an inability to  |                   |     |   |          |   |

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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     | E CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299   | B. WING           |     |  | 10/2      | 24/2016                             |
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| FRAZEE                   | CARE CENTER   |  |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |           |                                     |
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| F 314                    | perform ADLs withous staff. The CAA further isk for developing prinability to move he was uncomfortable, her needs and ensue CAA further identified mattress and whee regular schedule of prevent pressure.<br>R66's care plan data at risk for developing fragile skin, not bein immobile and was to plan also identified the bed or wear shee feet, and was to be according to her tur care plan further idea and was to be check hours.<br>Review of the Aide 10/17/16, identified with cares, was to be every 2 hours, and or wear sheepskin like to be floated off the Review of physiciar R66's heels were not show the state of the sheet of the sheet off the sheet | but significant assistance from<br>her identified R66 was at high<br>pressure ulcers related to her<br>rself or ask for help when she<br>, and staff were to anticipate<br>ure she was repositioned. The<br>ed R66 required a special<br>lchair cushion, and required a<br>turning and repositioning to<br>red 2/18/16, identified R66 was<br>be pressure ulcers related to<br>ng able to turn herself, was<br>bed and chair bound. The care<br>R66 was to suspend heels off<br>eepskin boots to protect her<br>turned and repositioned<br>ming and positioning plan. The<br>entified R66 was incontinent<br>ked and changed every 2<br>Care Plan, Group B, dated<br>R66 required total assistance<br>be turned and repositioned<br>was to float heels off the bed<br>boots.<br>an note dated 12/31/15,<br>heel was at risk for<br>e ulcers, Eucerin cream was<br>els twice a day and heels were | F                 | 314 |  |           |                                     |

|                          |   | AND HUMAN SERVICES  |                   |     |  | FORM     | : 12/15/2016<br>APPROVED<br>. 0938-0391 |
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|                          |   | 245299  | B. WING           | i   |  | 10/      | 24/2016                                 |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                   | 9   | STREET ADDRESS, CITY, STATE, ZIP CODE  | •        |   |
| FRAZEE                   | CARE CENTER   |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |          |   |
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| F 314                    | 10/5/16, identified F<br>heels off of her bed<br>alteration in skin int<br>R66's comprehensi<br>1/4/16, identified R6<br>admission and had<br>precaution.<br>R66's Braden Scale<br>pressure sores) dat<br>at high risk for deve<br>document also ider<br>mattress, heels wer<br>R66 continued to no<br>had special cushior<br>R66 had a history of<br>R66's tissue tolerar<br>resident could be in<br>skin damage) dated<br>required 2 hour rep<br>ulcers.<br>R66's progress not<br>10/17/16 identified:<br>2/3/16, R66 had a 2<br>right shin and ankle<br>PROFO boot, staff<br>heels. R66's wheeld<br>relief pedals.<br>2/4/16, R66 had an<br>ankle<br>2/6/16, Family expr | R66 had orders to suspend her<br>levery shift for preventing<br>regrity.<br>ive analysis of skin dated<br>66 had pink heels on<br>been free floated for<br>e (assessment for predicting<br>ted 7/13/16, identified R66 was<br>eloping pressure ulcers. The<br>ntified R66 had a special<br>re to be kept off the bed and<br>eed to be repositioned and<br>n in her wheelchair because<br>of pressure ulcers.<br>nce test (length of time<br>n the same position without<br>d 7/13/16, identified R66<br>ositiong to prevent pressure<br>es reviewed from 12/31/15 to<br>2 cm X 0.5 cm area on her<br>e from possible rubbing on<br>removed boot and floated her<br>chair had built-in pressure<br>intact blister on her right<br>essed concern with R66's right<br>ned areas were from boot and | F                 | 314 |  |          |   |

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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     |   | (X3) DAT | E SURVEY<br>IPLETED        |
|                          |   | 245299  | B. WING            |     |   | 10/:     | 24/2016                    |
| NAME OF F                | PROVIDER OR SUPPLIER  |   | •                  | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   | -        |                            |
| FRAZEE                   | CARE CENTER   |   |                    |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |          |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | х   | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) BE     | (X5)<br>COMPLETION<br>DATE |
| F 314                    | Continued From pa   | ge 121  | F3                 | 814 |   |          |                            |
|                          | 2/8/16, R66's areas resolving   | to right skin and ankle were  |                    |     |   |          |                            |
|                          | area on her shin fro<br>her inner ankle fron  | perficial, abraded/scraped<br>om profo boot and a blister to<br>n being up in her wheelchair<br>suspected foot rubbed on foot   |                    |     |   |          |                            |
|                          | 2/10/16, blister hea  | ling, heels free floated  |                    |     |   |          |                            |
|                          | 2/13/16, areas to rig<br>resolved.  | ght foot/ankle and right shin   |                    |     |   |          |                            |
|                          | dark, and her door<br>dressed in a hospita<br>her back in bed. Re<br>and her body was o<br>legs were straight, a<br>on her mattress. Sh<br>boots. R66's sheep<br>be piled up on R66'<br>7:19 a.m. R66 was<br>bed, her eyes were<br>loud mouth breathin<br>the mattress and wa<br>boots. At 7:39 a.m.<br>in her bed with her | 00 a.m. R66's bedroom was<br>was fully open. R66 was<br>al gown, and was asleep on<br>66's arms rested on her chest<br>covered with a blanket. R66's<br>and her heels rested directly<br>he was not wearing sheep skin<br>skin boots were observed to<br>'s dresser across the room. At<br>in the same position in her<br>now open, continued with<br>ng and heels rested directly on<br>as not wearing her sheep skin<br>R66 was in the same position<br>eyes closed. R66's heels<br>ectly on her bed and was not<br>skin boots. |                    |     |   |          |                            |
|                          | entered R66's room<br>were not free floate<br>sheep skin boots. I<br>heels were, "kind of   | ed practical nurse (LPN)-A<br>n. LPN-A stated R66's heels<br>d and she was not wearing<br>LPN-A stated she felt R66's<br>f," floated by the bubbles in<br>A then pulled a flat pillow down  |                    |     |   |          |                            |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                   |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|-------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,               |     | LE CONSTRUCTION   | (X3) DATI | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING           |     |   | 10/       | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER  |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                                     |
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| F 314                    | to approximately on<br>however it did not li<br>LPN-A laid R66's he<br>immediately left the<br>At 8:03 a.m. the reg<br>walked in to R66's n<br>out, towards the nu<br>remained in the sar<br>asleep. R66 remain<br>heels floated, or sh<br>a.m.<br>At 10:03 a.m. LPN-<br>developing pressure<br>think R66 had press<br>stated R66 sometin<br>and sometimes the<br>bed. LPN-A stated I<br>pressure mattress a<br>repositioned and ch<br>hours. LPN-A confir<br>been repositioned v<br>that morning. At 10<br>observation (3 hour<br>confirmed both R66<br>and R66 had not we<br>heels and bottom w<br>R66's room and as<br>morning cares.<br>At 10:33 a.m. NA-E<br>last time R66 was r<br>was supposed to b<br>checked and chang<br>she would have to o<br>see when she reposi- | ie inch under R66's calves<br>ft R66's heels off the mattress.<br>eels directly on the bed, and | F                 | 314 |   |           |                                     |

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|                          |  | 245299   | B. WING             |  | 10/2     | 24/2016                             |
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| FRAZEE                   | CARE CENTER  |  |                     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |          |                                     |
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| F 314                    | ulcers, but she didn<br>problems. NA-E sta<br>bed because R66 h<br>and had an air bed.<br>didn't wear her shee<br>her current care she<br>sheepskin boots. N<br>room after R66 was<br>floated by a pillow of<br>On 10/19/16, at 10:<br>didn't know if R66 w<br>pressure ulcers, or<br>her to do for R66's<br>special mattress, ar<br>would be at risk. NA<br>R66 had a history o<br>aware of any sheep<br>stated she did not r<br>and stated she thou<br>been repositioned w<br>by the night staff.<br>On 10/19/16, at 12:<br>recliner in front of h<br>heels floated on a p<br>sheep skin boots. F<br>the foot rest of her n<br>On 10/19/16, at 1:0<br>interview NA-E stat<br>on staff for cares, a<br>tell what R66's cogr | <ul> <li><sup>1</sup>t think R66 had any skin<br/>ted R66 heels could be on the<br/>had no breakdown at this time<br/>NA-E further stated R66<br/>ep skin boots. NA-E confirmed<br/>eet did not direct the use of<br/>A-E and LPN-A left R66's<br/>in her recliner with her heels<br/>on the footrest of the recliner.</li> <li>40 a.m. NA-D stated she<br/>vas at risk for developing<br/>what R66's care plan directed<br/>skin. She stated R66 had a<br/>nd stated she assumed R66<br/>A-D stated she didn't know if<br/>f pressure ulcers and wasn't<br/>o skin boots for R66. NA-D<br/>eposition R66 this morning,<br/>ught the last time R66 had<br/>vas at approximately 630 a.m.</li> <li>10 p.m. R66 was seated in<br/>er TV. R66 did not have her<br/>billow and was not wearing her<br/>R66's heels rested directly on</li> </ul> | F 314               | 4  |          |                                     |

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|                          |   | I AND HUMAN SERVICES<br>E & MEDICAID SERVICES  |                    |     |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|--------------------|-----|--|-----------|-------------------------------------|
| STATEMENT                | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                |     | E CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299   | B. WING            |     |  | 10/:      | 24/2016                             |
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| F 314                    | On 10/19/16, at 1:1<br>back, legs straight of<br>directly on her bed.<br>floated with a pillow<br>skin boots.<br>On 10/19/16, at 1:1<br>interview, LPN-A sta<br>dependent on staff<br>R66 was clearer so<br>stated she thought<br>she was clearer.<br>On 10/19/16, at 1:3<br>totally dependent of<br>she didn't think R66<br>ulcers, and didn't kr<br>ulcers in the past. N<br>rested directly on he<br>wearing sheepskin<br>Aide Care Sheet an<br>had sheepskin boot<br>sheet, but R66's he<br>and R66 was suppor<br>2 hours.<br>On 10/24/16, at 10:<br>(RN)-A stated R66<br>impairment and was<br>cares. She stated F<br>pressure ulcers bed<br>had ever had any si<br>R66's heels were si<br>her bed, and the NA<br>R66 every 2 hours. | 11 p.m. R66 laid in bed on her<br>out with her heels resting<br>. R66 did not have her heels<br>w, and was not wearing sheep<br>16 p.m. during follow up<br>tated R66 was totally<br>for cares, and stated she felt<br>ome day's versus others and<br>R66 understood them when<br>84 p.m. NA-B stated R66 was<br>in staff for cares, and stated<br>R66's cognition. She stated<br>6 was at risk for pressure<br>now if R66 had pressure<br>NA-B confirmed R66's heels<br>her bed and she was not<br>boots. NA-B confirmed R66's<br>and stated she didn't know R66<br>its as they weren't on her<br>eels were supposed to floated<br>osed to be repositioned every<br>:38 a.m. registered nurse<br>had severe cognitive<br>is totally dependent on staff for<br>R66 was at risk for developing<br>cause she couldn't reposition<br>she didn't remember if R66<br>skin problems. She stated<br>supposed to be floated off of<br>A's were supposed reposition | F 3                | ;14 |  |           |                                     |

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|--------------------------|---|---|--------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | · /                |     |   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING            |     |   | 10/;      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |                    | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER   |   |                    |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE          |
| F 314                    | stated R66 had sev<br>was dependent on a<br>was supposed to be<br>her heels were supp<br>bed, or R66 was to<br>had a history of pre<br>remembered R66 had<br>remembered R66 had fev<br>and that's when the<br>implemented floatin<br>confirmed R66's mod<br>directed staff to floa<br>wear sheep skin bo<br>R66 every 2 hours.<br>to follow R66's care<br>apply sheep skin bo<br>reposition R66 ever<br>ulcers. She stated s<br>needed more educa<br>floating of heels.<br>On 10/24/16, at 1:4<br>(NP)-A confirmed R<br>pressure ulcers on<br>physician's order to<br>12/31/15. NP-A com<br>physician's or nursii<br>boots.<br>On 10/25/16, at 5:0<br>stated R66 had dev<br>shin, and about a q<br>of her ankle on her<br>facility. She stated th<br>boot rubbing on her<br>tight. She stated sh<br>R66 didn't move her | rere cognitive impairment and<br>staff for cares. She stated R66<br>e repositioned every 2 hours,<br>posed to be floated off of her<br>wear sheepskin boots. R66<br>ssure ulcers. She stated she<br>had a blister on her heel in<br>ofo boot or splint she wore,<br>ey discontinued the boot and<br>ng R66's heels. UM-A<br>ost recent care plan which<br>at R66's heels off the bed or<br>oots, and turn and reposition<br>She stated she expected staff<br>e plan and float her heels or<br>oots to R66's feet, and<br>ry 2 hours to prevent pressure<br>she felt nursing assistants<br>ation on repositioning and<br>5 p.m. nurse practitioner<br>R66's left heel was at risk for<br>admission, and there was a<br>float R66's heels since<br>offirmed there was not a<br>ng order to use the sheepskin<br>5 p.m. family member (FM)-A<br>arely move her arms now. She<br>reloped a deep ulcer on her<br>uarter size blister on the inside<br>right foot after she got to the<br>they told her it was from her<br>r skin, and the boot was too<br>e questioned them because<br>er legs and feet enough to<br>stated no staff went into | F3                 | 314 |   |           |                                     |

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    | TIPLE CONSTRUCTION  |  | E SURVEY<br>PLETED        |
|--------------------------|---|---|--------------------|---|--|---------------------------|
|                          |   | 245299  | B. WING            |   | 10/  | 24/2016                   |
| NAME OF I                | PROVIDER OR SUPPLIER  |   | l T                | STREET ADDRESS, CITY, STATE, 1  |  | 24/2010                   |
| RAZEE                    | CARE CENTER   |   |                    | 219 WEST MAPLE AVENUE, PO<br>FRAZEE, MN 56544   | ) BOX 96   |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | PROVIDER'S PLAN OF<br>X (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN  | TION SHOULD BE<br>THE APPROPRIATE  | (X5)<br>COMPLETIC<br>DATE |
| F 314<br>F 318<br>SS=G   | Review of facility po<br>Integrity/Wound Ma<br>determined at risk f<br>receive the proper t<br>included specific ph<br>pressure reliving ec<br>per resident assess<br>483.25(e)(2) INCRE<br>IN RANGE OF MO<br>Based on the comp<br>resident, the facility<br>with a limited range<br>appropriate treatme    | blicy, Pressure Ulcer/Skin<br>anagement identified residents<br>or loss of skin integrity would<br>creatment/services which<br>hysician ordered treatments,<br>quipment, and repositioning<br>sment.<br>EASE/PREVENT DECREASE<br>TION<br>orehensive assessment of a<br>must ensure that a resident<br>of motion receives<br>ent and services to increase<br>d/or to prevent further       | F 3                |   |  | 12/14/16                  |
|                          | by:<br>Based on observat<br>review the facility fa<br>motion (ROM) servi<br>prevent further decl<br>extremities for 1 of<br>ROM. This deficient<br>harm for R66.<br>Findings include:<br>R66's quarterly Min<br>7/13/16, identified F<br>included traumatic I<br>and diabetes. The N<br>severe cognitive im | NT is not met as evidenced<br>ion, interview and document<br>iled to provide range of<br>ices and hand splints to<br>line in ROM for upper<br>4 residents (R66) reviewed for<br>t practice resulted in actual<br>imum Data Set (MDS) dated<br>R66 had diagnoses which<br>brain injury, seizure disorder<br>MDS identified R66 had<br>pairment, and was totally<br>for assistance with all |                    | <ul> <li>F 318 Increase/Preventation</li> <li>Resumption of restorative performing upper extreme splinting. Residents AD reviewed quarterly with therapy as appropriate. Restorative Nursing PIF established and will be a beginning November 17 include representatives therapy.</li> <li>All residents have the affected in this area. A coded on the MDS as here.</li> </ul> | ed by therapy with<br>e nursing staff<br>nity ROM and<br>L scores will be<br>referrals to<br>Facility<br>team has been<br>meeting monthly<br>(, 2016; team will<br>from Nursing and<br>he potential to be<br>list of residents |                           |

Facility ID: 00730

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245299 **B** WING 10/24/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE CARE CENTER FRAZEE, MN 56544 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 318 Continued From page 127 F 318 activities of daily living (ADLs). R66's MDS ROM has been generated and all current identified R66 had functional limitations in range residents will be reviewed and receive of motion on both sides, upper and lower adequate assistance with ROM and extremities, and did not receive therapy services splinting restorative nursing programs. or restorative nursing services. R66's annual MDS dated 1/11/16, identified R66 3. Mandatory nursing staff education had severe cognitive impairment, and was totally was provided on November 16 and 17, dependent on staff for assistance with all ADLs. 2016 on the procedure titled. Restorative The MDS identified R66 had functional limitations Nursing ROM Program with a focus on on both sides, upper and lower extremities, and the requirement to prevent avoidable did not receive therapy services or restorative decline of residents in ADLS/ROM. nursing services. 4. An observation and chart audit was developed to monitor identification of R66's Care Area Assessment (CAA) dated 1/11/16, identified R66 was dependent on staff for ROM/ADL score decline and appropriate all ADLs related to traumatic brain injury over the therapy referrals; restorative nursing care last year, and had difficulty with mobility, plan and documentation accuracy, communication and cognition. monthly review and documentation of restorative programs by licensed nurse R66's care plan dated 2/18/16, identified R66 was and MDSs accuracy of section O on the aphasic (non verbal) due to traumatic brain injury. MDS. The audit will be completed by the and was unable to make her needs known. R66's DON or designee weekly X 4 weeks, then care plan also identified R66 was to wear hand monthly X 2 months. Audit findings will be splints for 2 hours on and 2 hours off during the provided monthly x 3 months to the QA committee with follow-up to committee day, and was to wear the splints all night. R66's care plan failed to identify R66 had contractures, recommendations. and did not identify a ROM or a restorative nursing program for R66 to prevent further 5. Deficient practice will be corrected by decline. December 14, 2016 Review of the Aide Care Plan, Group B dated 10/17/16, identified R66 required total assistance with cares and was to wear hand splints on and off every 2 hours during the day and leave them on all night. The Aide Care Plan did not identify R66 had contractures or that she required a ROM or restorative nursing program to prevent further decline.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/15/2016

|                          |  | AND HUMAN SERVICES  |                    |     |   | FORM      | APPROVED<br>0938-0391      |
|--------------------------|--|---|--------------------|-----|---|-----------|----------------------------|
| STATEMENT                | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | · · /              |     | LE CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED         |
|                          |  | 245299  | B. WING            |     |   | 10/;      | 24/2016                    |
| NAME OF F                | PROVIDER OR SUPPLIER   |   | <u> </u>           |     | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                            |
| FRAZEE                   | CARE CENTER  |   |                    |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                            |
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| F 318                    | Continued From pa  | ge 128  | F3                 | 818 |   |           |                            |
|                          | 12/31/15, indicated<br>non-weight bearing<br>mechanical lift, and<br>R66's Admission As<br>R66's hand grasps<br>Review of R66's Re<br>Interdepartmental O<br>1/12/16, identified of<br>complete R66's pas<br>to both upper extrem<br>(AROM) to left hand<br>have R66 open and<br>R66 squeeze staff's<br>to maintain strength<br>Review of a second<br>therapy dated 2/18/<br>splint wearing sche<br>2 hours on, 2 hours<br>at night.<br>R66's progress note<br>10/17/16 identified:<br>-1/3/16, R66 reacher<br>remote with her left<br>remote in her left ha<br>-1/21/16, R66 was or<br>remote.<br>R66's progress note<br>documentation rega | had elbow contractures.<br>ssessment form indicated<br>had not been assessed.<br>esident Referral<br>Communication form dated<br>directions for nursing to<br>ssive range of motion (PROM)<br>mities, active range of motion<br>d, and included instruction to<br>d close fingers and to have<br>s hand with her left hand daily<br>n.<br>d Resident Referral from<br>(16, identified R66's hand<br>dule as for R66 to wear splints<br>s off throughout the day and on<br>es reviewed from 1/3/16 to<br>ed over and grabbed the TV<br>c hand and could hold her TV<br>and.<br>changing TV channels with |                    |     |   |           |                            |

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|                          |   | AND HUMAN SERVICES   |                     |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
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|                          |   | 245299   | B. WING             |  | 10/:      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  | -         |                                     |
| FRAZEE                   | CARE CENTER   |  |                     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |           |                                     |
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| F 318                    | Continued From pa   | uge 129  | F 318               |  |           |                                     |
|                          | upper extremity mo<br>function.   | tion, exercises, or decline in   |                     |  |           |                                     |
|                          | Review of R66's ph<br>2/9/16 to 10/16/16 i  | nysician progress notes from identified:   |                     |  |           |                                     |
|                          | injury in 12/14, had<br>care facility, but fan<br>closer to their home<br>communicate verba<br>did not communica<br>push her call light b   | R66 suffered a traumatic brain<br>been in a former long term<br>nily had requested a transfer<br>e. R66's could not<br>ally. Nursing had reported R66<br>te verbally but was able to<br>button and could change the<br>with her TV remote.               |                     |  |           |                                     |
|                          | which involved the physician would ma   | R66 still had some movement<br>left upper extremity, and the<br>ake sure therapy had a<br>len from a contracture and<br>point for R66.   |                     |  |           |                                     |
|                          | -10/6/16, identified with left hand.  | R66 could squeeze his fingers  |                     |  |           |                                     |
|                          | On 10/19/16, obser<br>a.m. were conducte  | rvations from 7:00 a.m. to 9:47<br>ed:   |                     |  |           |                                     |
|                          | back in bed, with he<br>arms were bent at t<br>in a fist position on<br>was in a "C" shaped<br>and hand slightly til<br>devices were not of<br>hands, and the split<br>in her room. | was observed lying on her<br>er eyes closed. Both R66's<br>the elbow, her right hand was<br>her chest, and her left hand<br>d position with fingers bent<br>ted away from her body. Splint<br>bserved on either of R66's<br>nt devices were not observed |                     |  |           |                                     |
| 1                        | -7:49 a.m. licensed   | practical nurse (LPN)-A  |                     |  | 1         |                                     |

|                          |  | AND HUMAN SERVICES  |                   |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
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|                          |  | 245299  | B. WING           | i   |   | 10/;      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                   | 5   | STREET ADDRESS, CITY, STATE, ZIP CODE   | -         |                                     |
| FRAZEE                   | CARE CENTER  |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                                     |
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| F 318                    | entered R66's room<br>(artificial opening at<br>confirmed R66 was<br>stated R66 had not<br>recent past because<br>uncomfortable for F<br>and did not apply R<br>-8:03 a.m. the nurs<br>room and immediat<br>station. R66 remain<br>her hands and arms<br>splints observed.<br>-8:20 a.m. R66 rem<br>same position with<br>and her hands reste<br>position. No hand s<br>hands and splints w<br>room.<br>-9:47 a.m. R66 rem<br>bed, no hand splints<br>present in R66's roo<br>On 10/19/16, at 10:<br>had not worn hand<br>wear the splints "at<br>aware when R66 la<br>indicated she thoug<br>past. LPN-A left roo<br>splints to R66.<br>On 10/19/16, at 10:<br>(NA)-E confirmed F<br>hand splints, and st<br>the last time R66 has<br>provided a copy of the second<br>content of the second second second second<br>provided a copy of the second second second second<br>cond second second second second second second second second<br>provided a copy of the second secon | n to provide her trachea<br>t windpipe) site care. She<br>a not wearing hand splints and<br>been wearing them in the<br>e she thought the splints were<br>R66. LPN-A exited R66's room<br>66's hand splints.<br>See consultant walked in R66's<br>tely walked down to the nurses<br>hed on her back in bed, with<br>s in the same positron, no<br>nained lying in bed in the<br>R66's arms bent at her elbows<br>ed on her chest in the same<br>plints were observed on R66's<br>were not observed in R66's | F                 | 318 | 3   |           |                                     |

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|                          |   | I AND HUMAN SERVICES<br>E & MEDICAID SERVICES  |                   |     |   | FORM   | 12/15/2016<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     |   | (X3) DATE                                    | E SURVEY<br>IPLETED                 |
|                          |   | 245299   | B. WING           | i   |   | 10/;   | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  | <u>,                                    </u> |                                     |
| FRAZEE                   | CARE CENTER   |  |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |  |                                     |
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| F 318                    | wear hand splints. S<br>aware R66 was to w<br>LPN-A exited R66's<br>hand splints.<br>On 10/19/16, at 10:<br>not aware of how R<br>care for R66. She s<br>R66 had hand splin<br>wear them.<br>On 10/19/16, at 12:<br>her recliner in her re<br>on her chest, right R<br>a "C" shape. R66 d<br>either hand.<br>On 10/20/16, at 9:3<br>interview, NA-B sta<br>receive range of mo<br>not receiving a rest<br>On 10/20/2016, at 9<br>interview, NA-D sta<br>her hands and was<br>stiffness had gotter<br>not aware if R66 wa<br>received range of m<br>reviewed the therap<br>assistant reference<br>and stated she felt<br>not current, and R6<br>motion services and<br>since the screen wa | age 131<br>She stated she had not been<br>wear hand splints. NA-A and<br>s room and did not apply her<br>:40 a.m. NA-D stated she was<br>R66's care plan directed her to<br>stated she was not aware if<br>nts or if R66 was supposed to<br>:10 p.m. R66 was seated in<br>com with both hands resting<br>hand in fist, left hand curled in<br>lid not have hand splints on<br>30 a.m., during follow up<br>tted R66 presently did not<br>otion services or presently was<br>torative nursing program.<br>9:36 a.m., during follow up<br>ated R66 did not routinely use<br>a not aware if R66's hand<br>n worse. She stated she was<br>as on a restorative program or<br>notion services. NA-D<br>py referral in the nursing<br>e book at the nursing station<br>R66's therapy screening was<br>56 did not need range of<br>d did not need to wear splints<br>as old (February 2016) She<br>e R66 got enough range of | F                 | 318 |   |  |                                     |
|                          |   | 15 a.m. assistant director of<br>was not aware if R66's splints  |                   |     |   |  |                                     |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                   |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
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|                          |   | 245299   | B. WING           |     |   | 10/       | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   | -         |                                     |
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| F 318                    | had been discontinues<br>she questioned if the<br>indicated she felt R<br>contracted than whe<br>On 10/20/16, at 10:<br>(OT)-A stated R66 I<br>time of admission, a<br>aware if R66 had con-<br>confirmed R66's the<br>2/18/16, and indicat<br>2/18/16, was complet<br>the style of splint for<br>stated a comprehen-<br>contractures had not<br>the facility did not h<br>consult. She stated<br>baseline for her cor-<br>not include measures<br>stated the ROM and<br>recommended for F<br>contracture and dis<br>OT-A stated the face<br>providing ROM serve<br>applying R66's splint<br>had a book of recor-<br>programs at the num-<br>was unable to move<br>independently. She<br>fingers were tighter<br>was slightly limited,<br>limitations were with<br>she felt R66's hand<br>high tone. She confi<br>splints were recomm-<br>high tone. She states<br>wear the splints all | ued in the past and indicated<br>le splints bothered R66 and<br>66 was not anymore<br>en she was admitted.<br>03 a.m. occupational therapist<br>had worn hand splints at the<br>and indicated she was not<br>ontractures on admission. She<br>erapy screens on 1/12/16 and<br>ted the therapy screen on<br>leted after the facility changed<br>r R66 per family request. She<br>nsive assessment of R66's<br>of been completed because<br>ave a physician order for a<br>she was not aware of R66's<br>ntractures as the screen did<br>ements of limitations and | F                 | 318 |   |           |                                     |

Facility ID: 00730

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|                          |   | AND HUMAN SERVICES   |                   |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
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|                          |   | 245299   | B. WING           | i   |   | 10/2      | 24/2016                             |
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| FRAZEE                   | CARE CENTER   |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 318                    | 12/31/15, and shou<br>services since 1/12.<br>At approximately 10<br>room and OT-A ask<br>splints. NA-B looked<br>locations and found<br>underneath blanket<br>R66 should have be<br>according to the scl<br>functional decline. N<br>the hand splints in a<br>sure why R66 had r<br>On 10/20/16, at 10:<br>R66's care plan did<br>program or ROM th<br>confirmed R66's ca<br>services were not o<br>R66 had never used<br>R66's ROM, "Was<br>On 10/20/16, at 10:<br>therapy assistant (0<br>stated their usual pl<br>ROM program for re<br>therapy screen and<br>recommended ROM<br>manager (CM.) She<br>the plan she was ep<br>program with NAs a<br>ADL Worksheet," in<br>ROM provided. Sh<br>documentation that<br>for R66 in her medi<br>She confirmed R66<br>services since 1/12. | Ald have received ROM<br>2/16.<br>0:10 a.m., NA-B entered R66's<br>ked her to locate R66's hand<br>id in R66's bedroom in various<br>d them on R66's wheelchair<br>ts and equipment. OT-A stated<br>een wearing her hand splints<br>hedule to prevent further<br>NA-B stated R66 had not worn<br>awhile, and stated she was not<br>not been wearing them.<br>35 a.m. LPN-A stated she felt<br>I not include a restorative<br>hat she knew of. She<br>are plan and stated that ROM<br>on R66's care plan. She stated<br>d hand splints, and she felt<br>about the same."<br>37 a.m. certified occupational<br>COTA)<br>rocess for implementing a<br>residents was to complete a | F                 | 318 | 3   |           |                                     |

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|                          |   | AND HUMAN SERVICES  |                   |     |   | FORM     | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|-------------------|-----|---|----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,               |     | LE CONSTRUCTION   | (X3) DAT | E SURVEY<br>PLETED                  |
|                          |   | 245299  | B. WING           |     |   | 10/2     | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |   |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   |          |                                     |
| FRAZEE                   | CARE CENTER   |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE     | (X5)<br>COMPLETION<br>DATE          |
| F 318                    | On 10/20/16, at 10:<br>R66's stiffness had<br>were more stiff now<br>was more stiff wher<br>they really had to m<br>put her shirts on.<br>On 10/20/16, at 11:<br>elbow ROM while F<br>physically picked up<br>manipulated both a<br>right elbow lacked 2<br>R66 was a little tigh<br>movements, and co<br>with movement. Sh<br>pain and grimaced<br>and R66's left elbow<br>extension.<br>On 10/20/2016 at 1<br>sometimes R66 wa<br>extremities, and sta<br>more depending on<br>her.<br>On 10/21/16, at 10:<br>totally dependent of<br>stated she was uns<br>program , but states<br>stated she knew R6<br>than her left arm. S<br>wearing hand splint<br>stated she had new<br>splints until today.<br>On 10/21/16, at 2:1<br>her back in bed with<br>right hand in a fist, | age 134<br>40 a.m. NA-B stated she felt<br>gotten worse and her arms<br>7. She stated she noticed R66<br>in they dressed her, and stated<br>hanipulate her arms when they<br>45 a.m. OT evaluated R66's<br>866 was awake in her bed. OT<br>50 R66's right arm and after she<br>rms, she confirmed R66's<br>25% extension. She confirmed<br>at with initial right side<br>52% extension. She confirmed<br>at with initial right side<br>52% extension. She confirmed<br>at with initial right side<br>52% extension. She confirmed<br>at with movement of her left arm,<br>70 lacked about 10% for<br>2:00 p.m. NA-D stated<br>s a little more stiff in her upper<br>aff had to manipulate her arms<br>in the shirt they were putting on<br>4:14 a.m. NA-A stated R66 was<br>in staff for all of her cares. She<br>sure if R66 was on a ROM<br>d she felt R66 should be. She<br>56's right arm was more stiff<br>he stated R66 just started<br>ts to both hands today and<br>er seen R66 wear see hand<br>6 p.m. R66 was observed on<br>h both arms resting on chest,<br>left hand in a "C" shape. No<br>red on either of R66's hands. A | F                 | 318 |   |          |                                     |

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|                          |  | AND HUMAN SERVICES  |                   |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     | LE CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING           |     |   | 10/:      | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER  |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                                     |
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| F 318                    | 8.5 X 11" white pie<br>instructions and har<br>was observed poste<br>across from her rec<br>show preferences.<br>On 10/21/16, at 2:5<br>pathologist (SLP) si<br>with R66 on commu<br>assessed her ability<br>in the past. SLP rep<br>assessment of R66<br>SLP held "Yes and<br>chest. SLP instructe<br>answered her ques<br>motion hand toward<br>use her eyes to lood<br>questions. R66 was<br>assessment at all. I<br>ended assessment<br>success today, whe<br>60% of her question<br>On 10/24/16, at 9:5<br>she was not aware<br>and stated she did<br>TV remote or use it<br>On 10/24/16, at 10:<br>might be able to us<br>you put them in her<br>On 10/24/16, at 10:<br>(RN-A) stated R66<br>impairment and wa<br>all cares. She state<br>on a ROM program<br>today, or had declin | ce of paper with both typed<br>nd-written notes, dated 8/3/16,<br>ed on R66's bedroom wall<br>cliner and identified R66's TV<br>5 p.m. speech language<br>tated she had been working<br>unication techniques and<br>y to use her hands and elbows<br>beated her functional<br>5. R66 was reclined in bed and<br>No" flash cards above R66's<br>ed R66 to point at the card that<br>tions. R66 unable to point or<br>d cards. SLP instructed R66 to<br>k at either card to answer her<br>s unable to participate in the<br>R66 began crying and SLP<br>. SLP confirmed R66 had 0%<br>ere R66 responded correctly to<br>ns during a past assessment.<br>0 a.m. NA-B stated at present,<br>if R66 could use her call light ,<br>not know if R66 could hold a | F                 | 318 |   |           |                                     |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                   |     |  | FORM     | : 12/15/2016<br>APPROVED<br>: 0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,               |     | PLE CONSTRUCTION   | (X3) DAT | E SURVEY<br>IPLETED                     |
|                          |   | 245299  | B. WING           | i   |  | 10/      | 24/2016                                 |
| NAME OF I                | PROVIDER OR SUPPLIER  |   | -                 | ę   | STREET ADDRESS, CITY, STATE, ZIP CODE  | -        |   |
| FRAZEE                   | CARE CENTER   |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |          |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) BE     | (X5)<br>COMPLETION<br>DATE              |
| F 318                    | ROM and wore her<br>therapy recommend<br>was not on R66's ca<br>On 10/24/16, at 10:<br>(CM)-A stated R66<br>impairment, and wa<br>cares. She indicate<br>contractures on addr<br>remember where the<br>side of R66's body of<br>remembered talking<br>past about R66's co<br>and stated she told<br>remote in her room<br>CM-A stated R66 w<br>since 1/12/16, and a<br>and off during the d<br>stated she expected<br>according to the scl<br>services from the N<br>no documentation in<br>the NA book that R6<br>services since adm<br>services were not o<br>On 10/24/16, at 12<br>while she was awak<br>COTA picked up R6<br>and put her call ligh<br>adjusted her fingers<br>fingers were very w<br>didn't move and the<br>picked up R66's left<br>call light between R<br>and fingers did not<br>were very weak and | arm splints according to the<br>dations and confirmed ROM<br>are plan.<br>53 a.m. clinical manager<br>had severe cognitive<br>as dependent on staff for<br>d she thought R66 had<br>mission, but stated she did not<br>be contractures were, or which<br>was affected. CM-A stated she<br>g to the physician in the distant<br>ontractures after admission<br>him she saw R66 use her TV<br>ras supposed to get ROM<br>was to wear hand splints on<br>lay, and keep on all night. She<br>d R66 to wear her hand splints<br>hedule and receive ROM<br>IA's. She confirmed there was<br>n R66's medical record or in<br>66 had ever received ROM<br>ission. She confirmed ROM | F                 | 318 | 3  |          |   |

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|                          |   | AND HUMAN SERVICES   |                   |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     | LE CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299   | B. WING           |     |   | 10/:      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   | -         |                                     |
| FRAZEE                   | CARE CENTER   |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE          |
| F 318                    | light. COTA also ex<br>TV remote. COTA a<br>remote in R66's right<br>R66's arm by her ef-<br>the TV remote at al<br>COTA lifted R66's la<br>put the remote betwore<br>remote slipped in R<br>the ceiling. R66 was<br>towards her TV or a<br>left hand and finger<br>R66 declined in her<br>On 10/24/16, at 12:<br>(AD) confirmed action<br>in R66's room at the<br>listed TV shows R6<br>at the time the sign<br>could hold and use<br>channel surf on the<br>shows she liked to<br>On 10/24/16, at 1:4<br>stated she felt if R6<br>remote or call light<br>it was evidence of a<br>stated the failure to<br>not a new concern<br>brought her concern<br>past, but continued<br>in the facility.<br>On 10/25/16, at 5:0<br>stated when R66 fir<br>use her TV remote,<br>call light, and write<br>She stated when R6 | valuated R66 for holding her<br>attempted to place R66's TV<br>ht hand while she supported<br>lbow. R66 was unable to hold<br>I with her right hand or fingers.<br>eft arm up by the elbow and<br>veen R66's left fingers. The TV<br>66's hand and pointed up to<br>s unable to hold the remote<br>activate the remote with her<br>s. She stated she was sure<br>rupper extreme ROM.<br>27 p.m. Activities Director<br>ivity staff had posted a paper<br>e time of admission, which<br>6 like to watch. AD indicated<br>was originally posted, R66<br>the remote, and liked to<br>TV and would stop on the | F                 | 318 |   |           |                                     |

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|                          |   | AND HUMAN SERVICES  |                                       |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |  |  |  |
|--------------------------|---|---|---------------------------------------|-----|---|-----------|-------------------------------------|--|--|--|
| STATEMENT                | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                                   |     | E CONSTRUCTION  | (X3) DATE | E SURVEY<br>PLETED                  |  |  |  |
|                          |   | 245299  | B. WING                               |     |   | 10/;      | 24/2016                             |  |  |  |
| NAME OF                  | PROVIDER OR SUPPLIER  |   | STREET ADDRESS, CITY, STATE, ZIP CODE |     |   |           |                                     |  |  |  |
| FRAZEE                   | CARE CENTER   |   |                                       |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |           |                                     |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG                   |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |  |  |  |
| F 318<br>F 323<br>SS=G   | arms in the arm hol<br>stated R66 could no<br>and indicated she for<br>cried. She stated R<br>affected by her brai<br>visited R66 over the<br>noticed staff were m<br>both hands. and state<br>of been using the h<br>time." FM-A stated<br>any exercises with<br>and stated she didr<br>stated R66 received<br>admission to this fa<br>asked facility staff v<br>exercises and state<br>they felt her brain w<br>them to do that.<br>Review of facility po<br>dated 4/1/08 identif<br>assessed on admis<br>such as ROM. If a F<br>identified need, a p<br>meet resident need<br>identified residents<br>highest level of fund<br>483.25(h) FREE OF<br>HAZARDS/SUPER<br>The facility must en<br>environment remain<br>as is possible; and | les of her night gown. FM-A<br>o longer do any of those things<br>elt R66 was sad and frequently<br>66's right side was most<br>in injury. She stated she had<br>e previous weekend and<br>now putting the hand splints on<br>ated she felt the facility should<br>and splints for R66 " the whole<br>she had never seen staff do<br>R66 for her hands and arms,<br>n't know if they ever had. She<br>d ROM all the time before<br>acility. She stated she had<br>why R66 did not get ROM<br>ed she had been told by staff<br>vas not working enough for<br>blicy, Restorative Program,<br>fied residents would be<br>ssion for a restorative program<br>ROM program was an<br>lan would be individualized to<br>ls and goals. The policy further<br>would be supported and their<br>ctioning maintained.<br>F ACCIDENT | F 3                                   | 318 |   |           | 12/14/16                            |  |  |  |

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|                          |  | & MEDICAID SERVICES  |                    | <b>T</b> 10 |  |   | 0938-039                  |
|--------------------------|--|--|--------------------|-------------|--|---|---------------------------|
|                          | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |             | PLE CONSTRUCTION   |   | E SURVEY<br>PLETED        |
|                          |  | 245299   | B. WING            | i           |  | 10/24/2016  |                           |
| NAME OF I                | PROVIDER OR SUPPLIER   | ·  |                    |             | STREET ADDRESS, CITY, STATE, ZIP CODE  | -   |                           |
| FRAZEE                   | CARE CENTER  |  |                    |             | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |   |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | ) BE  | (X5)<br>COMPLETIO<br>DATE |
| F 323                    | Continued From pa  | age 139  | F3                 | 323         | 3  |   |                           |
|                          |  | NT is not met as evidenced   |                    |             |  |   |                           |
|                          | Based on observareview, the facility fassess a resident's new interventions stodecrease the risk residents (R78) reversidents (R78) reversidents (R78) reversidents (R78) reversidents a high substained a high su | tion, interview and document<br>ailed to comprehensively<br>a falls to determine whether<br>should have been implemented<br>k of further falls for 1 of 3<br>viewed for accident hazards.<br>ice resulted in harm for R78<br>p fracture with a fall. |                    |             | <ul> <li>F 323 Free of accidents/hazards/supervision/Dev tual harm G</li> <li>1. R78 s fall risk assessment wareviewed and updated on Novembe 2016. A bowel and bladder assess was completed for R78 on 10-20-2 care plan was reviewed and revise according to all assessment finding Falls reports will be analyzed mont characteristics and trends.</li> <li>2. All residents have the potential affected in this area. A list of reside that have fallen in the past 30 days generated, reviewed for assessme care plans updated as needed to e compliance in this area.</li> </ul> | as<br>er 17,<br>sment<br>016;<br>d<br>gs.<br>hly for<br>to be<br>ents<br>s will be<br>nt, and |                           |
|                          | R78's quarterly MD<br>R78 had intact cog<br>assistance to trans<br>personal hygiene, v<br>urine, continent of t<br>toileting plan.<br>R78's significant ch<br>identified R78 had<br>impairment, was to<br>transfers, dressing  | PS dated 9/14/16, identified<br>nition, required limited<br>fer, walk, toilet and for<br>was occasionally incontinent of<br>bowel and was not on a<br>nange MDS dated 10/3/16,   |                    |             | <ol> <li>Mandatory nursing staff educatives provided on November 16 and 2016 on the procedure titled, Accident/Falls with a focus on the range for the facility to comprehensively a a resident to determine what new interventions could be implemented decrease the risk of future falls.</li> <li>System change: Daily review of all incidents and accidents by facility management.</li> </ol>   | l 17,<br>need<br>assess<br>d to   |                           |
|                          | not on a toileting pl<br>R78's Care Area As<br>10/3/16, identified F   | an.<br>ssessment (CAA) dated   |                    |             | 4. An audit was developed to mor<br>risk assessments, fall prevention c<br>plan interventions for residents ide<br>at risk for falls, post fall incident rep<br>timely reporting of falls to administr   | are<br>entified<br>ports,   |                           |

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|  |  |   |                                       |    |  | FORM                                | 12/15/2016<br>APPROVED<br>0938-0391 |  |  |
|--|--|---|---------------------------------------|----|--|-------------------------------------|-------------------------------------|--|--|
| CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |  |   |                                       |    | E CONSTRUCTION   | (X3) DATE                           | E SURVEY<br>PLETED                  |  |  |
|  |  | 245299  | B. WING _                             |    |  | 10/2                                | 24/2016                             |  |  |
| NAME OF  | PROVIDER OR SUPPLIER   |   | STREET ADDRESS, CITY, STATE, ZIP CODE |    |  |                                     |                                     |  |  |
| FRAZEE   | CARE CENTER  |   |                                       |    | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |                                     |                                     |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                   | <  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)  | BE                                  | (X5)<br>COMPLETION<br>DATE          |  |  |
| F 323  | reassurance, remin<br>things. The CAA ide<br>a decline in conditionand<br>surgical interver<br>was receiving therat<br>established for toile<br>impulsive leading to<br>had a history of falls<br>resulting in a fractur<br>R78's care plan rew<br>had a self care defii<br>unsteady gait and t<br>related to history of<br>incontinence and po-<br>dementia. The care<br>urinal at night per h<br>mattress related to<br>with hoyer (full body<br>beside bed, rearran<br>for mobility.<br>The facility form title<br>dated 10/17/16, dire<br>one staff for ADL's<br>falls, used a mechar<br>request toileting an<br>toileting.<br>On 10/19/16, at 7:1<br>the room was dark<br>R78's bed a thin gra<br>the right side a thin<br>square white perso<br>grab bar attached to<br>and the call light wa<br>also. | age 140<br>Inders to help make sense of<br>entified R78 had experienced<br>on related to fall with fracture<br>ention and incontinence. R78<br>apy services with goal<br>sting transfers. R78 had been<br>o poor safety awareness and<br>a and experienced a fall<br>re with surgical intervention.<br>Arised 9/28/16, indicated R78<br>cit related to cognitive loss,<br>ransfers, was at risk for falls<br>falls, unsteady gait,<br>oor judgment related to<br>e plan indicated R78 used a<br>is request, App (concave)<br>decreased mobility, transfer<br>y lift) and two staff, floor mats<br>age room to allow extra room<br>ed Aide Care Plan Group B,<br>ected R78 required assist of<br>(activity of daily living), had<br>anical lift for transfers, would<br>d required assist of one for<br>5 a.m. R78 was lying in bed,<br>and quiet. On the left side of<br>ay fall mat on the floor and on<br>brown fall mat was present. A<br>nal alarm was secured to the<br>o the right side of R78's bed<br>as attached to the grab bar | F 3                                   | 23 | the investigation of falls and reports<br>OHFC as appropriate. The audit w<br>completed by the DON or designee<br>weekly X 4 weeks, then monthly X<br>months. Falls trend reports and au<br>findings will be provided monthly x<br>months to the QA committee with<br>follow-up to committee recommend<br>5. Deficient practice will be correct<br>December 14, 2016 | ill be<br>2<br>dit<br>3<br>lations. |                                     |  |  |

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|                          |   | AND HUMAN SERVICES  |                                       |    |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |  |  |  |  |
|--------------------------|---|---|---------------------------------------|----|---|-----------|-------------------------------------|--|--|--|--|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                                       |    | E CONSTRUCTION  | (X3) DATE | E SURVEY<br>PLETED                  |  |  |  |  |
|                          |   | 245299  | B. WING _                             |    |   | 10/2      | 24/2016                             |  |  |  |  |
| NAME OF I                | PROVIDER OR SUPPLIER  |   | STREET ADDRESS, CITY, STATE, ZIP CODE |    |   |           |                                     |  |  |  |  |
| FRAZEE                   | CARE CENTER   |   |                                       |    | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |           |                                     |  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                   |    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |  |  |  |  |
| F 323                    | nurse (LPN)-A prop<br>in a wheel chair, the<br>was secured to the<br>On 10/19/16, from<br>independently ate th<br>wheel chair with the<br>the back of his whe<br>On 10/21/16, at 10<br>wheelchair in the h<br>watching the activity<br>the personal alarm<br>the wheelchair.<br>A review of R78's c<br>following 8 docume<br>admitted on March<br>(1) 3/8/16-at 9:50 p<br>beside his bed. Res<br>stated,"I was going<br>placed a bed alarm<br>(IDT) reviewed the<br>following the fall). T<br>"Resident attempts<br>[bathroom]. The inte<br>Placed pressure ala<br>(2) 3/9/16-1:00 a.m<br>staff to R78's room<br>next to bed. R78 su<br>elbow 1 cm (centim<br>note identified R78<br>tried to get up. Inter<br>as a result of the as<br>mat, urinal placed.<br>on 3/17/16 (8 days | <ul> <li>belled R78 to the dining room<br/>e white square personal alarm<br/>back of R78's wheel chair.</li> <li>8:27 a.m. to 8:40 a.m. R78<br/>he breakfast meal seated in a<br/>e personal alarm secured to<br/>eel chair.</li> <li>0:33 a.m. R78 was seated in a<br/>nall outside of his room<br/>y of staff and other residents,<br/>was secured to the back of</li> <li>linical record revealed the<br/>ented falls since R78 was<br/>7, 2016:</li> <li>a.m. R78 was found on floor<br/>sident interview indicated R78<br/>to the bathroom." Staff initially</li> <li>The interdisciplinary team<br/>fall on 3/18/16 (10 days<br/>The post fall findings identified,<br/>to self transfer to BRM<br/>ervention to be implemented:</li> </ul> | F 32                                  | 23 |   |           |                                     |  |  |  |  |

Facility ID: 00730

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|                          |  | AND HUMAN SERVICES  |                   |     |   |       | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|-------------------|-----|---|-------|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | • •               |     | PLE CONSTRUCTION  |       | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING           |     |   |       | 10/2      | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                   | 5   | STREET ADDRESS, CITY, STATE, ZIP CO   | DE    |           |                                     |
| FRAZEE                   | CARE CENTER  |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX<br>FRAZEE, MN 56544   | 96    |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | HOULD | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 323                    | <ul> <li>included: floor mathand not a new international of a new international of a laceration of floor with the Resident interview in was getting up to get sustained a laceration on a laceration on the floor new got up he had bare. The information of the IDT reviewed to following the fall). In implemented as a resident needs a construction of the floor mation floor indicated he was get chair. The nursing a bathroom and to get note indicated R78 mat by the bed was indicated R78 had a awareness, recently recommendations whelp, does not composel for the fall. The transferring without the call light. Intervea a result of the assessing the assessing the assessing the assessing the fall. The transferring without the call light. Intervea a result of the assessing the assessing the assessing the advantagement of the</li></ul> | nges to the care plan<br>(which was currently in use<br>vention).<br>.m. R78 was found lying face<br>nead against night stand.<br>indicated R78 had stated he<br>to the bathroom. R78<br>ion to the right eyebrow 2.5 cm<br>on to the left side bridge of his<br>neident note identified a mat<br>xt to R78's bed, when resident<br>feet and slipped on the mat.<br>the fall on 3/14/16 (2 days | F                 | 323 |   |       |           |                                     |

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|                          |   | AND HUMAN SERVICES   |                   |     |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|-------------------|-----|--|-----------|-------------------------------------|
| STATEMENT                | CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1)           PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:  |  |                   |     | LE CONSTRUCTION  | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299   | B. WING           | i   |  | 10/2      | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  |           |                                     |
| FRAZEE                   | CARE CENTER   |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 323                    | Resident was unab<br>doing. The nurses r<br>reviewed the fall on<br>should use call ligh<br>will add a lipped ma<br>perimeters.<br>(6) 7/27/16- 6:20 p.<br>residents room and<br>in bed. The form idd<br>inititated at time of fall a<br>IDT on 8/2/16 (6 da<br>(7) 9/19/16-5:20 a.r<br>occurred in room an<br>sleeping. The note<br>identified-found lyin<br>bathroom door, res<br>The notes indicated<br>forgetful and had a<br>awareness. The no<br>interventions to be<br>fall for R78. The ID<br>on 9/27/16 (8 days<br>(8) 9/22/16-8:15 a.r<br>to room by roomma<br>sideways on floor o<br>finished going and s<br>note indicated R78'<br>underneath residen<br>Further, the inciden<br>have BM (bowel mo<br>prior to fall. The pos<br>identified R78 comp<br>motion of left leg ar<br>be shorter than the | le to identify what he had been<br>notes also indicated the IDT<br>n 7/15/16, did not remember he<br>nt to alert staff for assistance,<br>attress to bed to define<br> | F                 | 323 |  |           |                                     |

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|                          |   | AND HUMAN SERVICES  |                         |    |  | FORM     | APPROVED<br>. 0938-0391    |
|--------------------------|---|---|-------------------------|----|--|----------|----------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDII |    | LE CONSTRUCTION  | (X3) DAT | E SURVEY<br>IPLETED        |
|                          |   | 245299  | B. WING _               |    |  | 10/      | 24/2016                    |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |                         |    | STREET ADDRESS, CITY, STATE, ZIP CODE  | <u> </u> |                            |
| FRAZEE                   | CARE CENTER   |   |                         |    | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |          |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | ×  | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) BE     | (X5)<br>COMPLETION<br>DATE |
| F 323                    | Continued From pa   | ge 144  | F 32                    | 23 | 3  |          |                            |
|                          | for readmission to t<br>9/26/16, indicated F  | harge interagency referral form<br>he nursing home dated,<br>R78 had left trochanteric<br>(surgical repair of the hip) of<br>on 9/23/16.  |                         |    |  |          |                            |
|                          | dated 3/7/16, identi  | Ill Risk Assessment form<br>fied R78 had three falls in last<br>icontinent of bladder, used a<br>e to use call light  |                         |    |  |          |                            |
|                          | dated 6/23/16, indic<br>remained current w<br>changes: "Has had   | all Risk Assessment form<br>cated R78's assessment<br>rith the following minor<br>multiple falls since admission.<br>call light but doesn't."   |                         |    |  |          |                            |
|                          | to comprehensively<br>include but not limit   | ssment forms completed failed<br>assess R78's risk for falls to<br>red to trends/patterns to falls,<br>causing the falls, and<br>erventions.  |                         |    |  |          |                            |
|                          | No Further Fall Risl<br>R78's record  | k Assessments were found in   |                         |    |  |          |                            |
|                          | Evaluation Tool date<br>incontinent of urine<br>void, and was able<br>void/defecate. The<br>use call light, able to<br>required assist to an<br>toilet/commode, and | owel and Bladder Functional<br>ed 3/14/16, revealed R78 was<br>and bowel, awoke at night to<br>to identify the need to<br>tool identified R78 was able to<br>o ask to go to the bathroom,<br>mbulate and transfer to<br>d was able to use the toilet<br>e evaluation tool did not<br>lan for R78. |                         |    |  |          |                            |

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|                          |   | AND HUMAN SERVICES  |                    |     |  | FORM                      | APPROVED                   |
|--------------------------|---|---|--------------------|-----|--|---------------------------|----------------------------|
| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | · ,                |     |  | (X3) DAT                  | E SURVEY                   |
|                          |   | 245299  | B. WING            |     |  | TION (X5<br>ULD BE COMPLE |                            |
| NAME OF                  | PROVIDER OR SUPPLIER  |   | <u>A</u>           | ę   | STREET ADDRESS, CITY, STATE, ZIP CODE  |                           |                            |
| FRAZEE                   | CARE CENTER   |   |                    |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |                           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE                      | (X5)<br>COMPLETION<br>DATE |
| F 323                    | Review of R78's Bo<br>Evaluation Tool dat<br>continent of bowel a<br>1-2 times weekly.<br>Review of R78's Re<br>Interdepartmental O<br>nursing and physica<br>following:<br>- 4/1/16, Physical T<br>[patient] to transfer<br>only. We are workin<br>transfers and gettin<br>[questions] call. Nu<br>Cont [continue] with<br>assist] and encoura<br>on getting back up<br>-5/8/16, Physical Th<br>D/C [discharged] fre<br>with RW [regular wa<br>x [times] daily Pt. an<br>The form included a<br>lacked any response<br>therapy.<br>Review of R78's un<br>Referral For Therap<br>had been demonstra<br>transfers and ambur<br>removed and nursin<br>screen. The form in<br>therapy personnel,<br>directed that R78 w<br>and ambulation with<br>from therapy. R78 r<br>issues with safety a<br>recommended R78 | wel and Bladder Function<br>ed 6/23/16, identified R78 was<br>and was incontinent of urine<br>esident Referral<br>Communication forms between<br>al therapy revealed the<br>herapy-"Please encourage Pt.<br>and toilet with stand-by-assist<br>ng towards independent<br>g rid of alarm. Any?<br>rsing responded on 4/6/16-<br>n alarm for now. SBA [stand by<br>age him to do himself. Working | F 3                | 323 | 3  |                           |                            |

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# PRINTED: 12/15/2016 FORM APPROVED

|                          |   | AND HUMAN SERVICES   |                    |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|--------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                |     |   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245299   | B. WING            | i   |   | 10/2      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                    | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER   |  |                    |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 323                    | Assessment dated<br>Alzheimer's, and a<br>assessment identifi<br>impaired cognitive s<br>decisions poor, cue<br>required limited ass<br>walking and superv<br>On 10/19/16, at 1:1<br>reports and progres<br>the assistant directo<br>The ADON verified<br>was unsure what in<br>place. The ADON ic<br>fall the post- fall clir<br>nursing, the adminis<br>reviewed the facility<br>Assessment. The for<br>nurse when resider<br>reviewed for approp<br>ADON indicated R7<br>to interpret what int<br>following the falls. T<br>believed the falls we<br>appropriate interver<br>falls. ADON confirm<br>fracture after the fa<br>Review of R78's pro<br>9/22/16, included va<br>R78 received assist<br>and self transferred<br>The progress notes<br>-5/18/16, Did a four<br>resident. Resident of | 6/13/16, identified R78 had<br>history of falls. The<br>ed R78 had moderately<br>skills for daily decision making,<br>is/supervision required, and<br>sistance with transferring and<br>ision with toileting.<br>7 p.m. a review of R78's fall<br>as notes was conducted with<br>or of nursing (ADON) present.<br>R78's multiple falls, although<br>terventions were currently in<br>dentified following a resident's<br>nical team which included<br>strator and social services,<br><i>r</i> form titled Fall Risk Post- Fall<br>orm was initiated by the floor<br>nt falls occurred and the team<br>oriate interventions. The<br>78's fall reviews were difficult<br>erventions were initiated<br>The ADON indicated she<br>ere fully assessed and<br>ntions were initiated for R78's<br>ned R78 had sustained a hip<br>II on 9/22/16.<br>Degress noted dated 3/10/16 to<br>arious notes which identified<br>tance with ADLS, transfers,<br>I at times.<br>included:<br>day trial of alarms off<br>did well, toileted self,<br>air/wheelchair without incident<br>t this time.<br>knees in front of | F                  | 323 |   |           |                                     |

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|                          |  | AND HUMAN SERVICES  |                     |    |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|---------------------|----|--|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 |    | E CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING             |    |  | 10/2      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                     |    | TREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER  |   |                     |    | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 323                    | -9/19/16, R78's roo<br>on the floor. R78 fo<br>in front of the bathres<br>stated he must of s<br>socks on.<br>-9/22/16, R78 found<br>on buttocks and sta<br>finished, stood up a<br>much pain left hip v<br>shortening of left lea<br>transport. The note<br>a fractured hip and<br>the following day.<br>On 10/20/16, at 10:<br>B stated she felt the<br>the facility must hav<br>large amount of res<br>On 10/20/16, at 10:<br>(NA)-I indicated R7<br>the bathroom by hir<br>indicated since R78<br>assistance to go to<br>R78 did not always<br>wheel chair brakes<br>on the wheel chair t<br>On 10/21/16, at 1:3<br>a recent decline be<br>hip. NA-B verified F<br>usually related to go<br>coming back from t<br>felt R78 was indepet<br>toilet prior to the fal<br>on for assistance w<br>pants or to shave. N | age 147<br>mmate alerted nurse R78 was<br>und on his back, on the floor<br>oom door, trying to sit up. R78<br>lipped on something, gripper<br>d on floor in bathroom, sitting<br>ated went to bathroom, sitting<br>ated went to bathroom, and fell, slipped. Complained of<br>vith internal rotation,<br>g. Ambulance called to<br>indicated R78 had sustained<br>would probably have surgery<br>and fells in the facility.<br>and falls in the facility.<br>and how had brakes<br>the bathroom. NA-I indicated<br>remember to check if the<br>were on and now had brakes<br>that locked automatically.<br>and p.m. NA-B verified R78 had<br>cause of a fall with fractured<br>ar8's frequent falls were<br>oing to the bathroom or when<br>the bathroom. NA-B stated she<br>endent to take himself to the<br>I and would turn the call light<br>then needed to pull up his<br>NA-B identified R78 at times<br>ppropriately and other times<br>ated a toileting program may | F 3                 | 23 |  |           |                                     |

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| CENTE<br>STATEMEN        | RS FOR MEDICARE  | AND HUMAN SERVICES<br>& MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA   | (X2) MUL          | TIPL |   | FORM<br>MB NO.<br>(X3) DATE | 12/15/2016<br>APPROVED<br>0938-0391<br>SURVEY |
|--------------------------|--|--|-------------------|------|---|-----------------------------|---|
| AND PLAN (               | OF CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILC          | ING  |   | COMI                        | PLETED  |
|                          |  | 245299   | B. WING           |      |   | 10/2                        | 24/2016                                       |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                   |      | STREET ADDRESS, CITY, STATE, ZIP CODE   |                             |   |
| FRAZEE                   | CARE CENTER  |  |                   |      | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |                             |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE                          | (X5)<br>COMPLETION<br>DATE                    |
| F 323                    | have been beneficia<br>a fractured hip.<br>On 10/21/16, at 2:1<br>was independent w<br>toileting before the<br>identified prior to th<br>trying to go to the b<br>On 10/21/16, at 2:3<br>did not work often v<br>be sitting in the hall<br>the bathroom" and<br>On 10/21/16, at 2:4<br>R78's fall resulting in<br>assistance of one to<br>ask for help to toilet<br>ask or did not ask for<br>toileting program was<br>needed to go to the<br>transfer self when<br>reviewed the 8 falls<br>review of the falls, N<br>been a pattern of th<br>off of the toilet. NM<br>a toileting program<br>a good idea."<br>On 10/21/16, at 3:0<br>with the ADON verif<br>hospitalization the f<br>toileting plan for R7<br>had been assessed<br>interventions had be<br>had not identified a | al for R78 prior to his fall with<br>3 p.m. NA-J indicated R78<br>ith dressing, hygiene and<br>fall and hip fracture. NA-J<br>e hip fracture R78 was always<br>athroom.<br>9 p.m. NA-A indicated she/he<br>with R78 and stated, "He will<br>and say 'hey', have to go to<br>staff would assist him.<br>9 p.m. NM-B indicated prior to<br>in a fracture, R78 required<br>o transfer and remind R78 to<br>t because he was reluctant to<br>or help. NM-B indicated R78's<br>as to sound call light when he<br>e bathroom or he attempted to<br>M-B stated, "He [R78] calls or<br>he needs toilet." NM-B<br>and interventions. After<br>NM-B stated she felt there had<br>he falls was going to or coming<br>-B confirmed R78 was not on<br>and stated," It may have been<br>7 p.m. a follow up interview<br>fied prior to R78's<br>facility had not initiated a<br>'8. The ADON felt R78's falls | F                 | 323  |   |                             |   |

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|                          |  | AND HUMAN SERVICES  |                     |   | FORM                          | APPROVED<br>0938-0391      |
|--------------------------|--|---|---------------------|---|-------------------------------|----------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|                          |  | 245299  | B. WING _           |   | 10/2                          | 24/2016                    |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                            |
| FRAZEE                   | CARE CENTER  |   |                     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE |
| F 323<br>F 334<br>SS=D   | Continued From pa<br>assessment for R78<br>On 10/24/16, at 2:0<br>(NP)-A indicated sh<br>assess falls routine<br>pattern or reason for<br>minimize further fall<br>On 10/24/16, at 4:1<br>R78's physician (MI<br>R78 had a fall which<br>however, was unaw<br>MD-A indicated R78<br>easily redirected. M<br>facility nursing staff<br>going to the bathroot<br>the falls, he would e<br>appropriate interver<br>needs.<br>The requested facili<br>was not provided.<br>483.25(n) INFLUEN<br>IMMUNIZATIONS<br>The facility must de<br>that ensure that<br>(i) Before offering th<br>each resident, or th<br>representative rece<br>benefits and potenti<br>immunization;<br>(ii) Each resident is<br>immunization Octob | ge 149<br>8.<br>0 p.m. nurse practitioner<br>he expected the facility staff to<br>ly and attempt to identify a<br>or the falls in an attempt to<br>ls.<br>17 p.m. a phone interview with<br>D)-A verified he was aware<br>h resulted in a fractured hip,<br>vare of the number of falls.<br>8 was demented and was not<br>ID-A verified he would expect<br>to assess the falls and if<br>om is the common reason with<br>expect staff to provide an<br>ntion related to R78's toileting<br>ity policy regarding facility falls<br>NZA AND PNEUMOCOCCAL<br>evelop policies and procedures<br>he influenza immunization,<br>e resident's legal<br>ives education regarding the<br>ial side effects of the<br>offered an influenza<br>per 1 through March 31 | F 32                | CEFICIENCY)   |                               | 12/14/16                   |
|                          | contraindicated or t<br>immunized during th<br>(iii) The resident or   |   |                     |   |                               |                            |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                    |     |  | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|--------------------|-----|--|-------------------------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                |     | PLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |   | 245299  | B. WING            |     |  | 10/:                          | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |                    | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                                     |
| FRAZEE                   | CARE CENTER   |   |                    |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>YMUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETION<br>DATE          |
| F 334                    | documentation that<br>following:<br>(A) That the reside<br>representative was<br>the benefits and poi<br>immunization; and<br>(B) That the reside<br>influenza immunization; and<br>(B) That the reside<br>influenza immunization<br>contraindications or<br>The facility must de<br>that ensure that<br>(i) Before offering th<br>immunization, each<br>legal representative<br>the benefits and poi<br>immunization;<br>(ii) Each resident is<br>immunization, unles<br>medically contraind<br>already been immuni<br>(iii) The resident or<br>representative has<br>immunization; and<br>(iv) The resident's n<br>documentation that<br>following:<br>(A) That the reside<br>representative was<br>the benefits and poi<br>pneumococcal imm<br>(B) That the reside<br>pneumococcal imm | nedical record includes<br>indicates, at a minimum, the<br>ent or resident's legal<br>provided education regarding<br>tential side effects of influenza<br>ent either received the<br>tion or did not receive the<br>tion due to medical<br>refusal.<br>velop policies and procedures<br>ne pneumococcal<br>resident, or the resident's<br>receives education regarding<br>tential side effects of the<br>offered a pneumococcal<br>as the immunization is<br>icated or the resident has<br>nized;<br>the resident's legal<br>the opportunity to refuse<br>nedical record includes<br>indicated, at a minimum, the<br>ent or resident's legal<br>provided education regarding<br>tential side effects of<br>unization; and<br>ent either received the<br>unization or did not receive<br>mmunization due to medical | F                  | 334 |  |                               |                                     |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                     |  | FORM   | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|---------------------|--|--|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | LE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED                  |                                     |
|                          |  | 245299  | B. WING             |  | 10/2   | 24/2016                             |
| NAME OF F                | NAME OF PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |  |                                     |
| FRAZEE CARE CENTER       |  |   |                     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)  | BE   | (X5)<br>COMPLETION<br>DATE          |
| F 334                    | (v) As an alternative<br>and practitioner rec<br>pneumococcal imm<br>years following the<br>immunization, unles<br>the resident or the r<br>refuses the second   | e, based on an assessment<br>ommendation, a second<br>unization may be given after 5<br>first pneumococcal<br>as medically contraindicated or<br>esident's legal representative<br>immunization.  | F 334               |  |  |                                     |
|                          | by:<br>Based on interview<br>facility failed to ensu<br>Conjugate Vaccine-<br>by the Centers for E<br>offered to 3 of 5 res<br>vaccination histories<br>Findings include:<br>The CDC identified<br>Immunization Pract<br>all adults 65 years of<br>of PCV13 followed 1<br>1 year later.<br>R3's Immunization 1<br>indicated the 73 yea<br>Pneumovax dose 1<br>medical record lack<br>was offered the PC<br>recommended by th<br>R66's undated Imm<br>the 50 year old had | the Advisory Committee on<br>ices (ACIP) recommends that<br>of age or older receive a dose<br>by a dose of PPSV23 at least<br>Record dated 9/2/08,<br>ar old had received<br>on 9/4/08. However, the<br>ed evidence R3 received or<br>V-13 vaccination as<br>he CDC.<br>unization Record, indicated<br>not received the PCV-13<br>medical record lacked |                     | <ul> <li>F 334 Influenza and pneumococca<br/>immunizations</li> <li>R3 s POA is being contacted f<br/>consent to administer the PVC 13<br/>vaccination. Once the consent is<br/>received, the residents vaccination<br/>done and documented in the MAR<br/>legal medical record.</li> <li>R66 s POA is being contacted for<br/>consent for PVC13 vaccination.</li> <li>R83 was discharged from facility sh<br/>following annual facility survey.</li> <li>The CDC immunization guideline w<br/>provided to each staff member at th<br/>educational meetings.</li> <li>All residents have the potential<br/>affected in this area and will be offer<br/>PVC13 at their next care conference<br/>all residents will be reviewed within<br/>months. After a signed consent an<br/>education received and provided, th<br/>residents PVC 13 vaccination will b<br/>administered and documented in the<br/>medical record.</li> </ul> | to be<br>red the<br>e and<br>3<br>d<br>ne<br>e |                                     |

Facility ID: 00730

| ND PLAN O                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |    |   | (X3) DATE SURVEY<br>COMPLETED<br><b>10/24/2016</b> |  |
|--------------------------|---|---|---------------------|----|---|--|--|
|                          |   | 245299  | B. WING             |    |   |  |  |
|                          | PROVIDER OR SUPPLIER  | 245255  | D. WING             |    | TREET ADDRESS, CITY, STATE, ZIP CODE  |  |  |
|                          | CARE CENTER   |   |                     | 21 | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | ×  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | (X5)<br>COMPLETIC<br>DATE                          |  |
| F 334                    |   |   |                     | 34 |   |  |  |
|                          | R83's undated Imm   | unization Record, indicated<br>not received the PCV-13  |                     |    | System change: Immunization form has been updated to include PVC13 vaccination.   | 5  |  |
|                          | vaccination. R83's evidence R83 was   | medical record lacked<br>offered the PCV-13<br>mmended by the CDC.  |                     |    | 3. Mandatory nursing staff education<br>was provided on November 16 and 17,<br>2016 on the procedure titled,<br>Immunizations: Pneumococcal Vaccine   | a  |  |
|                          | When interviewed on 10/24/16, at 2:00 p.m. unit<br>manager (UM)-B who was responsible for the<br>facility's infection control program confirmed the<br>facility was aware of the CDC recommendation<br>related to PCV13 vaccination. UM-B reported she<br>had discussed the PCV13 vaccination guidelines<br>with the medical director at the last quarterly |   |                     |    | focus on the CDC recommendations for<br>all nursing home residents to receive<br>two pneumococcal vaccinations that<br>include the PCV 13 and PSSV23<br>according to a recommended schedule.  |  |  |
|                          | quality meeting, but<br>orders on implement<br>recommendations.<br>did not have an act  | t did not get any direction or<br>nting the CDC<br>UM-B confirmed the facility<br>ive plan in place to offer or<br>/13 vaccination to residents |                     |    | 4. An audit was developed to monitor vaccinations. The audit will monitor the physician s order for PCV 13 and PVC23, resident signed consent form, vaccination information sheet (VIS), and documentation of administration of vaccination.  | 00   |  |
|                          | 11/14, indicated all<br>encouraged to obta<br>PCV13 and PPSV2<br>contraindicated. Th<br>resident was offere<br>education of risks a<br>with the resident; if<br>refusal would be do   | in both the pneumococcal  |                     |    | vaccination. Immunization records will be<br>reviewed bi-monthly to identify timing of<br>needed subsequent<br>recommended/ordered vaccinations. The<br>audit will be completed by the infection<br>control nurse or designee weekly X 4<br>weeks, then monthly X 2 months. Audit<br>findings will be provided monthly x 3<br>months to the QA committee with<br>follow-up to committee recommendations | e  |  |
| F 353                    | 483.30(a) SUFFICI   | ENT 24-HR NURSING STAFF   | F 3                 | 53 | 5. Deficient practice will be corrected b<br>December 14, 2016  | 12/14/16   |  |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                   |     |  | FORM  | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|-------------------|-----|--|---|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED                           |                                     |
|                          |   | 245299   | B. WING           |     |  | 10/24/2016  |                                     |
| NAME OF F                | ROVIDER OR SUPPLIER   |  |                   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |   |                                     |
| FRAZEE CARE CENTER       |   |  |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |   |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)  | BE  | (X5)<br>COMPLETION<br>DATE          |
| F 353                    | maintain the highes<br>and psychosocial w<br>determined by resid-<br>individual plans of of<br>The facility must pro-<br>numbers of each of<br>personnel on a 24-h<br>care to all residents<br>care plans:<br>Except when waive<br>section, licensed nu-<br>personnel.<br>Except when waive<br>section, the facility in<br>nurse to serve as a<br>duty.<br>This REQUIREMEN<br>by:<br>Based on observat<br>interview and docur<br>to ensure sufficient<br>resident needs relat<br>ambulation (R38, R<br>motion (ROM) servi<br>pressure ulcers (R1)<br>prevention (R78) ch<br>services (R61.) The<br>potential to affect al<br>residing in the facility<br>R66 and R78. | I related services to attain or<br>t practicable physical, mental,<br>ell-being of each resident, as<br>lent assessments and | F                 | 353 | F353 Sufficient 24 hour Nursing St<br>Care Plans<br>F353 Sufficient 24 hour Nursing St<br>Care Plans<br>F353 Sufficient 24 hour Nursing<br>per Care Plans<br>1. System change: Reorganization<br>resident rooms to increase resident<br>proximity and nursing structure was<br>completed on 11-16-2016. Staffing<br>committee established and meeting<br>weekly discussing staffing status ar<br>hiring efforts. Facility applied to pro-<br>for CNA training at facility. Utilizing<br>and CNA agency staff currently. Net<br>DON started 10-24-2016. | g Staff<br>on of<br>t room<br>s<br>nd<br>ovide<br>nurse |                                     |
|                          | Findings include:   |  |                   |     |  |   |                                     |

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|  | & MEDICAID SERVICES<br>X1) PROVIDER/SUPPLIER/CLIA   | PRINTED: 12/15<br>FORM APPR<br>OMB NO. 0938<br>(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV |      |   |                            |  |
|--|---|--|------|---|----------------------------|--|
| AND PLAN OF CORRECTION   | IDENTIFICATION NUMBER:  | A. BUILC   | DING | CC  | MPLETED                    |  |
| 245299   |   | B. WING  | i    | 10  | )/24/2016                  |  |
| NAME OF PROVIDER OR SUPPLIER   |   |  | S    | TREET ADDRESS, CITY, STATE, ZIP CODE  |                            |  |
| FRAZEE CARE CENTER   |   |  |      | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |                            |  |
| PREFIX (EACH DEFICIENCY I  | EMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>C IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG  |      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | (X5)<br>COMPLETION<br>DATE |  |
| directed by therapy of<br>see F310.<br>R18 did not receive to<br>personal cares as di<br>F314 and F312.<br>R44, R29 and R46 do<br>program as directed<br>R78 did not receive as<br>related to a pattern of<br>insufficient staffing, s<br>On 10/21/16, at 11:2<br>assistant (PTA) states<br>residents had not be<br>programs including F<br>insufficient staffing. If<br>some residents lose<br>in ambulation and Red<br>due to not receiving<br>stated she had voices<br>management in wee<br>which both the facilit<br>of nursing (DON) wo<br>had been told by bot<br>DON they were work<br>she had voiced conco<br>last 4-5 months and<br>improvement with stat<br>On 10/21/16, at 1:43<br>nursing (ADON) state<br>working on staffing of<br>ADON stated the ad | any ambulation services as<br>due to insufficient staffing,<br>timely repositioning and<br>rected by care plan, see<br>did not receive ambulation<br>by therapy, see F311.<br>accurate assessments<br>of multiple falls due to<br>see F323.<br>0 a.m. physical therapy<br>ed she had concerns<br>en receiving restorative<br>ROM and ambulation due to<br>PTA stated she had seen<br>their abilities and/or decline<br>OM including R66 and R38<br>restorative services. PTA<br>ed her concerns to facility<br>kly medicare meetings,<br>y administrator and director<br>ould attend. PTA stated she<br>h the administrator and the<br>sing on staffing. PTA stated<br>perns about staffing for the<br>had not seen any | F  | 353  | <ol> <li>All residents have the potential to be<br/>negatively affected by insufficient staffing<br/>and all residents are receiving adequate<br/>assistance with cares.</li> <li>Mandatory nurse education provided<br/>on November 16 and 17, 2016 on the<br/>procedure titled, Nursing Administration<br/>Staffing with a focus on the need of staff<br/>to meet the residents needs. Staff was<br/>educated on the plan to merge all<br/>residents into one nurses station. The<br/>audit will monitor staff call ins, analysis of<br/>fall patterns monthly with goals to<br/>increase nursing per diem hours</li> <li>Observational and documentation<br/>review audit has been created to monitor<br/>staff call ins, resident counsel satisfactio<br/>and DON attendance, monthly fall<br/>trending and analysis, monthly review of<br/>facility Quality Measures, monitoring of<br/>assistance with ADL s, review of<br/>restorative nursing program<br/>documentation, call light response time,<br/>urinary incontinence checks every 2 hour<br/>and routine monthly cna and licensed<br/>nurse meetings for ongoing education an<br/>input on identified concerns. The audit<br/>will be completed by the DON or designe<br/>weekly X 4 weeks, then monthly X 2<br/>months. Audit findings will be provided<br/>monthly x 3 months to the QA committee<br/>with follow-up to committee<br/>recommendations.</li> <li>Deficient practice will be corrected by<br/>December 14, 2016</li> </ol> | n<br>,<br>d                |  |

Facility ID: 00730

|                          |   | AND HUMAN SERVICES  |                    |     |   | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                |     | PLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |   | 245299  | B. WING            | i   |   | 10/24/2016                    |                                     |
| NAME OF F                | NAME OF PROVIDER OR SUPPLIER  |   |                    | 5   | STREET ADDRESS, CITY, STATE, ZIP CODE   | -                             |                                     |
| FRAZEE CARE CENTER       |   |   |                    |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) BE                          | (X5)<br>COMPLETION<br>DATE          |
| F 353                    | ADON stated she h<br>meetings as she ha<br>that role due to hav<br>another registered n<br>felt call ins were a p<br>number of staff as a<br>facility had used nu<br>September, howeve<br>staff from any agen<br>half. ADON stated s<br>NA were unable to o<br>manner and cares o<br>insufficient staffing.<br>the other nurse man<br>provide oversight of<br>according to care p<br>ADON stated she fe<br>care plans were not<br>a consistent basis of<br>ADON stated she h<br>residents and staff<br>ADON stated NA ha<br>cares were not cons<br>staffing concerns. A<br>together in an attern<br>however was difficu<br>ADON stated she w<br>restorative program<br>implemented or sta<br>complete the requir<br>basis. ADON stated the fa<br>admissions though<br>look at acuity.<br>R27's annual MDS | affing with weekly meetings.<br>ad not been attending those<br>ad been trying to back out of<br>ring to work nights along with<br>nurse (RN.) ADON stated she<br>problem as well as not enough<br>a whole. ADON stated the<br>trying pool staff last in<br>er they had been unable to find<br>acy in the last month and a<br>she felt there were times the<br>complete tasks in a timely<br>would get missed due to<br>. ADON stated she felt she and<br>nagers (NM) were unable to<br>f cares to ensure cares were<br>lans and completed timely.<br>elt resident assessments and<br>t completed and/or updated on<br>due to insufficient staffing.<br>ad reported to her resident<br>sistently completed due to<br>ADON stated the staff worked<br>npt to meet residents needs,<br>ult due to insufficient staffing.<br>vas aware the facility<br>ns had not been consistently<br>arted due to not enough staff to<br>red programs on a routine<br>d she felt there had been in<br>shes due to insufficient staffing.<br>adility continued to take<br>would screen residents to<br>dated 8/17/16, identified R27 | F3                 | 353 |   |                               |                                     |
|                          | was cognitively inta  | ct, required extensive  |                    |     |   |                               |                                     |

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|--------------------------|---|---|-------------------|-----|--|-------------------------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | • •               |     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |   | 245299  | B. WING           |     |  | 10/24/2016                    |                                     |
| NAME OF F                | PROVIDER OR SUPPLIER  |   | -                 | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                                     |
| FRAZEE                   | CARE CENTER   |   |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |
| F 353                    | including transfers,<br>personal hygiene.<br>On 10/17/16, at 6:4<br>believed the facility<br>because she had to<br>R27 identified she of<br>go to the bathroom<br>have had to wait an<br>she had told staff at<br>assistance; howeve<br>she had told. R27 in<br>urine because of th<br>R27 stated,"it make<br>had not told staff ho<br>R61's quarterly Min<br>7/24/16, identified F<br>had diagnoses whic<br>diabetes, congestiv<br>anxiety. The MDS is<br>extensive assistant<br>The MDS also iden<br>injections daily.<br>On 10/20/16, at 10:<br>had concerns and r<br>only use her call lig<br>working. R61 stated<br>(NA) would walk pa<br>was on and others of<br>shut the light off and | 5 of Daily Living (ADL's,)<br>dressing, toileting and<br>7 p.m. R27 indicated she<br>did not have enough staff<br>o wait for staff to get to her.<br>often waited for assistance to<br>or go to bed. R27 stated,"I<br>n hour or more." R27 indicated<br>bout the long wait times for<br>er, did not remember whom<br>indicated being incontinent of<br>e long wait for assistance.<br>e me feel miserable;" however | F                 | 353 |  |                               |                                     |
|                          | about her call light,   | she had voiced her concerns<br>baths and blood sugars to<br>nferences and her son and   |                   |     |  |                               |                                     |

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|                          |  | AND HUMAN SERVICES  |                   |     |   | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,               |     | PLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245299  | B. WING           |     |   | 10/:                          | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                   | ę   | STREET ADDRESS, CITY, STATE, ZIP CODE   | -                             |                                     |
| FRAZEE                   | CARE CENTER  |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) BE                          | (X5)<br>COMPLETION<br>DATE          |
| F 353                    | Continued From pa<br>was not sure if he h  | ige 157<br>nad spoken with staff.   | F                 | 353 | 3   |                               |                                     |
|                          | nurse (LPN)-C state<br>census was 52. LPI<br>usual staff schedule<br>and five nursing ass<br>there were four NA'<br>indicated the facility<br>staffing and as rece<br>short staffing on bo<br>LPN-C indicated sh<br>incidents of short st<br>and the HR. LPN-C<br>call-ins and overall<br>in for scheduled shi | 8:50 a.m. licensed practical<br>ed at that time the facility<br>N-C indicated the day shift<br>e included three floor nurses,<br>sistants (NA), however today<br>'s. At 9:17 a.m. LPN-C<br>y did not have sufficient<br>ent as last weekend there was<br>th the day and the night shift.<br>he had reported the recent<br>taffing to the facility scheduler<br>c stated the facility had a lot of<br>staff did not consistently come<br>ifts. LPN-C stated she was<br>dministration had planned for |                   |     |   |                               |                                     |
|                          | staff (HC)-A indicate<br>assistants (NA) were<br>when there were not<br>lights, she would ar<br>residents the NA we<br>wait longer. HC-A s   | 1:01:33 p.m. house keeping<br>ed at that time the nursing<br>re working short. HC-A stated<br>of enough staff to answer call<br>nswer them and inform the<br>ere busy and would have to<br>tated she felt when the facility<br>took longer to attend to   |                   |     |   |                               |                                     |
|                          | (NM)-B indicated s<br>past year. NM-B sta<br>the floor and was u<br>managerial work. N<br>to continue to work<br>time, they would ge   | 10:11 a.m. nurse manager<br>taffing had not improved in the<br>ated she was often working on<br>nable to routinely complete her<br>IM-B stated she felt if staff had<br>under the conditions at that<br>to burned out. NM-B stated the<br>floor must have had   |                   |     |   |                               |                                     |

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| DEPARTMENT OF HEALTH AN<br>CENTERS FOR MEDICARE & N  |   |                    |     |  | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |
|--|---|--------------------|-----|--|-------------------------------|-------------------------------------|
|  | ) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                |     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|  | 245299  | B. WING            |     |  | 10/24/2016                    |                                     |
| NAME OF PROVIDER OR SUPPLIER   |   |                    | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                                     |
| FRAZEE CARE CENTER   |   |                    |     | PRAZEE, MN 56544   |                               |                                     |
| PREFIX (EACH DEFICIENCY MUS  | ENT OF DEFICIENCIES<br>ST BE PRECEDED BY FULL<br>DENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |
| <ul> <li>falls, such as R78.</li> <li>On 10/20/16, at 2:00 p. had lost staff left and rig NA-F stated she did no staff in the facility to rou needs on a consistent b had heard staff, family a about staffing shortage noticed an increase in r incontinence and behave staff were burning out of hours. NA-F stated she required 2 staff assist (R27,) and those who converbalize their needs (R27,)</li></ul> | me large amount of resident<br>m. NA-F stated the facility<br>ght the last 5 months.<br>In feel there was sufficient<br>utinely meet resident<br>basis. NA-F stated the she<br>and residents complain<br>tes. NA-F stated she had<br>resident falls, skin rashes,<br>viors. NA-F stated she felt<br>due to working too many<br>e felt residents who<br>(such as R18, R26, R15,<br>ould not/would not<br>R61) were the residents<br>received the cares they<br>m. NA-B stated she felt<br>ic insufficient staffing which<br>the last year. NA-B stated<br>ble to routinely meet<br>insufficient staffing. NA-B<br>stall-ins on at least a weekly<br>ot able to replace the staff.<br>sidents were not receiving<br>bileting, ambulation, ROM<br>R27, R37, R18, R47, R66,<br>tated she had spoken with<br>ximately ago a month<br>ng. NA-B stated she felt staffing<br>e were times R51 would<br>bor to get staffs attention. | F 3                | 353 |  |                               |                                     |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                   |     |  | FORM                          | APPROVED<br>0938-0391 |  |
|--------------------------|--|---|-------------------|-----|--|-------------------------------|-----------------------|--|
| STATEMENT                | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | • •               |     |  | (X3) DATE SURVEY<br>COMPLETED |                       |  |
|                          |  | 245299  | B. WING           |     |  | 10/24/2016                    |                       |  |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                   | :   | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                       |  |
| FRAZEE CARE CENTER       |  |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |                               |                       |  |
| (X4) ID<br>PREFIX<br>TAG |  |   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ULD BE COMPLÉTIO              |                       |  |
| F 353                    | assistant (PTA) stat<br>with residents ambu<br>programs being cor<br>stated felt there was<br>the facility to compl<br>maintenance progra<br>confirmed a decline<br>stated residents sur<br>routinely receive the<br>On 10/21/2016, at 1<br>interview, NA-B stat<br>increase in skin irrit<br>not receiving cares<br>staff.<br>On 10/21/2016, at<br>there was not an ac<br>meet resident need<br>had not been suffic<br>needs for the last s<br>there were times wi<br>working for the eve<br>be 5 on the shift. No<br>weekly. NA-J stated<br>done in a timely ma<br>repositioning, ambu<br>consistent basis. No<br>administrator and D<br>needs not being me<br>unaware of any acti<br>DON had taken to i | <ul> <li>and serious concerns ulation and maintenance inpleted consistently. PTA is not enough nursing staff in ete ambulation and ams on a routine basis. PTA in ambulation for R38 and is a R44 and R29 did not eir ambulation programs.</li> <li>1:35 p.m. during a follow up ted she felt R37 had an ation from incontinence due to routinely because of short</li> <li>2:17 p.m. NA-J stated she felt dequate amount of staff to s. NA-J stated she felt there ient staff to meet residents everal months. NA-J stated hen only 3 NA's would be ning shift when there were to A-J stated that would occur d routine cares would not get inner such as toileting, ilation and baths on a A-J stated she felt the PON were aware of resident et consistently, but was ons the admininstrator or</li> </ul> | F                 | 353 | 3  |                               |                       |  |

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# PRINTED: 12/15/2016

|                          |  | AND HUMAN SERVICES  |                   |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|-------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,               |     | LE CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING           |     |   | 10/:      | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   | -         |                                     |
| FRAZEE                   | CARE CENTER  |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                                     |
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| F 353                    | and repositioning w<br>or timely. NA-A stat<br>call light to alert sta<br>however due to insu-<br>get assistance time<br>NA-A also stated sh<br>assistance with her<br>program.<br>On 10/21/16, at 2:5<br>representative of fa<br>felt there was not e<br>meet all of the resid<br>was at the facility er<br>residents call lights<br>long periods of time<br>few days ago her fa<br>been soiled and cor<br>stated she continue<br>nursing staff about<br>of her family memb<br>staff cut corners to<br>concerns at a famil<br>2016. FM-B stated<br>not the place to voic<br>had been directed t<br>FM-B stated she be<br>of staff. FM-B state<br>concerns about suf<br>conference for her<br>told again the facilit<br>stated she felt she f<br>members linens an<br>daily basis.<br>On 10/24/16, at 9:3<br>not heard any recer | age 160<br>vere not being done routinely<br>red she felt R46 would use her<br>ff of her toileting needs,<br>ufficient staffing R46 would not<br>ely and would be incontinent.<br>The felt R44 did not receive<br>to care planned ambulation<br>and unily council (FM)-B stated she<br>nough staff in the facility to<br>dents needs. FM-B stated she<br>very day and often saw other<br>had gone unanswered for<br>the FM-B stated has recent as a<br>amily members bedding had<br>vered with a blanket. FM-B<br>ed to reported concerns to the<br>soiled linens and wheelchair<br>ther. FM-B stated she felt the<br>save time had verbalized her<br>y council meeting in August,<br>she had been told that was<br>ce concerns about staffing and<br>to fill out a grievance form.<br>Seen told the facility had "plenty"<br>d she had also voiced her<br>ficient staffing in the last care<br>family member and had been<br>ty had plenty of staff. FM-B<br>had to make sure her family<br>d wheelchair were clean on a<br>45 a.m. NM-A stated she had<br>nt staffing complaints from<br>members. NM-A stated she had<br>ht staffing complaints from<br>members. NM-A stated she | F                 | 353 |   |           |                                     |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                    |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|--------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                |     | E CONSTRUCTION  | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299   | B. WING            |     |   | 10/2      | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                    |     | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER  |  |                    |     | PARENT MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 353                    | had been working r<br>nursing position.<br>On 10/24/16, at 1:1<br>worker (LSW) state<br>complaints regardir<br>members or staff. L<br>when a complaint w<br>to write a grievance<br>facility had met the<br>staffing. LSW state<br>would be tied up wit<br>(who required 3 stat<br>there were sufficient<br>on a routine basis.<br>On 10/24/16, at 1:3<br>stated she had hea<br>"seems like we're s<br>the dining room dur<br>DM stated she had<br>insufficient nursing<br>director, NM's, DON<br>few months. DM stat<br>was aware of staffir<br>though, has not see<br>On 10/24/16, at 2:0<br>Registered Nurse/C<br>Practitioner(NP)-A<br>facility staff to asses<br>to identify a pattern<br>attempt to minimize<br>she would expect fl<br>care plans and prov<br>and exercise. NP-A | 15 p.m. the Licensed social<br>d she could not recall any<br>ng staffing by residents, family<br>SW stated her usual process<br>vas brought forward would be<br>form. LSW stated she felt the<br>"state requirements," for<br>d there were times when staff<br>th a bariatric (obese) resident<br>ff assistance,) but felt overall<br>t staff to meet resident needs<br>5 p.m. dietary manager (DM)<br>rd casual comments such as<br>hort today", from residents in<br>ing meals on a weekly basis.<br>verbalized concerns about<br>staff from residents to the HR<br>V and administrator in the last<br>ated she felt the administrator<br>ng concerns in the facility<br>en any improvement.<br>0 p.m. Advanced Practice | F                  | 853 |   |           |                                     |

|                          |  | AND HUMAN SERVICES  |                    |     |  | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|--------------------|-----|--|-----------|-------------------------------------|
| STATEMENT                | T OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | PLE CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING            | i   |  | 10/:      | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                    | 5   | STREET ADDRESS, CITY, STATE, ZIP CODE  |           |                                     |
| FRAZEE                   | CARE CENTER  |   |                    |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |           |                                     |
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| F 353                    | On 10/24/16, at 2:4<br>(MR)-B staff indicat<br>scheduled is detern<br>for the shift. If there<br>number of staff to s<br>the administrator. M<br>52 residents in hour<br>five NA's for the da<br>evening shift, and the<br>Review of the facilit<br>from 9/5/16 to 10/20<br>varied number of st<br>consistently have the<br>had identified as ap<br>inconsistencies wer<br>- the day shift did not<br>determined by the a<br>days<br>- the evening shift did<br>determined by the a<br>days<br>- the night shift did<br>determined by the a<br>days<br>- the night shift did<br>determined by the a<br>on these two night s<br>was scheduled rath<br>and then 56 resider<br>-9/26/16, one NA to<br>increase in licensed<br>On 10/24/16, at 3:0<br>interview, LSW stat<br>family council meet<br>LSW stated the fac<br>members had quit g<br>they did not want to<br>decorating. LSW st | O p.m. the medicals records<br>ted the number of staff<br>nined by the resident census<br>is a question regarding the<br>schedule MR-B would consult<br><i>I</i> R-B indicated at this time with<br>se she attempted to schedule<br>ay shift, five NA's for the<br>wo NA's for the overnight shift.<br>ties daily assignments sheets<br>0/16, revealed the facility had<br>taff scheduled and did not<br>ne staffing ratios the facility<br>opropriate. The following<br>re found:<br>ot have the staffing<br>administrator for 20 out of 48<br>did not have the staffing<br>administrator for 2 of 48 days,<br>shifts one nursing assistant<br>ner than two for 55 residnets<br>nts.<br>o care for 55 residents-no | F3                 | 353 | 3  |           |                                     |

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|                          |  | AND HUMAN SERVICES   |                   |     |  | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|-------------------|-----|--|-------------------------------|-------------------------------------|
|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,               |     | PLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245299   | B. WING           |     |  | 10/                           | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                                     |
| FRAZEE                   | CARE CENTER  |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) BE                          | (X5)<br>COMPLETION<br>DATE          |
| F 353                    | versus discussing t<br>LSW stated she ke<br>the family member<br>form. LSW stated s<br>met on a routine ba<br>On 10/24/16, at 3:2<br>she felt there was a<br>however felt resider<br>DON stated she fel<br>finding licensed and<br>DON stated the fac<br>from nursing pool a<br>they had been unat<br>stated as of Novem<br>one agency pool nu<br>she was unaware ro<br>done according to r<br>not been told by an<br>attended a recent ri<br>which call light wait<br>residents. DON stated<br>DON stated she for<br>a call light to be<br>DON further stated<br>complaints from res<br>staff regarding insu<br>staff performance.<br>would be the one to<br>and unlicensed staff<br>On 10/24/16, at 3:4<br>stated he had beer<br>Monday (when he s<br>meet with the clinic<br>resident acuity. He<br>staffing in the facilit | he concern at the meeting.<br>pt a log of all grievances and<br>did not fill out a grievance<br>the felt residents needs were<br>asis.<br>88 p.m. the interim DON stated<br>a staffing concern in the facility,<br>ints needs were being met.<br>t the facility had difficulty in<br>d unlicensed nursing staff.<br>illity had tried to obtain staff<br>agencies and due to a "cap"<br>ole to up to that point. DON<br>aber 1st, the facility will have<br>urse coming in. DON stated<br>esident cares were not getting<br>resident care plans as she had<br>y NA's. DON stated she had<br>esident council meeting in<br>times were brought up by<br>ted a call light audit had been<br>felt the matter was resolved.<br>he felt a 5-15 minute wait time<br>answered was acceptable.<br>she had not had any<br>sidents, family members or<br>fficient staffing, only about<br>DON stated the administrator<br>o set the number of licensed | F                 | 353 |  |                               |                                     |

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|                          |   | AND HUMAN SERVICES  |                   |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |  |
|--------------------------|---|---|-------------------|-----|---|-----------|-------------------------------------|--|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     | PLE CONSTRUCTION  | (X3) DATI | (X3) DATE SURVEY<br>COMPLETED       |  |
|                          |   | 245299  | B. WING           | ì   |   | 10/       | 24/2016                             |  |
| NAME OF F                | PROVIDER OR SUPPLIER  |   | I                 | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |  |
| FRAZEE                   | CARE CENTER   |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                                     |  |
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| F 353                    | problem was with fu<br>stated the facility ha<br>open, 4 NA position<br>that time he had no<br>plans for staffing, th<br>recruitment plan fro<br>to work on employe<br>implemented at tha<br>On 10/24/16, at 4:0<br>(AD) stated she bro<br>from resident count<br>meetings to all depa<br>concerns were alwa<br>quality assurance in<br>sometimes she fille<br>Concern Follow-up<br>nursing, or put the f<br>stated nursing com<br>to her before the ne<br>meeting.<br>On 10/24/16, at 5:0<br>stated she had new<br>with R66 for her ha<br>didn't know if they e<br>received ROM all th<br>this facility. She sta<br>why R66 did not ge<br>she had been told to<br>not working enough<br>stated she R66 cou<br>could before she ca<br>one full calander ye<br>light, the TV remote<br>word mom. FM-A st | of staff and stated he felt the<br>ull and part time ratios. He<br>ad 4 licensed nursing positions<br>is at that time. FA stated at<br>it implemented any action<br>hough had just received a staff<br>om HR. FM stated he planned<br>be relations, though had not<br>it time.<br>08 p.m. the activities director<br>ought up resident concerns<br>cil verbally during morning<br>artment heads, and resident<br>ays brought up at monthly<br>neetings. She stated<br>id out a Resident Council<br>form, and delivered it to<br>form in their mailboxes. She<br>pleted and returned the form<br>ext scheduled resident council<br>5 p.m. family member (FM)-A<br>er seen staff do any exercises<br>nds and arms, and stated she<br>ever had. She stated R66<br>ne time before admission to<br>ted she had asked facility staff<br>t ROM exercises and stated<br>by staff they felt her brain was<br>n for them to do that. FM-A<br>ald no longer do things she<br>ame to the facility (less than<br>ear ago,) such as using her call<br>e and write her name and the<br>tated she felt there were not<br>facility to ensure R66's needs | F                 | 353 | 3   |           |                                     |  |

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|                          |  | AND HUMAN SERVICES   |                   |     |   | FORM    | : 12/15/2016<br>APPROVED<br>. 0938-0391 |
|--------------------------|--|--|-------------------|-----|---|---------|---|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     | E CONSTRUCTION  | (X3) DA | TE SURVEY<br>MPLETED                    |
|                          |  | 245299   | B. WING           |     |   | 10      | /24/2016                                |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |         |   |
| FRAZEE                   | CARE CENTER  |  |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |         |   |
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| F 353                    | Continued From pa  | ge 165   | F                 | 353 |   |         |   |
|                          |  | council meeting minutes from mber 2016, revealed the   |                   |     |   |         |   |
|                          | revealed 8 resident<br>and a concern over<br>hours was voiced. A<br>resident council res<br>had completed call<br>and there had been<br>response also reve                         | hinutes dated 7/27/16,<br>s had attended the meeting<br>call light wait time of up to 2<br>An undated and unsigned<br>sponse note revealed nursing<br>light monitoring and audits<br>n room for improvement. The<br>aled nursing staff had been<br>and department heads had<br>concern.                    |                   |     |   |         |   |
|                          | revealed 11 resider<br>and voiced concern<br>response from nurs  | hinutes dated 8/31/16,<br>hts had attended the meeting<br>his over call light wait time. The<br>sing dated 8/31/16, revealed<br>hen communicated to nursing<br>gional director.  |                   |     |   |         |   |
|                          | revealed 10 resider<br>and voiced concern<br>averaged 30 to 60 r<br>occurred at all hour<br>response from nurs<br>10/6, and 10/7/16, o<br>completed regardin<br>placement. The not | ninutes dated 9/28/16,<br>nts had attended the meeting<br>is over call light wait times had<br>minute wait time which had<br>is of the day. An undated<br>sing form revealed on 10/5,<br>call light audits had been<br>ig response and call light<br>the further revealed FA and<br>d been informed of the |                   |     |   |         |   |
|                          |  | mily council meeting minutes<br>September 2016, revealed no<br>sufficient staffing.  |                   |     |   |         |   |

Facility ID: 00730

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| ATEMENT                  | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULT           | IPLE CONSTRUCTION  | (X3) DAT  | E SURVEY                  |
|--------------------------|--|--|---------------------|--|---|---------------------------|
|                          | OF CORRECTION  | IDENTIFICATION NUMBER:   |                     | IG   | · /   | IPLETED                   |
|                          |  | 245299   | B. WING _           |  | 10/   | 24/2016                   |
| AME OF I                 | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |   |                           |
| RAZEE                    | CARE CENTER  |  |                     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |   |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | LD BE   | (X5)<br>COMPLETIC<br>DATE |
| F 353                    |  | ge 166<br>staffing was requested, and not  | F 35                | 53   |   |                           |
| F 412<br>SS=D            |  | E/EMERGENCY DENTAL   | F 41                | 2  |   | 12/14/16                  |
|                          | an outside resource<br>§483.75(h) of this p<br>covered under the s<br>dental services to n<br>resident; must, if ne<br>making appointmen<br>transportation to an   | must provide or obtain from<br>e, in accordance with<br>wart, routine (to the extent<br>State plan); and emergency<br>neet the needs of each<br>ecessary, assist the resident in<br>hts; and by arranging for<br>ind from the dentist's office; and<br>r residents with lost or<br>to a dentist.   |                     |  |   |                           |
|                          | by:<br>Based on observat<br>review the facility fa<br>were provided and/<br>(R41) reviewed with<br>in poor repair.<br>Findings include:<br>R41's quarterly Min<br>7/21/16, identified of<br>diabetes mellitus, d<br>MDS indicated R41<br>impairments, and re<br>for all activities of d<br>extensive assistant<br>hygiene and eating | NT is not met as evidenced<br>tion, interview and document<br>ailed to ensure dental services<br>or offered for 1 of 3 residents<br>in broken/missing natural teeth<br>imum Data Set (MDS) dated<br>diagnoses which included:<br>epression and anxiety. The<br>had severe cognition<br>equired extensive assistance<br>aily living (ADLs) and<br>be of one staff for personal<br>. Further, the MDS indicated<br>dental problems and a<br>t. |                     | <ul> <li>F 412 Routine/Emergency Denta<br/>Services in SNF</li> <li>1. R41 had a dental assessme<br/>completed on 10-29-16 with subsidentist appointment scheduled.<br/>dental care plan implemented.</li> <li>2. All residents have the potent<br/>affected in this area. All resident<br/>have their dental assessment rev<br/>and updated as needed.</li> <li>3. Mandatory nursing staff educ<br/>was provided on November 16 a<br/>2016 to educate staff on the proof<br/>titled, Dental Services with a focu-<br/>need to assess resident is dental services</li> </ul> | nt<br>R41 s<br>ial to be<br>s will<br><i>r</i> iewed<br>cation<br>nd 17,<br>cedure<br>us on the<br>l status |                           |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                    |     |  | FORM   | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|--------------------|-----|--|--|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | E CONSTRUCTION   | (X3) DATE  | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING            |     |  | 10/2   | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                    | ST  | TREET ADDRESS, CITY, STATE, ZIP CODE   |  |                                     |
| FRAZEE                   | CARE CENTER  |   |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)  | BE   | (X5)<br>COMPLETION<br>DATE          |
| F 412                    | R41's care plan was<br>indicated R41 had u<br>teeth on the bottom<br>indicated R41 was f<br>morning, evening, a<br>assistance of one s<br>Review of the curre<br>indicated staff would<br>Review of Frazee C<br>Assessment dated<br>needed daily cleani<br>by staff. R41 was u<br>brush her teeth.<br>Review of Nutritiona<br>indicated R41's tee<br>partial dentures and<br>10/20/16 The NR at<br>in poor condition, has<br>eating a regular me<br>During observations<br>nursing assistant (N<br>her activities of dail<br>assistance. NA-D e<br>and assisted NA-A<br>to her wheelchair vi<br>left the room. R41 v<br>dentures and missin<br>natural teeth across<br>The broken off natu<br>her gum line were r<br>with no signs of acu<br>to answer whether s<br>bottom teeth. At 8:5<br>down to the dining r | s revised on 10/17/16,<br>upper dentures and natural<br>of her mouth. The care plan<br>to have oral cares done every<br>and as needed and required<br>taff for dental care.<br>Int Aid Care Plan Group C,<br>d assist R41 with oral cares.<br>Care Center Quarterly ADL<br>10/17/16 indicated R41<br>ng of teeth or daily mouth care<br>nable to remember how to<br>al Review (NR) dated 7/28/16<br>th were in poor condition, had<br>d was eating a regular diet. On<br>so indicated R41's teeth were<br>ad partial dentures and was | F 4                | .12 | <ul> <li>needed et ongoing thereafter. Phy<br/>will be informed of dental needs. It<br/>responsible party doesn t wish the<br/>resident to have outside dental<br/>examinations, a waiver for dental se<br/>will be obtained. Resident dental ne<br/>will be care planned.</li> <li>4. An audit has been developed to<br/>completion of dental assessments a<br/>receipt of assessed needed dental<br/>services/interventions. The audit w<br/>completed by the LSW or designee<br/>weekly X 4 weeks, then monthly X<br/>months. Audit findings will be provi<br/>monthly x 3 months to the QA comm<br/>with follow-up to committee<br/>recommendations.</li> <li>5. Deficient practice will be correct<br/>December 14, 2016</li> </ul> | f the<br>ervices<br>eeds<br>o audit<br>and<br>vill be<br>2<br>ided<br>mittee |                                     |

|                          | -  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                    |     |  | FORM     | : 12/15/2016<br>APPROVED<br>. 0938-0391 |
|--------------------------|--|---|--------------------|-----|--|----------|---|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     |  | (X3) DAT | E SURVEY<br>IPLETED                     |
|                          |  | 245299  | B. WING            |     |  | 10/      | 24/2016                                 |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                    | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  |          |   |
| FRAZEE                   | CARE CENTER  |   |                    |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |          |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETION<br>DATE              |
| F 412                    | on her chest area. <i>A</i><br>mechanical soft die<br>consisted of scraml<br>orange juice, hot ch<br>assisted R41 to cut<br>sizes, sat down nex<br>R41 her breakfast.<br>Review of R41 Fraz<br>Care Conference S<br>10/18/16 failed to a<br>teeth or dental cono<br>medical record lack<br>exams, identificatio<br>decayed teeth or de<br>offered or discusses<br>since her admission<br>On 10/19/16 at 12:3<br>needed staff assista<br>and stated "we bru<br>sometimes."<br>On 10/24/16 at 11:1<br>needed staff assista<br>and stated "she do<br>dentures, so not su<br>indicated she would<br>see what care R41<br>On 10/24/16 at 11:2<br>confirmed R41 need<br>dental hygiene and<br>natural teeth on the<br>condition. UM-B als<br>R41 medical chart a<br>documentation R41<br>dental services since | At 9:09 a.m. R41 was served a<br>t for breakfast, which<br>bled eggs, oatmeal, toast,<br>nocolate and water. NA-H<br>up her toast in small bite<br>at to her and began to feed<br>eee Care Center Resident<br>ummary dated 1/26/16 and<br>ddress any issues with R41's<br>cerns. Further review of R41's<br>cerns. Further review of R41's<br>and documentation of any oral<br>n of missing, broken, cracked,<br>ental services completed,<br>d with R41 and/or her family<br>n on 4/14/15.<br>38 p.m. NA-A confirmed R41<br>ance with her dental hygiene<br>sh her teeth or swab them<br>15 a.m. NA-F confirmed R41<br>ance with her dental hygiene<br>es not have a cup for<br>re what she has." NA-F<br>d look at her aid care plan to | F 4                | 112 |  |          |   |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                   |     |   | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|-------------------|-----|---|-------------------------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     |   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245299   | B. WING           |     |   | 10/2                          | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                   | 5   | STREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                                     |
| FRAZEE                   | CARE CENTER  |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |
| F 412<br>F 431<br>SS=D   | were assessed for offered dental servi<br>admission. UM-B a<br>issues were not add<br>and stated "knowin<br>been in poor shape<br>Review of facility poor<br>(General) dated 4/1<br>provide or obtains,<br>and emergency der<br>of each resident.<br>483.60(b), (d), (e) E<br>LABEL/STORE DR<br>The facility must en<br>a licensed pharmac<br>of records of receip<br>controlled drugs in a<br>accurate reconciliant<br>records are in order<br>controlled drugs is a<br>reconciled.<br>Drugs and biological<br>labeled in accordant<br>professional princip<br>appropriate accesss<br>instructions, and the<br>applicable.<br>In accordance with<br>facility must store a<br>locked compartmer<br>controls, and permi<br>have access to the | dental care on admission and<br>ces if needed at the time of<br>lso indicated R41's dental<br>dressed with her or her family<br>by that they [teeth] would have<br>, I would of asked them."<br>olicy titled, Dental Services<br>/08 indicated the facility<br>from outside resource, routine<br>that services to meet the need<br>DRUG RECORDS,<br>UGS & BIOLOGICALS<br>nploy or obtain the services of<br>cist who establishes a system<br>t and disposition of all<br>sufficient detail to enable an<br>cion; and determines that drug<br>r and that an account of all<br>maintained and periodically<br>als used in the facility must be<br>the with currently accepted<br>bles, and include the<br>ory and cautionary<br>e expiration date when<br>State and Federal laws, the<br>II drugs and biologicals in<br>ths under proper temperature<br>t only authorized personnel to |                   | 412 |   |                               | 12/14/16                            |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                    |     | F   | FORM /  | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|--------------------|-----|---|---|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     |   | X3) DATE                                      | SURVEY<br>PLETED                    |
|                          |   | 245299   | B. WING            |     |   | 10/2  | 4/2016                              |
| NAME OF F                | ROVIDER OR SUPPLIER   |  |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |   |                                     |
| FRAZEE                   | CARE CENTER   |  |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |   |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  |   | (X5)<br>COMPLETION<br>DATE          |
| F 431                    | controlled drugs list<br>Comprehensive Dru<br>Control Act of 1976<br>abuse, except when<br>package drug distril   | compartments for storage of<br>ed in Schedule II of the<br>ug Abuse Prevention and<br>and other drugs subject to<br>the facility uses single unit<br>bution systems in which the<br>inimal and a missing dose can                                    | F 4                | 131 |   |   |                                     |
|                          | by:<br>Based on observat<br>review, the facility fa<br>labeled with open o<br>opened for 2 of 5 re<br>addition, the facility<br>for consistent and ti<br>discontinued narcot<br>diversion in 2 of 2 r<br>medication storage.<br>Findings include:<br>On 10/24/16, at 1:0<br>observed to have the<br>drops were opened<br>the discard date con<br>-R31's Timolol Male<br>dispensed on 6/4/10<br>-R43's Latanoprost<br>on 8/8/16. | ics to prevent loss or potential<br>medication rooms reviewed for<br>0 p.m. medication cart B was<br>the following bottles of eye<br>without a date identified so<br>uld be determined:<br>the PF Solution 0.5%,<br>5.<br>Solution 0.005%, dispensed |                    |     | <ul> <li>F 431 Drug records, Proper<br/>Label/Storage of Drugs &amp; Biologicals</li> <li>1. R31 (date unlabeled) eye drop Ti<br/>Maleate PF Solution 0.5% was replace</li> <li>R42 (date unlabeled) eye drop<br/>Latanoprost Solution 0.555% was<br/>replaced .</li> <li>Discontinued Narcotic medications si<br/>in A wing medication room have beer<br/>destroyed by 2 facility nurses.</li> <li>2. All residents receiving medication<br/>with specific expiration dates can be<br/>negatively affected by this deficient<br/>practice. All residents that receive eye<br/>medications will have their eye drops<br/>prescriptions review for date opened.</li> <li>All residents who receive narcotic<br/>medication have the potential to be<br/>negatively affected in this area.</li> <li>3. Mandatory nursing staff education</li> </ul> | imolol<br>ced.<br>tored<br>n<br>ns<br>ye<br>s |                                     |
|                          | Solution 0.5% Solut   | prescribed Timolol Maleate PF<br>ion, 1 drop in left eye one time<br>, with an ordered start date of   |                    |     | <ol> <li>Mandatory nursing staff educatio<br/>was provided on November 16 and 1<br/>2016 to educate staff on the procedu</li> </ol>   | 17,   |                                     |

Facility ID: 00730

| STATEMENT                | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA   |                     |      | E CONSTRUCTION  | (X3) DATE                                      | 0938-039                  |
|--------------------------|--|---|---------------------|------|---|--|---------------------------|
| IND PLAN (               | OF CORRECTION  | IDENTIFICATION NUMBER:  | A. BUILDI           | NG . |   | COM  | PLETED                    |
|                          |  | 245299  | B. WING _           |      |   | 10/2   | 24/2016                   |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                     |      | TREET ADDRESS, CITY, STATE, ZIP CODE  |  |                           |
| FRAZEE                   | CARE CENTER  |   |                     |      | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |  |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (    | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | BE   | (X5)<br>COMPLETIO<br>DATE |
| F 431                    | Continued From pa<br>4/16/16.<br>R43's signed physic   | age 171<br>cian orders dated 10/6/16,   | F 40                | 31   | titled, Drugs and Biological<br>Storage-Labeling, Medications-Dis<br>of Discontinued Controlled   | position                                       |                           |
|                          | indicated R43 was Solution 0.005%, 1   | prescribed Latanoprost<br>drop in both eyes at bedtime<br>an ordered4 start date of   |                     |      | Medication-Discontinued narcotics<br>deceased or discharged residents<br>focus on the need to date all medic<br>with specific expiration dates; i.e. e<br>bottles, with date opened . Staff                                       | with a<br>cations<br>eye drop                  |                           |
|                          | (RN)-D confirmed t<br>were not dated whe<br>stated they should<br>she did not work or<br>but stated any nurs | rvation, registered nurse<br>the eye drop medication bottles<br>en they were opened, and<br>have been. RN-D reported<br>in the B medication cart often,<br>se can date the drops when |                     |      | also educated on Medication: Nard<br>medication with a focus on the new<br>two nurses to destroy narcotic med<br>timely upon discontinuation of narc<br>documenting destruction in the na<br>leather bound book.                  | ed for<br>lication<br>otic,                    |                           |
|                          | pharmacist comes<br>the medication cart  | RN-D also reported a to the facility monthly to review s for expired medications.   |                     |      | <ol> <li>Observational audits of staff has<br/>soiled linens has been started and<br/>Medication carts will be audited for</li> </ol>   | proper   |                           |
|                          | of nursing (ADON)<br>date the eye drops<br>have been done. T   | 36 p.m. the assistant director<br>stated the expectation was to<br>when opened, and it should<br>The ADON then stated she was<br>nacist did not flag the undated<br>nedications.      |                     |      | labeling of medications of date of<br>and removal of discontinued medic<br>from medication carts. Narcotic si<br>areas will be audited for timely disp<br>and documentation of disposed na<br>The audits will be completed by the | ations<br>torage<br>oosal<br>rcotics.<br>e DON |                           |
|                          | Medicine dated 3/1 the dating of medic   | or Labeling and Storing<br>4 and 4/15, did not address<br>ation bottles or indicate when<br>6 medications once they were  |                     |      | or designee weekly X 4 weeks, the<br>monthly X 2 months. Audit findings<br>provided monthly x 3 months to the<br>committee with follow-up to commi<br>recommendations.  | s will be<br>e QA<br>ttee                      |                           |
|                          | Expiration Guidelin expired 28 days aft  | Specialty Pharmacy Eye Drop<br>es indicated Timolol would be<br>er opened, and Latanoprost<br>weeks after opened.   |                     |      | 5. Deficient practice will be correc<br>December 14, 2016   | cied by  |                           |
|                          | conducted of the fa  | 7 p.m. observations were<br>cility's medication storage<br>licensed practical nurse   |                     |      |   |  |                           |

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|                          |  | AND HUMAN SERVICES  |                   |     |   | FORM      | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|-------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     |   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245299  | B. WING           |     |   | 10/;      | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   |           |                                     |
| FRAZEE                   | CARE CENTER  |   |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 431                    | (LPN)-C unlocked a<br>the west medication<br>two shelves filled widiscontinued and wi<br>bottles of morphine<br>shelf, some with ph<br>2015 and Septembor<br>filled with various na<br>morphine, hydromo<br>On the outside of the<br>the destruction of ca<br>also on the counter<br>were 12 bound narco<br>On 10/24/16, at 1:2<br>nursing (ADON) un<br>cupboard in the eas<br>cupboard were two<br>narcotics which wer<br>destruction. One boa<br>adjacent to the narco<br>The Inventory And I<br>Substances Form: I<br>affixed to the west r<br>The document iden<br>drug name, strengtl<br>medication was pla-<br>signature of the nur<br>entries from 8/31/16<br>document.<br>During interview on<br>stated all discontinu-<br>stored in the double<br>reported when a na<br>nurses were to doce<br>ledger, and on the s | a double locked cupboard in<br>n room. In the cupboard were<br>were observed on the upper<br>harmacy label dates of January<br>er 2015. The lower self was<br>arcotics such as oxycodone,<br>orphone and fentanyl patches.<br>he cupboard door was taped<br>ontrolled substances form,<br>below the narcotic cupboard<br>cotic ledgers.<br>25 p.m. the assistant director of<br>locked a double locked<br>st medication room. In the<br>smaller shelves filled with<br>re discontinued and waiting for<br>bund narcotic ledger was noted<br>cotic cupboard.<br>Destruction Of Controlled<br>Long-Term Care Facilities was<br>medication room cupboard.<br>tified the prescription number, | F                 | 431 |   |           |                                     |

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|                          |  | AND HUMAN SERVICES   |                    |     |  | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|--------------------|-----|--|-------------------------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                |     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245299   | B. WING            |     |  | 10/2                          | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |  | •                  | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                                     |
| FRAZEE                   | CARE CENTER  |  |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |
| F 431                    | placed in the cupbor<br>medications were n<br>were destroyed. LP<br>narcotics in the faci<br>a long time. LPN-C<br>nurse managers ha<br>narcotic cupboards<br>want to be response<br>discontinued narcot<br>She stated the curre<br>large amounts of di<br>periods of time "sca<br>During interview on<br>ADON confirmed be<br>contained many dis<br>double locked cupb<br>several months. The<br>started destroying t<br>member, but did no<br>medications. The A<br>Of The Inventory Ar<br>Substances Form v<br>discontinued narcot<br>The ADON confirmed<br>on the form were de<br>bound ledger, and v<br>the time of destruct<br>was a large quantity<br>the facility. The ADO<br>had access to the k<br>discontinued narcot<br>the medications we<br>they were placed in<br>ADON confirmed th<br>process for storage<br>discontinued narcot | bard. LPN-C stated the<br>not counted again until they<br>N-C reported discontinued<br>ility had not been destroyed in<br>stated 3 different nurses and<br>ad keys to the discontinued<br>. LPN-C indicated she did not<br>ible for the large volume of<br>tic medications in the facility.<br>ent facility practice of storing<br>iscontinued narcotics for long<br>ared" her.<br>10/24/16, at 1:30 p.m. the<br>oth medication rooms<br>continued narcotics in the<br>board accumulated over<br>the ADON stated the prior DON<br>them with another staff<br>ot destroy all of the<br>.DON confirmed the Certificate<br>and Destruction Of Controlled<br>was not a complete list of all<br>tics waiting for destruction.<br>ed all of the medications not<br>ocumented in the narcotic<br>would be cross referenced at<br>tion. The ADON stated there<br>y of discontinued narcotics in<br>ON also stated multiple nurses<br>keys which opened the<br>tic cupboard, and confirmed<br>are not counted again after<br>the locked cupboard. The<br>the facility lacked a consistent<br>and destruction of | F 4                | .31 |  |                               |                                     |

Facility ID: 00730

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245299 B. WING 10/24/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE CARE CENTER FRAZEE, MN 56544 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 431 Continued From page 174 F 431 3/1/14, indicated unused controlled medications and the control record be taken to the nursing director's office, and should be locked up until time for destruction in accordance with State Pharmacy Board. 483.65 INFECTION CONTROL, PREVENT F 441 F 441 12/14/16 SPREAD, LINENS SS=F The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -(1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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.

FORM CMS-2567(02-99) Previous Versions Obsolete

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|                          |  | AND HUMAN SERVICES  |                   |     |  | ORM APPROV<br>3 NO. 0938-03      |  |
|--------------------------|--|---|-------------------|-----|--|----------------------------------|--|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     |  | (X3) DATE SURVEY<br>COMPLETED    |  |
|                          |  | 245299  | B. WING           |     |  | 10/24/2016                       |  |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                   |     | TREET ADDRESS, CITY, STATE, ZIP CODE   |                                  |  |
| FRAZEE                   | CARE CENTER  |   |                   |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |                                  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |                                  |  |
| F 441                    |  | age 175<br>ndle, store, process and<br>as to prevent the spread of  | F 4               | 441 |  |                                  |  |
|                          | by:<br>Based on interview<br>facility failed to esta<br>program which incl<br>surveillance of resid<br>surveillance and invidentified. This had<br>residents who resid<br>the facility failed to<br>soiled clothing and  | NT is not met as evidenced<br>v and document review, the<br>ablish an infection control<br>uded comprehensive<br>dent symptoms, analysis of the<br>vestigation of patterns<br>the potential to affect all 52<br>ded in the facility. In addition,<br>ensure proper handling of<br>linens during personal cares<br>(R18) observed for personal   |                   |     | F 441 Infection control, prevention, a<br>spread<br>1. R18 is asymptomatic for signs an<br>systems of infection and is receiving<br>timely assistance with toileting and<br>personal hygiene. R18 s care plan h<br>been reviewed; bowel and bladder<br>assessment will be completed.<br>Observation findings are that soiled lin<br>is not thrown on the floor. Nursing sta<br>will bring soiled linen disposal recepta<br>down hallways to place soiled linens i  | nd<br>nas<br>nen<br>aff<br>acles |  |
|                          | reviewed from 4/11<br>identified tracked o<br>which antibiotics we<br>surveillance process<br>of the following: loc<br>facility, if the infecti<br>community associa<br>onset of symptoms<br>present, cultures per<br>treatment provided<br>resolved. Furtherm<br>and/or investigation | on Control Logs were<br>/16, through 9/22/16. The logs<br>nly residents with infections for<br>ere prescribed. The facility's<br>eses also lacked identification<br>ration of the resident within the<br>on was healthcare or<br>tted, site of infection, date<br>, specific symptoms that were<br>erformed/ organism identified,<br>and the date the infection<br>ore, the logs lacked analysis<br>of patterns identified. |                   |     | <ol> <li>All residents have the potential to<br/>negatively affected by this practice. T<br/>educating and monitoring of resident<br/>cleanliness and the completing of the<br/>monthly infection control log with the<br/>inclusion of infections not treated by<br/>antibiotics including viral infections ar<br/>analysis of all infections, rates, and<br/>patterns will ensure compliance in<br/>infection prevention and spread.</li> <li>Mandatory nursing staff education<br/>was provided on November 16 and 11<br/>2016 to educate staff on the procedun<br/>titled, Linens-Handling and infection<br/>Control and Infection Control and NO</li> </ol> | The<br>Ind<br>7,<br>re           |  |

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

|                          |  |   |                     |  |   | 0938-039                   |
|--------------------------|--|---|---------------------|--|---|----------------------------|
|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | IPLE CONSTRUCTION  |   | E SURVEY<br>PLETED         |
|                          |  | 245299  | B. WING _           |  |   | 24/2016                    |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP COL   |   |                            |
| FRAZEE                   | CARE CENTER  |   |                     | 219 WEST MAPLE AVENUE, PO BOX 9<br>FRAZEE, MN 56544  | 96  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY)   | HOULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 441                    | facility's infection or<br>monthly infection for<br>thoroughly for each<br>stated in her lack o<br>incomplete. UM-B<br>tracked infections w<br>antibiotics, and cor<br>currently in place to<br>viral illnesses's suc<br>gastroenteritis or in<br>she was assigned in<br>control program, sh<br>or direction on what<br>the program. UM-F<br>has not had any out<br>Review of the facility<br>maintained an infect<br>program that provid<br>comfortable environ | who was responsible for the<br>ontrol program, confirmed the<br>ogs were not completed<br>a resident identified. UM-B<br>f time the logs were<br>also stated the facility only<br>which were treated with<br>of firmed there was no system<br>o track and trend any other<br>thas the common cold,<br>offluenza. UM-B stated when<br>responsibility of the infection<br>ne did not receive any training<br>t should have been included in<br>B confirmed the facility luckily | F 44                | <ul> <li>placing solid linens on the floot timely provision of assistance personal hygiene cares. Infect Nurse was educated on the transmission of all fainfections, including those not antibiotics.</li> <li>An observation and chart developed to monitor handling completion of infection surveil the center with the tracking/transmission of infections, and communication of infections, and communication of infections completed by the Infection Co or designee weekly X 4 weeks monthly X 2 months. Audit fir provided monthly x 3 months committee with follow-up to correcommendations. Infections and rates will be reported (ong monthly at monthly QA meeting).</li> <li>Deficient practice will be constructed with a construction of the construction of</li></ul> | with<br>stion Control<br>acking and<br>ucility<br>treated with<br>audit was<br>of linens,<br>lance within<br>ending of<br>nfections<br>are planning<br>n the CNA<br>t will be<br>ntrol Nurse<br>s, then<br>dings will be<br>to the QA<br>ommittee<br>s, patterns<br>going)<br>gs. |                            |
|                          | (MDS) dated 7/26/<br>cognitive impairme<br>communicate with<br>included, dementia<br>MDS identified R18  | uarterly Minimum Data Set<br>16, identified R18 had severe<br>nt, was unable to<br>staff and had diagnoses which<br>, depression and anxiety. The<br>3 was totally dependent on staff<br>y living (ADL's) and required 2  |                     |  |   |                            |

|                          |  | AND HUMAN SERVICES   |                   |     |   | FORM     | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|-------------------|-----|---|----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,               |     | PLE CONSTRUCTION<br>G   | (X3) DAT | E SURVEY<br>IPLETED                 |
|                          |  | 245299   | B. WING           | ì   |   | 10/      | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                   |     | STREET ADDRESS, CITY, STATE, ZIP CODE   |          |                                     |
| FRAZEE                   | CARE CENTER  |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRON<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETION<br>DATE          |
| F 441                    | staff for assistance<br>hygiene and toiletin<br>was frequently inco<br>The MDS identified<br>program for bowel of<br>Review of R18's an<br>identified R18 was<br>ADL's. The MDS id<br>incontinent of bowe<br>identified R18 was<br>bowel or bladder inco<br>Review of R18's Co<br>Area Assessment (<br>R18 had cognitive I<br>was unable to cohe<br>The CAA revealed I<br>spite of her inability<br>Communication CA<br>be anticipated by fai<br>Incontinent of bowe<br>assistance with all r<br>changed as needed<br>Review of R18's cu<br>10/7/16, revealed F<br>was unable to comm<br>totally dependent of<br>repositioning needs<br>incontinent brief . T<br>check and change<br>incontinence with re<br>On 10/17/16, at 3:4<br>wheelchair in her ro | with bed mobility, personal<br>g. The MDS identified R18<br>ntinent of bowel and bladder.<br>R18 was not on a toileting<br>or bladder incontinence.<br>unual MDS dated 4/26/16,<br>totally dependent on staff for<br>entified R18 was frequently<br>and bladder. The MDS<br>not on a toileting program for<br>continence.<br>Degnitive Loss/ Dementia Care<br>CAA) dated 4/26/16, identified<br>oss related to dementia and<br>erently verbalize her needs.<br>R18's needs were to be met in<br>to make requests. R18's<br>A identified R18's needs must<br>acility staff. Urinary<br>dentified R18 was frequently<br>and bladder and needed<br>mobility and was toileted or<br>d.<br>rrent care plan last updated<br>R18 had severe cognitive loss,<br>municate her needs and was<br>n staff for toileting,<br>s and was frequently<br>and bladder and wore an<br>the care plan directed staff<br>R18 every 2 hours for | F 4               | 441 |   |          |                                     |

| CENTE                    | RS FOR MEDICARE  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                   |     | O  | FORM.<br>MB NO. | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|-------------------|-----|--|-----------------|-------------------------------------|
|                          | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,               |     | LE CONSTRUCTION  |                 | E SURVEY<br>PLETED                  |
|                          |  | 245299   | B. WING           |     |  | 10/;            | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  |                 |                                     |
| FRAZEE                   | CARE CENTER  |  |                   |     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |                 |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE              | (X5)<br>COMPLETION<br>DATE          |
| F 441                    | and had fecal matter<br>up to her first knuck<br>her thumb. R18's ri-<br>leg also had smear<br>entire hand. R18 be<br>covered right hand<br>that time the director<br>down the hall and w<br>At 3:41 p.m. nursing<br>R18's room and as<br>the bathroom, R18<br>reached up with hel<br>hair. NA-H took a p<br>and cleansed R18's<br>reached down with<br>soiled area on her so<br>obtaining clean clot<br>would re-wipe R18's<br>reach down and ha<br>times. At that time I<br>dependent on 2 sta<br>frequently incontine<br>3:44 p.m. NA-H req<br>cares. R18 continue<br>re-soiling her right h<br>pant leg and NA-H<br>the wipes.<br>-At 3:53 p.m. NA-H<br>requested assistant<br>were times when sh<br>another staff memb<br>requiring 2 staff assis<br>stated she had bee<br>when the DON pullo<br>3:56 p.m. NA-H left<br>out assistance with | er on her right hand, covering<br>kles on all of her fingers and<br>ght upper (thigh height) pant<br>ed fecal matter the size of her<br>egan to move her fecal<br>towards the front of her. At<br>or of nursing was walking<br>vas notified of R18's condition.<br>g assistant (NA)-H entered<br>ked R18 if she wanted to use<br>lifted her head out of her shirt,<br>r right hand and touched her<br>ackaged pre-moistened wipe<br>s right hand. R18 repeatedly<br>her hand and touched the<br>slacks while NA-H was<br>hes from her closet. NA-H<br>s hand, and R18 would again<br>ndle the soiled slacks several<br>NA-H stated R18 was totally<br>ff for all of her cares and was<br>int of bowel and bladder. At<br>uested assistance with R18's<br>ed to repeat the process of<br>hand with the bowel on her<br>would re-wipe her hand with<br>used her walkie talkie and<br>ce, NA-H then stated there<br>he had to wait a long time for<br>her to help with residents<br>sistance, including R18. NA-H<br>n assigned to another wing<br>ed her into R18's room. At<br>R18's room to physically seek<br>out covering the bowel on<br>B re-soiled her right hand | F 4               | 441 |  |                 |                                     |

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|                          |   | AND HUMAN SERVICES  |                    |      |  | FORM | APPROVED                   |
|--------------------------|---|---|--------------------|------|--|------|----------------------------|
| 1                        | TOF DEFICIENCIES  | & MEDICAID SERVICES   |                    | וחוד |  |      | 0938-0391                  |
|                          | OF DEFICIENCIES<br>OF CORRECTION  | IDENTIFICATION NUMBER:  |                    |      | E CONSTRUCTION   |      | PLETED                     |
|                          |   | 245299  | B. WING            |      |  | 10/; | 24/2016                    |
| NAME OF                  | PROVIDER OR SUPPLIER  | -   |                    | S    | TREET ADDRESS, CITY, STATE, ZIP CODE   |      |                            |
| FRA7FF                   | CARE CENTER   |   |                    |      | 19 WEST MAPLE AVENUE, PO BOX 96  |      |                            |
|                          | OANE OENTEN   |   |                    | F    | RAZEE, MN 56544  |      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE   | (X5)<br>COMPLETION<br>DATE |
| F 441                    | Continued From pa   | ge 179  | F4                 | 41   |  |      |                            |
|                          | in a grape sized am<br>the floor near R18's<br>as she approached<br>hands with a washo<br>NA-F backed away<br>gait belt across R18<br>R18's room, both N<br>R18 from the whee<br>the bathroom. NA-F<br>incontinent brief wh<br>and bladder and bla<br>incontinent brief in<br>soiled slacks on the<br>shirt and placed it of<br>slacks. NA-F and N<br>cleansing, applied a<br>clothing for R18. N<br>cushion and stated<br>the floor with a wipe<br>shirt and slacks and<br>floor with her gloved<br>entered the soiled h<br>R18 with a baby do<br>room.<br>On 10/17/16, at 4:1<br>usual practice to pla<br>floor. NA-F stated th<br>place the soiled ho<br>she was unaware of<br>assisted with toiletin<br>get a report from th<br>resident cares were<br>not that day. NA-F | entered R18's room, stepped<br>nount of bowel which was on<br>a front right wheelchair wheel<br>R18. NA-F washed R18's<br>cloth. R18 pushed NA-F away,<br>, reproached R18, donned a<br>B's torso and NA-H entered<br>IA-F and NA-H transferred<br>Ichair, assisted R18 to walk to<br>F removed R18's slacks and<br>ich were saturated with bowel<br>adder. NA-F discarded R18's<br>the garbage and placed R18's<br>on the floor next to R18's soiled<br>IA-H assisted R18 with<br>a clean brief and donned clean<br>A-H checked R18's seat<br>she felt it was clean, washed<br>a. NA-F picked up R18's soiled<br>d soiled washcloths from the<br>d hands, left the room and<br>nopper room. NA-H provided<br>II, her call light and left R18's<br>7 p.m. NA-F stated it was not<br>aced soiled clothing on the<br>he usual practice would be<br>thing in a bag and bring the<br>opper room. NA-F also stated<br>of the last time R18 had been<br>ng. NA-F stated she used to<br>e previous shift NA of when<br>a last completed, though did<br>stated she had not been<br>the previous shift NA on a |                    |      |  |      |                            |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |  |  |  | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|--|--|--|-------------------------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |  | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245299  | B. WING                                |  |  | 10/;                          | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |  |  | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                                     |
| FRAZEE                   | CARE CENTER  |   |  |  | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                     |  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |
| F 441<br>F 520<br>SS=F   | nursing stated it wa<br>soiled clothing on th<br>usual practice was<br>bags, then to bring<br>hopper rooms to be<br>bags. The ADON st<br>follow the facility po<br>Review of a facility<br>dated 4/1/08, revea<br>when handling, pro-<br>linens, staff were to<br>prevent the spread<br>directed staff to imm<br>from the residents m<br>room.<br>483.75(o)(1) QAA<br>COMMITTEE-MEM<br>QUARTERLY/PLAN<br>A facility must main<br>assurance committen<br>nursing services; a<br>facility; and at least<br>facility; staff.<br>The quality assess<br>committee meets an<br>issues with respect<br>and assurance activid<br>develops and imple<br>action to correct ide | e to short staffing.<br>7 p.m. the assistant director of<br>s not usual practice to place<br>he floor. ADON stated the<br>to place soiled clothing in<br>the closed bags into the<br>e rinsed and placed in laundry<br>ated she expected staff to<br>licy.<br>policy titled., Linens-Handling,<br>led it was the facility's policy<br>cessing and transporting<br>use specific procedures to<br>of infection. The policy<br>nediately remove soiled linens<br>room and taken to a utility<br>IBERS/MEET | F 4                                    |  |  |                               | 12/14/16                            |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                    |     | I   | FORM /   | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|--------------------|-----|---|--|-------------------------------------|
|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | LE CONSTRUCTION (>  | (X3) DATE SURVEY<br>COMPLETED  |                                     |
|                          |  | 245299   | B. WING            | i   |   | 10/2   | 24/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |  |                                     |
| FRAZEE                   | CARE CENTER  |  |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   |  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE          |
| F 520                    | except insofar as su<br>compliance of such<br>requirements of this<br>Good faith attempts<br>and correct quality of<br>a basis for sanction<br>This REQUIREMEN<br>by:<br>Based on observat<br>review, the facility O<br>Assurance (QA&A)<br>and implement app<br>previously identified<br>insufficient staffing,<br>implementation and<br>rehabilitative nursin<br>ambulation and ran<br>by physical and occ<br>to develop and impl<br>harm for 1 of 1 resid<br>in range of motion (<br>decline in ambulatio<br>of multiple falls. Thi<br>potential to affect al<br>residing in the facilit<br>Findings include:<br>See F353 the facilit<br>staffing was availab<br>On 10/21/16, at 10:<br>noticed residents w | Cords of such committee<br>uch disclosure is related to the<br>committee with the<br>s section.<br>The by the committee to identify<br>deficiencies will not be used as<br>s.<br>NT is not met as evidenced<br>ion, interview, and document<br>Quality Assessment and<br>committee failed to develop<br>ropriate action plans for<br>l areas of concern related to<br>and the lack of<br>l documentation of<br>g services which included<br>ge of motion cares as directed<br>upational therapy. The failure<br>ement action plans caused<br>dent (R66) who had a decline<br>ROM), (R38) who had a<br>pn, (R78,) who had a pattern<br>s deficient practice had the<br>l 52 residents currently | F                  | 520 | <ul> <li>F 520 Quality Committee-members quarterly</li> <li>1. Resident grievances and resider counsel concerns will be reviewed at monthly QA meeting for further suggestions on ensure compliance in these areas. Each survey deficiency will be analyzed and the finding will b reported to the QA committee for furt recommendation to ensure ongoing compliance. Staffing numbers and patterns will be reviewed. Recruitme interventions and success will be reviewed.</li> <li>2. All residents have the potential to negatively affected due to insufficient staffing and deficient practices. Qua Assurance performance improvement in Staffing, Nursing rehabilitation programs, and Falls.</li> <li>3. Mandatory nursing staff educatio was provided on November 16 and 1 2016 to educate staff on the procedu titled, Quality Council Assurance a</li> </ul> | nt<br>t each<br>n<br>y audit<br>be<br>ther<br>ent<br>ent<br>ality<br>nt<br>for |                                     |

Facility ID: 00730

If continuation sheet Page 182 of 184

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245299 B. WING 10/24/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE CARE CENTER FRAZEE, MN 56544 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 520 Continued From page 182 F 520 not enough staff. PTA stated she had placed Improvement and Nursing Services: residents on maintenance programs and has had Quality of Resident Care with a focus on them referred back to therapy for treatment due the need for performance improvement to a decline. PTA stated she felt this was due to projects with team committee involvement not enough staff to consistently carry out on adequate staffing, Nursing residents programs. PTA stated the facility NA's Rehabilitation programs, and Prevention were responsible for residents and management of Falls. ambulation/maintenance programs, however, there were not enough NA'S on the floor. PTA 4. An audit has been developed to stated she had voiced her concerns about monitor progress of PIP team meetings residents ambulation/maintenance programs to monthly, to monitor the completion and nursing and administration during the weekly progress (findings) of all post survey medicare meeting as recently as a month or so audits. QA committee will provide ago. PTA stated the response she had received additional auditing and recommendations until resolution of concerns identified. was the staff were going to "talk" to the NA's. Audits will be completed by the Executive On 10/24/16, at 3:41 p.m. the administrator Director or designee monthly x 3 months. stated he had started employment in the facility on 10/17/16, one week prior. He stated he was 5. Deficient practice will be corrected by not aware of the facility nursing had been working December 14, 2016 on staffing since last Monday (when he started,) and had planned to meet with the clinical managers to identify resident acuity. The administrator stated he was unsure if the staffing in the facility was sufficient. The administrator stated the facility had 4 licensed nursing positions open, 4 NA positions at that time. He stated at that time he had not implemented any action plans for staffing, though had just received a staff recruitment plan from HR. The administrator stated in the future he planned to work on employee relations, though had not implemented at that time. On 10/24/16, at 4:08 p.m. the activity director (AD) stated she routinely attended the facility QA meetings. AD stated in the past staffing concerns and call light wait times had been discussed at

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/15/2016

|                          |  | AND HUMAN SERVICES  |                    |     |  | FORM                          | 12/15/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|--------------------|-----|--|-------------------------------|-------------------------------------|
| STATEMENT                | T OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245299  | B. WING            |     |  | 10/;                          | 24/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                                     |
| FRAZEE                   | CARE CENTER  |   |                    |     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |
| F 520                    | the QA meetings ar<br>discussed or impler<br>conditions. AD state<br>resident council rou-<br>voiced complaints r<br>times, up to 2 hours<br>resident concerns t<br>each month after re-<br>On 10/24/16, at app<br>director of nursing (<br>one person in the fac<br>included administra<br>managers, pharma<br>stated the QA com<br>DON stated the fac<br>included administra<br>managers, pharma<br>stated the QA comr<br>again quarterly with<br>DON stated the co<br>staffing concerns in<br>recruitment and reti-<br>committee had also<br>pressure ulcers. Do<br>current action plan<br>areas: sufficient sta<br>services for ambula<br>DON confirmed the<br>monitoring and had<br>to ensure residents | and felt no plan had been<br>mented to improve staffing<br>ed residents who had attended<br>utinely in the last 3 months had<br>regarding long call light wait<br>s. AD stated she had reported<br>to the administrator and DON<br>esident council meetings.<br>proximately 5:00 p.m. interim<br>(DON) stated at that time no<br>acility was responsible for QA,<br>mittee continued to meet.<br>cility QA committee members<br>ator, DON, department<br>cy and social services. DON<br>mittee would meet monthly and<br>n the medical director present.<br>ommittee had discussed<br>n the past such as staff<br>ention. DON stated the QA<br>o discussed resident falls and<br>ON was unable to identify a<br>was in place for the following<br>affing, falls, restorative nursing<br>ation and range of motion.<br>e facility had no current<br>d not completed audits of cares<br>is needs were met and<br>y continued to accept resident | F                  | 520 |  |                               |                                     |

Facility ID: 00730

If continuation sheet Page 184 of 184

|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1 Y Y               | TIPLE CONSTRUCTION<br>NG 01 - MAIN BUILDING  |         | TE SURVEY<br>MPLETED      |
|--------------------------|---|--|---------------------|--|---------|---------------------------|
|                          |   | 245299   | B. WING             |  | 10      | /19/2016                  |
| IAME OF I                | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |         |                           |
| RAZEE                    | CARE CENTER   |  |                     | 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544   | )       |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>( MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | DULD BE | (X5)<br>COMPLETIC<br>DATE |
| K 000                    | INITIAL COMMEN  | rs   | КO                  | 00   |         |                           |
|                          | FIRE SAFETY   |  |                     |  |         |                           |
|                          | ALLEGATION OF O<br>DEPARTMENTS A<br>SIGNATURE AT TH<br>PAGE OF THE CM   | OC WILL SERVE AS YOUR<br>COMPLIANCE UPON THE<br>CCEPTANCE. YOUR<br>HE BOTTOM OF THE FIRST<br>S-2567 FORM WILL BE<br>ATION OF COMPLIANCE.   |                     |  |         |                           |
|                          | ONSITE REVISIT<br>CONDUCTED TO<br>SUBSTANTIAL CC<br>REGULATIONS HA  | OF AN ACCEPTABLE POC, AN<br>OF YOUR FACILITY MAY BE<br>VALIDATE THAT<br>MPLIANCE WITH THE<br>AS BEEN ATTAINED IN<br>ITH YOUR VERIFICATION.   |                     |  |         |                           |
|                          | Minnesota Departn<br>Fire Marshal Divisi<br>the time of this surr<br>Main Building was<br>compliance with T<br>participation in Med | Survey was conducted by the<br>nent of Public Safety, State<br>on on November 18, 2015. At<br>vey Frazee Care Center 01<br>found not in substantial<br>he requirements for<br>dicare/Medicaid at 42 CFR, |                     |  |         |                           |
|                          | 2000 edition of Nat<br>Association (NFPA  | Life Safety from Fire, and the<br>ional Fire Protection<br>) Standard 101, Life Safety<br>ter 19 Existing Health Care.   |                     |  |         |                           |

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<br>AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION<br>A BUILDING 01 - MAIN BUILDING       (X3) DAT<br>COM         NAME OF PROVIDER OR SUPPLIER       245299       B. WING       10/         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544         (X4) ID<br>PREFIX       SUMMARY STATEMENT OF DEFICIENCIES<br>PREFIX       ID<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>PREFIX       PROVIDER'S PLAN OF CORRECTION<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>PREFIX       PROVIDER'S PLAN OF CORRECTION<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>PREFIX       PREFIX       PROVIDER'S PLAN OF CORRECTION<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>PREFIX       PREFIX       CACH CORRECTION<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>PREFIX       PREFIX       CACH CORRECTION<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>PREFIX       PREFIX       CACH CORRECTION<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>PREFIX       PREFIX       CACH CORRECTION<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>PREFIX       PREFIX       CACH CORRECTION<br>(EACH DEFICIENCY ACTION PROVIDER)       PREFIX                | 0938-0391                  |
|---|----------------------------|
| NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       FRAZEE CARE CENTER     219 WEST MAPLE AVENUE, PO BOX 96       FRAZEE, MN 56544     FRAZEE, MN 56544       (X4) ID<br>PREFIX     SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>PREFIX     ID<br>PREFIX     PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>(EACH CORRECTIVE ACTION SHOULD BE  | E SURVEY<br>IPLETED        |
| FRAZEE CARE CENTER     219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544       (X4) ID<br>PREFIX     SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>PREFIX     ID<br>PREFIX     PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CHOCK DEFICIENCY ON UST BE PRECEDED BY FULL<br>PREFIX   | 19/2016                    |
| FRAZEE CARE CENTER     FRAZEE, MN 56544       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES<br>PREFIX     ID     PROVIDER'S PLAN OF CORRECTION<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>PREFIX     PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>PREFIX     PREFIX     (EACH CORRECTIVE ACTION SHOULD BE<br>(EACH CORRECTIVE ACTION SHOULD BE<br>(EACH CORRECTIVE ACTION SHOULD BE   |                            |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE   |                            |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE AFFRONTIATE DEFICIENCY)  | (X5)<br>COMPLETION<br>DATE |
| K 000       Continued From page 1       K 000         By e-mail to:       Marian.Whitney@state.mn.us       Angela.Kappenman@state.mn.us         Angela.Kappenman@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 uses. I main entrance addition is separated rom the apartment Building was not surveyed at this time.         The facility is divided into 5 smoke zones with |                            |

Event ID: LSCM21

Facility ID: 00730

|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                     |  | FORM      | : 11/18/2016<br>APPROVED<br>. 0938-0391 |
|--------------------------|---|---|---------------------|--|-----------|---|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | TIPLE CONSTRUCTION<br>ING 01 - MAIN BUILDING     | (X3) DAT  | E SURVEY<br>IPLETED                     |
|                          |   | 245299  | B. WING             |  | 10        | /19/2016                                |
| NAME OF F                | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CO              |           |   |
| FRAZEE                   | CARE CENTER   |   |                     | 219 WEST MAPLE AVENUE, PO BO<br>FRAZEE, MN 56544 | K 96      |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG |  | SHOULD BE | (X5)<br>COMPLETION<br>DATE              |
|                          | rated fire barriers.<br>The facility is comp<br>accordance with NI<br>Installation of Sprim<br>The facility has a fin<br>detection throughout<br>the common space<br>NFPA 72 "The Nati<br>edition). The fire all<br>automatic fire depa<br>areas have automat<br>are on the fire alarr<br>the Minnesota Stat<br>the 1971 building is<br>The facility has a c<br>census of 53 at the<br>NOT MET.<br>NFPA 101 LIFE SA<br>Doors protecting cor<br>required enclosure<br>hazardous areas s<br>as those constructor<br>core wood, or capa<br>20 minutes. Cleara<br>and floor covering<br>in fully sprinklered<br>required to resist th<br>no impediment to to<br>open devices that<br>pushed or pulled a<br>provided with a me | a of 30 minutes and 90 minute<br>letely sprinkler protected in<br>FPA 13 Standard for the<br>kler Systems (1999 edition).<br>re alarm system with smoke<br>ut the corridor system and in<br>as installed in accordance with<br>onal Fire Alarm Code" (1999<br>arm system is monitored for<br>artment notification. Hazardous<br>atic fire smoke detection that<br>m system in accordance with<br>e Fire Code (2007 edition). In<br>a now fully sprinkler protected.<br>apacity of 74 beds and had a<br>e time of the survey.<br>A 42 CFR, Subpart 483.70(a) is<br>AFETY CODE STANDARD<br>orridor openings in other than<br>s of vertical openings, exits, or<br>hall be substantial doors, such<br>ed of 13/4 inch solid-bonded<br>able of resisting fire for at least<br>ince between bottom of door<br>is not exceeding 1 inch. Doors<br>smoke compartments are only<br>ne passage of smoke. There is<br>he closing of the doors. Hold<br>release when the door is<br>re permitted. Doors shall be<br>eans suitable for keeping the | κo                  |  |           | 11/17/16                                |
|                          | provided with a me<br>door closed. Dutch  |   |                     |  |           |   |

Event ID: LSCM21

Facility ID: 00730

If continuation sheet Page 3 of 7

| ATEMENT                  |   | & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | ON<br>E CONSTRUCTION<br>01 - MAIN BUILDING  | (X3) DATE SURVEY<br>COMPLETED<br>10/19/2016 |                           |
|--------------------------|---|--|---------------------|---|---|---------------------------|
|                          |   | 245299   | B. WING             |   |   |                           |
|                          | PROVIDER OR SUPPLIER  |  | 2                   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544                        |   |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE C  | (X5)<br>COMPLETIO<br>DATE |
| K 018                    | with 8.2.3.2.1. Roll<br>CMS regulations in<br>19.3.6.3<br>This STANDARD<br>Based on observa<br>facility failed to ma<br>1 resident room do<br>(00) section 19.3.6<br>could affect the sal<br>and an undetermin<br>if smoke from a fire<br>access corridors m<br>Findings include:<br>On the facility tour   | her materials in compliance<br>er latches are prohibited by<br>all health care facilities.<br>is not met as evidenced by:<br>tion and staff interview, the<br>intain the smoke resistance of<br>or according to NFPA 101 LSC<br>.3.1. This deficient practice<br>fety of 13 of the 53 residents<br>ed amount of staff and visitors,<br>e were allowed to enter the exit  | K 018               | K 018<br>Resident room 106 door replaced o<br>11-17-2016 by maintenance.  | 'n  |                           |
| K 029<br>SS=E            | revealed the door of<br>tightly in the frame<br>This deficient cond<br>Maintenance Supe<br>NFPA 101 LIFE SA<br>One hour fire rated<br>fire-rated doors) of<br>extinguishing syste<br>and/or 19.3.5.4 pro-<br>the approved auto<br>option is used, the<br>other spaces by sr<br>doors. Doors are<br>field-applied protect<br>48 inches from the<br>permitted. 19.3.<br>This STANDARD | on resident room 106 did not fit<br>dition was confirmed by the<br>ervisor.<br>AFETY CODE STANDARD<br>d construction (with o hour<br>an approved automatic fire<br>em in accordance with 8.4.1<br>btects hazardous areas. When<br>matic fire extinguishing system<br>areas are separated from<br>noke resisting partitions and<br>self-closing and non-rated or<br>ctive plates that do not exceed<br>a bottom of the door are<br>2.1<br>is not met as evidenced by:<br>ations and staff interview, it was | K 029               | К 029   | 1   | 1/17/16                   |

Facility ID: 00730

If continuation sheet Page 4 of 7

|                          |  | & MEDICAID SERVICES  |                     |  | MB NO. 0938<br>(X3) DATE SURV |                       |
|--------------------------|--|--|---------------------|--|-------------------------------|-----------------------|
|                          | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 | E CONSTRUCTION<br>01 - MAIN BUILDING   | 10/19/2016                    |                       |
|                          |  | 245299   | B. WING             |  |                               |                       |
| NAME OF I                | PROVIDER OR SUPPLIER   |  | S                   | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                       |
| FRAZEE                   | CARE CENTER  |  |                     | 19 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544   |                               |                       |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMP                       | X5)<br>PLETIOR<br>ATE |
| K 029                    | NFPA Life Safety C<br>19.3.2.1. This defic<br>event of a fire, allow<br>throughout the com<br>making them unter<br>affect the exiting ca   | age 4<br>the facility in accordance with<br>code 101 (2000 edition) section<br>tient conditions could in the<br>w smoke and flames to spread<br>ridor and adjacent areas<br>hable, which could negatively<br>apabilities for 23 of the 53 of<br>indetermined amount of staff   | K 029               | cracks sealed with fire caulk on<br>10-21-2016 by the maintenance dir  | rector.                       |                       |
|                          | on 10/19/2016 obs<br>revealed a penetra<br>in diameter in the k<br>corridor.<br>This deficient conc  | between 8:00 am to 12:00 pm<br>ervations and staff interview<br>tion approximately 2.5 inches<br>poiler room wall separating the<br>lition was confirmed by the  |                     |  |                               |                       |
| K 062<br>SS=E            | Required automati<br>continuously maint<br>condition and are i<br>periodically. 19.<br>9.7.5<br>This STANDARD<br>Based on record r<br>facility has failed to<br>the automatic sprin<br>with NFPA 101 Life<br>19.7.6, and 4.6.12<br>Sprinkler Systems<br>for the Inspection,<br>Water Based Fire<br>deficient practice of | rvisor.<br>NFETY CODE STANDARD<br>c sprinkler systems are<br>ained in reliable operating<br>nspected and tested<br>7.6, 4.6.12, NFPA 13, NFPA 25,<br>is not met as evidenced by:<br>eview and staff interview, the<br>properly inspect and maintain<br>hkler system in accordance<br>a Safety Code (00), Section<br>NFPA 13 Installation of<br>(99), and NFPA 25 Standard<br>Testing and Maintenance of<br>Protection Systems, (98). This<br>loes not ensure that the fire<br>rould function properly in the | K 062               | Ceiling title replaced by maintena<br>director on 10-21-2016.  |                               | 7/16                  |

| ATEMENT                  | OF DEFICIENCIES   | & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | · ·                |              | CONSTRUCTION (X3) DA  | ). 0938-039<br>TE SURVEY<br>MPLETED |
|--------------------------|---|---|--------------------|--------------|---|-------------------------------------|
| ID PLAN O                | F CORRECTION  | IDENTIFICATION NOWBER.  | A. BUILD           | ING <b>0</b> | 1 - MAIN BUILDING   |                                     |
|                          |   | 245299  | B. WING            |              |   | /19/2016                            |
|                          | PROVIDER OR SUPPLIER  |   |                    | 21           | REET ADDRESS, CITY, STATE, ZIP CODE<br>9 WEST MAPLE AVENUE, PO BOX 96<br>RAZEE, MN 56544  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | (X5)<br>COMPLETION<br>DATE          |
| K 062                    | Continued From pa<br>the 53 residents, a<br>staff and visitors.<br>Findings include:  | age 5<br>nd an undetermined amount of   | ĸ                  | 062          |   |                                     |
|                          | On the facility tour<br>on 10/19/2016 obs<br>revealed a hole in   | between 8:00 am to 12:00 pm<br>ervations and staff interview<br>a corridor ceiling tile in the<br>the cross corridor doors.   |                    |              |   |                                     |
|                          | Maintenance Supe  | ition was confirmed by the<br>rvisor.<br>\FETY CODE STANDARD  | K                  | 072          |   | 11/17/16                            |
| SS=D                     | free of all obstructi<br>instant use in the of<br>No furnishings, de-<br>obstruct exits, accor-<br>or visibility thereof<br>7.1.10. 18.2.1, 19.<br>This STANDARD<br>Based on observa-<br>facility failed to kee<br>continuous and free<br>impediments to ful<br>or other emergend<br>Life Safety Code 1<br>Section 7.1.10. The<br>interfere with the of<br>of all residents, star<br>room in an emerged | is not met as evidenced by:<br>ations and staff interview the<br>ep the means of egress<br>e of all obstructions or<br>l instant use in the case of fire<br>ey, in accordance with NFPA<br>01 (2000 edition) Chapter 7,<br>his deficient practice could<br>convenient and effective exiting<br>aff or visitors using the dining |                    |              | K 072<br>The area was cleared of obstructions on<br>10-27-2016 by maintenance director. Al<br>residents have the potential to be affected<br>in this area. Education provided to<br>nursing and activity staff on November 1<br>and November 17, 2016 on the procedu<br>"Clearing of egress doors and Fire Risk"<br>The area will be audited for no<br>obstructions weekly X 4 weeks, the then<br>monthly for 2 months. The audit results<br>will be reported to the QA committee for | l<br>ed<br>re                       |
|                          | on 10/19/2016 obs   | between 8:00 am to 12:00 pm<br>servations and staff interview<br>ible storage in the vestibule  |                    |              | further recommendations. The audit will<br>be completed by the maintenance<br>director.   |                                     |

|                     |  |  | F   | TED: 11/18/2016<br>ORM APPROVED<br>NO: 0938-0391  |
|---------------------|--|--|---|---|
| OF DEFICIENCIES     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |  |   | 3) DATE SURVEY<br>COMPLETED   |
|                     | 245299   | B. WING  |   | 10/19/2016  |
|                     |  | 24   | 19 WEST MAPLE AVENUE, PO BOX 96   |   |
| (EACH DEFICIENC     | Y MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE  |   |
| This deficient cond | lition was confirmed by the  | K 072  |   |   |
|                     |  |  |   |   |
|                     | RS FOR MEDICARE<br>TOF DEFICIENCIES<br>OF CORRECTION<br>PROVIDER OR SUPPLIER<br>CARE CENTER<br>SUMMARY STJ<br>(EACH DEFICIENC<br>REGULATORY OR I<br>Continued From pa<br>This deficient cond | DF CORRECTION IDENTIFICATION NUMBER:<br>245299<br>PROVIDER OR SUPPLIER | RS FOR MEDICARE & MEDICAID SERVICES         In of Deficiencies       (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:       (X2) MULTIPL<br>A BUILDING         PROVIDER OR SUPPLIER       245299       B. WING         PROVIDER OR SUPPLIER       S         CARE CENTER       S         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       ID<br>PREFIX<br>TAG         Continued From page 6       K 072         This deficient condition was confirmed by the       K 072 | TMENT OF HEALTH AND HUMAN SERVICES       Free         RS FOR MEDICARE & MEDICAID SERVICES       OMB         T OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3)         DF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3)         DF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3)         DF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3)         PROVIDER OR SUPPLIER       245299       B. WING       (X3)         CARE CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE       219 WEST MAPLE AVENUE, PO BOX 96         FRAZEE, MN 56544       FRAZEE, MN 56544       FRAZEE, MN 56544         SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION SHOULD BE         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX       (EACH CORRECTIVE ACTION SHOULD BE         (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)       PREFIX       CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)         Continued From page 6       K 072       K 072       K 072 |



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered November 10, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5299028

Dear Mr. Mogard:

The above facility was surveyed on October 17, 2016 through October 24, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rulesd. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

Frazee Care Center November 10, 2016 Page 2

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson by phone at (218) 332-5140 or email: gail.anderson@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

## PRINTED: 12/15/2016 FORM APPROVED

| Minnesc                  | ota Department of He   | alth  |                      |  |                   |                          |
|--------------------------|--|---|----------------------|--|-------------------|--------------------------|
| -                        | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                      | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|                          |  | 00730   | B. WING              |  | 10/2              | 24/2016                  |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S       | STATE, ZIP CODE  |                   |                          |
| FRAZEE                   | CARE CENTER  |   | MAPLE AV<br>MN 56544 | ENUE, PO BOX 96  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| 2 000                    | Initial Comments   |   | 2 000                |  |                   |                          |
|                          | ****ATTE   | NTION*****  |                      |  |                   |                          |
|                          | NH LICENSING   | CORRECTION ORDER  |                      |  |                   |                          |
|                          | 144A.10, this correct<br>pursuant to a surver<br>found that the defic<br>herein are not corrected shall<br>with a schedule of f<br>the Minnesota Depa<br>Determination of wh<br>corrected requires of<br>requirements of the<br>number and MN Ru<br>When a rule contain<br>comply with any of<br>lack of compliance.<br>re-inspection with a<br>result in the assess | hether a violation has been   |                      |  |                   |                          |
|                          | that may result fron<br>orders provided tha<br>the Department wit  | hearing on any assessments<br>n non-compliance with these<br>at a written request is made to<br>hin 15 days of receipt of a<br>ent for non-compliance.  |                      |  |                   |                          |
|                          | electronic receipt of<br>consistent with the<br>Health Informationa<br>http://www.health.s<br>obul.htm The Stat<br>delineated on the M   | FS:<br>eed to participate in the<br>f State licensure orders<br>Minnesota Department of<br>al Bulletin 14-01, available at<br>tate.mn.us/divs/fpc/profinfo/inf<br>e licensing orders are<br>finnesota Department of |                      |  |                   |                          |
| LABORATOR                | epartment of Health<br>Y DIRECTOR'S OR PROVIE<br>ically Signed   | DER/SUPPLIER REPRESENTATIVE'S SIGI  | NATURE               | TITLE  |                   | (X6) DATE<br>11/30/16    |

Electronically Signed

If continuation sheet 1 of 165

### PRINTED: 12/15/2016 FORM APPROVED

|                          | Dta Department of He<br>NT OF DEFICIENCIES<br>N OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                           | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED    |                         |  |
|--------------------------|--|---|---------------------------|--|----------------------------------|-------------------------|--|
|                          | 00730  |   | B. WING                   |  | 10/                              | 10/24/2016              |  |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AI   | DDRESS, CITY, S           | TATE, ZIP CODE   |                                  |                         |  |
| FRAZEE                   | CARE CENTER  |   | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                  |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 000                    | Health orders being<br>Although no plan of<br>State Statutes/Rule<br>"corrected" in the b<br>indicate in the elect<br>under the heading of<br>orders will be corre<br>submitting to the M<br>Health.<br>On January 17-24,<br>Department's staff<br>the following licensic<br>corrections are com<br>on the bottom of the<br>with "Laboratory Din<br>Representative's sit<br>these orders for you<br>original to the addres<br>Minnesota Departm<br>1505 Pebble Lake I<br>MN 56537<br>c/o Gail Anderson,<br>Minnesota Departm<br>the State Licensing<br>federal software. Ta<br>assigned to Minness<br>Nursing Homes.<br>The assigned tag n<br>column entitled "ID<br>statute/rule out of c<br>"Summary Statement<br>and replaces the "T<br>correction order. Th<br>findings which are i<br>after the statement | <ul> <li>submitted electronically.</li> <li>correction is necessary for<br/>es, please enter the word<br/>ox available for text. Then<br/>ronic State licensure process,<br/>completion date, the date your<br/>cted prior to electronically<br/>innesota Department of</li> <li>2016 surveyors of this<br/>visited the above provider and<br/>ing orders were issued. When<br/>heleted, please sign and date<br/>e first page in the line marked<br/>rector's or Provider/Supplier<br/>gnature." Make a copy of<br/>ur records and return the<br/>ess below:</li> <li>nent of Health<br/>Road, Suite 300, Fergus Falls,</li> </ul> | 1                         |  | Υ)                               |                         |  |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                        |
|--------------------------|--|--|---|--|-------------------------------|------------------------|
|                          |  | 00730  | B. WING                                 |  | 10/                           | 24/2016                |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S                          | TATE, ZIP CODE   |                               |                        |
| RAZEE                    | CARE CENTER  |  | T MAPLE AVE<br>MN 56544                 | ENUE, PO BOX 96  |                               |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | N SHOULD BE                   | (X5)<br>COMPLE<br>DATE |
| 2 000                    | Time period for Con<br>PLEASE DISREGA<br>FOURTH COLUMN<br>"PROVIDER'S PLA<br>APPLIES TO FEDE<br>THIS WILL APPEA<br>THERE IS NO REC<br>PLAN OF CORREC   | Method of Correction and rection.<br>RD THE HEADING OF THE   | 2 000                                   |  |                               |                        |
| 2 255                    | Assurance Commit<br>A nursing home mu<br>assessment and as<br>of the administrator<br>services, the medic<br>designated by the r<br>three other membe<br>representing discip<br>resident care. The<br>assurance committ<br>respect to which qu<br>necessary and dev<br>appropriate plans of<br>quality deficiencies<br>address, at a minim<br>reporting, infection<br>pharmacy services. | est maintain a quality<br>surance committee consisting<br>a director of nursing<br>al director or other physician<br>nedical director, and at least<br>rs of the nursing home's staff,<br>lines directly involved in<br>quality assessment and<br>ee must identify issues with<br>ality assurance activities are<br>elop and implement<br>f action to correct identified<br>. The committee must<br>num, incident and accident<br>control, and medications and | 2 255                                   |  |                               | 11/17/1                |
|                          | review, the facility (<br>Assurance (QA&A)   | on, interview, and document<br>Quality Assessment and<br>committee failed to develop<br>ropriate action plans for  |   | corrected.   |                               |                        |

LSCM11

If continuation sheet 3 of 165

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | ealth<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                           |  |                                | E SURVEY<br>PLETED      |  |
|--------------------------|--|---|---------------------------|--|--------------------------------|-------------------------|--|
|                          |  | 00730   | B. WING                   |  | 10/                            | 10/24/2016              |  |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, ST          | TATE, ZIP CODE   |                                |                         |  |
| FRAZEE                   | CARE CENTER  |   | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 255                    | Continued From par<br>previously identified<br>insufficient staffing,<br>implementation and<br>rehabilitative nursin<br>ambulation and ran<br>by physical and occ<br>to develop and imp<br>harm for 1 of 1 resi<br>in range of motion<br>decline in ambulation<br>of multiple falls. Th<br>potential to affect a<br>residing in the facilit<br>Findings include:<br>See F353 the facilit<br>staffing was availab<br>On 10/21/16, at 10<br>noticed residents witheir ambulation/main<br>not enough staff. P<br>residents on mainter<br>them referred back<br>to a decline. PTA si<br>not enough staff to<br>residents programs<br>were responsible for<br>ambulation/mainter<br>there were not eno<br>stated she had void<br>residents ambulation | age 3<br>d areas of concern related to<br>, and the lack of<br>d documentation of<br>ng services which included<br>nge of motion cares as directed<br>cupational therapy. The failure<br>lement action plans caused<br>ident (R66) who had a decline<br>(ROM), (R38) who had a decline<br>(ROM), (R38) who had a pattern<br>is deficient practice had the<br>II 52 residents currently<br>ity.<br>ty failed to ensure sufficient<br>ble to meet resident needs.<br>:50 a.m. PTA stated she had<br>vere not consistently receiving<br>aintenance programs due to<br>TA stated she had placed<br>enance programs and has had<br>to therapy for treatment due<br>tated she felt this was due to<br>consistently carry out<br>s. PTA stated the facility NA's | 2 255                     | DEFICIENC  |                                |                         |  |
|                          | was the staff were   | e response she had received<br>going to "talk" to the NA's.   |                           |  |                                |                         |  |

| Minnesc       | ota Department of He   | alth  |                |   | I Only     | APPROVE          |
|---------------|------------------------|---|----------------|---|------------|------------------|
| STATEMEN      | NT OF DEFICIENCIES     | (X1) PROVIDER/SUPPLIER/CLIA                               | (X2) MULTIPLE  | CONSTRUCTION                                  |            | E SURVEY         |
| AND PLAN      | OF CORRECTION          | IDENTIFICATION NUMBER:                                    | A. BUILDING:   |   | СОМ        | PLETED           |
|               |                        | 00730   | B. WING        |   | 10/24/2016 |                  |
| NAME OF       | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S | TATE, ZIP CODE                                |            |                  |
|               |                        |   |                | ENUE, PO BOX 96                               |            |                  |
| FRAZEE        | CARE CENTER            |   | MN 56544       |   |            |                  |
| (X4) ID       |                        |   | ID             | PROVIDER'S PLAN OF                            |            | (X5)             |
| PREFIX<br>TAG |                        | / MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | PREFIX<br>TAG  | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T |            | COMPLETE<br>DATE |
| inte          |                        | ,   |                | DEFICIENC                                     |            |                  |
| 2 255         | Continued From pa      | ae 4  | 2 255          |   |            |                  |
|               |                        | -   |                |   |            |                  |
|               |                        | ed employment in the facility ek prior. He stated he was  |                |   |            |                  |
|               |                        | cility nursing had been working                           |                |   |            |                  |
|               |                        | st Monday (when he started,)                              |                |   |            |                  |
|               |                        | meet with the clinical                                    |                |   |            |                  |
|               |                        | y resident acuity. The                                    |                |   |            |                  |
|               |                        | he was unsure if the staffing                             |                |   |            |                  |
|               | in the facility was su | ufficient. The administrator                              |                |   |            |                  |
|               |                        | ad 4 licensed nursing positions                           |                |   |            |                  |
|               |                        | is at that time. He stated at                             |                |   |            |                  |
|               |                        | t implemented any action                                  |                |   |            |                  |
|               |                        | hough had just received a staff                           |                |   |            |                  |
|               |                        | om HR. The administrator                                  |                |   |            |                  |
|               |                        | he planned to work on<br>, though had not implemented     |                |   |            |                  |
|               | at that time.          | , mough had not implemented                               |                |   |            |                  |
|               | at that time.          |   |                |   |            |                  |
|               | On 10/24/16 at 4:0     | 8 p.m. the activity director                              |                |   |            |                  |
|               |                        | itinely attended the facility QA                          |                |   |            |                  |
|               |                        | d in the past staffing concerns                           |                |   |            |                  |
|               |                        | mes had been discussed at                                 |                |   |            |                  |
|               |                        | nd felt no plan had been                                  |                |   |            |                  |
|               | discussed or implei    | mented to improve staffing                                |                |   |            |                  |
|               |                        | ed residents who had attended                             |                |   |            |                  |
|               |                        | tinely in the last 3 months had                           |                |   |            |                  |
|               |                        | egarding long call light wait                             |                |   |            |                  |
|               |                        | s. AD stated she had reported                             |                |   |            |                  |
|               |                        | o the administrator and DON esident council meetings.     |                |   |            |                  |
|               |                        | saent council meetings.                                   |                |   |            |                  |
|               | On 10/24/16. at and    | proximately 5:00 p.m. interim                             |                |   |            |                  |
|               |                        | (DON) stated at that time no                              |                |   |            |                  |
|               |                        | acility was responsible for QA,                           |                |   |            |                  |
|               |                        | mittee continued to meet.                                 |                |   |            |                  |
|               | DON stated the fac     | ility QA committee members                                |                |   |            |                  |
|               |                        | ttor, DON, department                                     |                |   |            |                  |
|               |                        | cy and social services. DON                               |                |   |            |                  |
|               |                        | nittee would meet monthly and                             |                |   |            |                  |
|               | again quarterly with   | the medical director present.                             |                |   |            |                  |

| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         |  |                              | E SURVEY<br>PLETED       |
|--------------------------|--|---|-------------------------|--|------------------------------|--------------------------|
|                          |  | 00730   | B. WING                 |  | 10/24/2016                   |                          |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AI   | DDRESS, CITY, S         | TATE, ZIP CODE   | •                            |                          |
| FRAZEE                   | CARE CENTER  |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                              |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| 2 255                    | Continued From pa  | age 5   | 2 255                   |  |                              |                          |
|                          | staffing concerns in<br>recruitment and ref<br>committee had also<br>pressure ulcers. D<br>current action plan<br>areas: sufficient sta<br>services for ambula<br>DON confirmed the<br>monitoring and had<br>to ensure residents<br>indicated the facility<br>admissions to the f<br>Suggested Method<br>administrator could<br>designee, medical<br>update polices and<br>and develop impro-<br>administrator and D<br>ensure resident ne | of Correction: The<br>I work with the DON or<br>director, and governing body to<br>procedures, identify issues  |                         |  |                              |                          |
| 2 555                    | days.  | rrection: Twenty-one (21)<br>5 Subp. 1 Comprehensive  | 2 555                   |  |                              | 11/17/16                 |
|                          | must develop a cor<br>each resident withi<br>completion of the c<br>assessment as def<br>comprehensive pla<br>by an interdisciplina  | elopment<br>Plopment. A nursing home<br>mprehensive plan of care for<br>n seven days after the<br>comprehensive resident<br>ined in part 4658.0400. The<br>in of care must be developed<br>ary team that includes the<br>n, a registered nurse with |                         |  |                              |                          |

|   | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                        | LE CONSTRUCTION  |             | E SURVEY<br>PLETED      |
|---|--|---|------------------------|--|-------------|-------------------------|
|   |  | 00730   | B. WING                |  | 10/24/2016  |                         |
| NAME OF I   | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY,           | STATE, ZIP CODE  |             |                         |
| FRAZEE  | CARE CENTER  |   | T MAPLE A\<br>MN 56544 | ENUE, PO BOX 96  |             |                         |
| (X4) ID<br>PREFIX<br>TAG                                      | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 2 555   | Continued From pa  | ige 6   | 2 555                  |  |             |                         |
| ai<br>pri<br>th<br>re<br>D<br>B<br>re<br>fc<br>st<br>th<br>ai | responsibility for the resident, and other<br>appropriate staff in disciplines as determined by<br>the resident's needs, and, to the extent<br>practicable, with the participation of the resident,<br>the resident's legal guardian or chosen<br>representative.<br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation, interview and record<br>review the facility failed to revise the plan of care<br>for 1 of 3 residents(R66) who was dependent on<br>staff to provide all leisure activities. In addition,<br>the facility failed to revise the care plan for<br>ambulation for 3 of 4 residents (R29, R46, R38)<br>reviewed for ambulation services. |   |                        |  |             |                         |
|   |  |   |                        | corrected  |             |                         |
|   | Findings include:  |   |                        |  |             |                         |
|   | 1/11/16 identified R<br>included traumatic<br>and diabetes. The I<br>severe cognitive im<br>dependent of staff<br>(ADLs), and require<br>transfers and locon<br>identified R66 enjoy<br>around animals suc<br>news, doing things   | inimum Data Set (MDS), dated<br>66 had diagnoses which<br>brain injury, seizure disorder<br>MDS identified R66 had<br>pairment, and was totally<br>for activities of daily living<br>ed 2 staff to assist with<br>notion off the unit. The MDS<br>yed listening to music, being<br>ch as pets, keeping up with the<br>with groups of people,<br>orite activities and spending |                        |  |             |                         |
|   | 1/11/16 identified R<br>brain injury, was un<br>needs known and w<br>her ADL. The CAA<br>people with her eye   | essessment (CAA), dated<br>66 suffered from a traumatic<br>hable to speak and make<br>was dependent on staff for all<br>further identified R66 followed<br>es and blinked to answer yes<br>d appeared to watch TV when  |                        |  |             |                         |

| STATEMEN      | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         |  |                                 | E SURVEY<br>PLETED |  |
|---------------|--|--|-------------------------|--|---------------------------------|--------------------|--|
|               |  | 00730  | B. WING                 | B. WING  |                                 | 10/24/2016         |  |
| NAME OF       | PROVIDER OR SUPPLIER   | STREET AL  | DDRESS, CITY, S         | TATE, ZIP CODE   |                                 |                    |  |
| FRAZEE        | CARE CENTER  |  | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                 |                    |  |
| (X4) ID       | SUMMARY STA  |  | ID                      | PROVIDER'S PLAN OF   | COBBECTION                      | (X5)               |  |
| PREFIX<br>TAG |  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG           | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | COMPLET            |  |
| 2 555         | Continued From pa  | ige 7  | 2 555                   |  |                                 |                    |  |
|               | it was on.   |  |                         |  |                                 |                    |  |
|               | a big fan of duck D<br>the Kardashians. R<br>liked to browse thro<br>enjoyed a good boo<br>directed activity sta<br>room to inform all s<br>Dynasty and Keepin<br>activity staff were to<br>and activity staff were<br>(people, Us Weekly<br>during 1:1 visits and<br>enjoy story time. Re<br>R66 required a mee<br>her up and into her<br>wheeled to all of he<br>in a timely manner. | R66's care plan dated 2/18/16 identified R66 was<br>a big fan of duck Dynasty and Keeping up with<br>the Kardashians. R66's care plan indicated she<br>iked to browse through gossip magazines and<br>enjoyed a good book at times. R66's care plan<br>directed activity staff had posted a sign in her<br>room to inform all staff that she enjoys Duck<br>Dynasty and Keeping up with the Kardashians,<br>activity staff were to complete 4 1:1 visits a week,<br>and activity staff would provide gossip magazines<br>(people, Us Weekly, Star) and would read to her<br>during 1:1 visits and would see if she was up to<br>enjoy story time. R66's care plan further directed<br>R66 required a mechanical lift and 2 staff to get<br>her up and into her wheelchair, and R66 would be<br>wheeled to all of her destinations as desired and<br>n a timely manner. |                         |  |                                 |                    |  |
|               | Assessment dated<br>staff indicated they<br>activities to let her of<br>and indicated R66<br>assessment further<br>included cards and<br>large group program<br>group activities suc   | Therapeutic Programs<br>1/4/16, identified activities<br>would try to bring her to<br>observe and be around people<br>was in bed a lot. The<br>r identified R66's past interests<br>games and plan included<br>ms and entertainment, small<br>th as manicures, 1:1<br>be needed, and R66 also<br>he birds and TV.  |                         |  |                                 |                    |  |
|               | dated 7/26/16, iden<br>involvement was fa<br>passive, R66 was u<br>a meaningful way.<br>watched TV on a da<br>watched movies. T  | tivities quarterly progress note<br>tified R66's activity<br>ir and participation was<br>unable to structure her time in<br>The note identified R66<br>aily basis, and sometimes<br>he note indicated R66 would<br>he birds, but staff felt R66  |                         |  |                                 |                    |  |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                           | CONSTRUCTION   |               | E SURVEY<br>PLETED      |  |
|--------------------------|--|---|---------------------------|--|---------------|-------------------------|--|
|                          |  | 00730   | B. WING                   |  | 10/           | 10/24/2016              |  |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AI   | DDRESS, CITY, S           | TATE, ZIP CODE   |               |                         |  |
| FRAZEE                   | CARE CENTER  |   | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |               |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE | (X5)<br>COMPLET<br>DATE |  |
| 2 555                    | would rather watch<br>visits by staff each   | age 8<br>TV and R66 would have 4, 1:1<br>week. The note also indicated<br>per week and took her   |                           |  |               |                         |  |
|                          | 10/11/16, identified<br>was fair, participati<br>R66 was unable to<br>meaningful way. Th<br>also watches movie<br>player. The note fu<br>4, 1:1 visits by active<br>would sometimes r<br>indicated family vis<br>wheeled her aroun<br>weather was nice.<br>R66's activity plan<br>goal for the last 3 r<br>were effective. and | s quarterly progress note dated<br>R66's activity involvement<br>on level remained passive and<br>structure her time in a<br>ne note indicated R66 loved TV<br>es on her personal DVD<br>rther identified R66 would have<br>vity staff each week and they<br>read her a book. The note also<br>ited once per week and<br>d or took her outside if the<br>The progress note identified<br>was appropriate, had met her<br>nonths, activity interventions<br>I no changes were<br>R66's activity program. |                           |  |               |                         |  |
|                          | residents from 4/16 activities per week  | ty activity calendar for<br>5 to 10/16 identified 4-5<br>which R66 had special interes<br>Bingo, movies, outside walks  | t                         |  |               |                         |  |
|                          | Chart forms from 4<br>R66 consistently w<br>However, the atten<br>consistent 1:1 visits<br>include attendance  | esident Activity Attendance<br>/1/16 to 10/17/16 revealed<br>atched TV and family visited.<br>dance charts did not include<br>s, and did not consistently<br>e at either large or small group<br>onthly documentation as  |                           |  |               |                         |  |
|                          | staff for the month,   | pportunities of 1:1 visits from<br>and 3 unable and 1 refused.<br>tation of large or small group  |                           |  |               |                         |  |

| STATEMEN                 | DIT DEPARTMENT OF HE<br>NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                           |  | (X3) DATE SURVEY<br>COMPLETED<br><b>10/24/2016</b> |                         |
|--------------------------|---|--|---------------------------|--|--|-------------------------|
|                          |   | 00730  | B. WING                   |  |  |                         |
| NAME OF                  | PROVIDER OR SUPPLIER  |  | DDRESS, CITY, ST          |  |  |                         |
| FRAZEE                   | CARE CENTER   |  | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | TION SHOULD BE                                     | (X5)<br>COMPLET<br>DATE |
| 2 555                    | Continued From pa   | ige 9  | 2 555                     |  |  |                         |
|                          | activities or activitie   | es out of room   |                           |  |  |                         |
|                          | staff for the month,  | pportunities for 1:1 visits from<br>1 in family lounge, 1 in<br>nail reading, and 2 cleaning   |                           |  |  |                         |
|                          |   | pportunities of 1:1 visits from<br>1 mail reading,1 glider, and 4  |                           |  |  |                         |
|                          | staff for the month,  | opportunities for 1:1 visits from<br>1 special event, 1 bird<br>g glasses, 2 outside, 1 glider   |                           |  |  |                         |
|                          |   | opportunities for 1:1 visits for<br>atching, 1 wheeling, 1 outside,<br>and 1 unable  |                           |  |  |                         |
|                          |   | pportunities for 1:1 visits for<br>le, 1 cleaning glasses, and 1   |                           |  |  |                         |
|                          |   | ut of 13 opportunities for 1:1<br>mily lounge, 2 cleaning  |                           |  |  |                         |
|                          | to 10:03 a.m. R66's<br>and her bedroom d<br>observed on her ba<br>hospital gown. R66<br>position with no me<br>and 3 minutes. R66<br>calendar posted on<br>the foot of her bed, | g observation from 7:00 a.m.<br>s room was dark and quiet,<br>oor was open. R66 was<br>ack in bed, dressed in a<br>6 remained in the same<br>eaningful activity for 3 hours<br>6 had a monthly activities<br>her closet door across from<br>and a hand written 8.5 X 11<br>the wall across from R66's<br>ed: |                           |  |  |                         |

| STATEME                  | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                               |                         | CONSTRUCTION   |                                  | E SURVEY<br>PLETED      |
|--------------------------|--|---|-------------------------|--|----------------------------------|-------------------------|
|                          |  | 00730   | B. WING                 |  | 10/24/2016                       |                         |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AI   | DDRESS, CITY, ST        | TATE, ZIP CODE   |                                  |                         |
| FRAZEE                   | CARE CENTER  |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 555                    | <ul> <li>-R66 was to be cha</li> <li>-No more Kardashia</li> <li>-Family Feud on ch</li> <li>-Wheel of fortune</li> <li>-Jeopardy 5:00 p.m</li> <li>-Judge Judy 9:00 a</li> <li>-get movie going ea</li> <li>On 10/19/16, at 10:</li> <li>were in R66's room</li> <li>her recliner. LPN-A</li> <li>going to watch on T</li> <li>those Kardashian g</li> <li>R66 a hard time ab</li> <li>you never now what</li> <li>On 10/19/16, at 12:</li> <li>seated in her recline</li> <li>type program was of</li> <li>turned away from th</li> <li>window.</li> <li>On 10/20/16, at 9:4</li> <li>dressed in a hospita</li> <li>and her eyes were</li> <li>On 10/21/16, at 10:</li> <li>nurse (LPN-A) state</li> <li>on staff for ADLs. S</li> <li>was after R66 got u</li> <li>TV in her recliner.</li> <li>On 10/24/16, at 10:</li> <li>stated R66 spent he</li> <li>get 1:1 visits. She s</li> <li>open curtains, and</li> <li>the TV shows she li</li> <li>stated she didn't km</li> </ul> | nged during check ups<br>ans'!<br>annel 11:00 a.m.                                  |                         |  |                                  |                         |

| STATEMEN                 | Dita Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | CONSTRUCTION  |                                 | E SURVEY<br>PLETED      |
|--------------------------|--|---|---------------------|---|---------------------------------|-------------------------|
|                          |  | 00730   | B. WING             | 10/24/2016  |                                 |                         |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AL   | DDRESS, CITY, ST    | TATE, ZIP CODE  |                                 |                         |
|                          |  | 219 WES   | T MAPLE AVE         | NUE, PO BOX 96  |                                 |                         |
| FRAZEE                   | CARE CENTER  | FRAZEE  | MN 56544            |   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 555                    | Continued From pa  | ge 11   | 2 555               |   |                                 |                         |
| 2 555                    | and asleep. She sta<br>provide 1:1 visits or<br>it was hard to provid<br>R66 required so mu<br>get up. She stated s<br>in her chair when fa<br>tried to get her out<br>difficult.<br>On 10/24/16, at 10:<br>(CM-A) stated staff<br>recliner and she wa<br>because they were<br>bed or her Broda ch<br>the time. She confin   | ts because she was in bed<br>ated activity staff tried to<br>an an attempt basis. She stated<br>de activities for R66 because<br>uch care, and was difficult to<br>she felt R66 was probably up<br>amily visited, and staff had<br>to story time but it was too<br>53 a.m. clinical manager<br>would get her up in her<br>atched the Kardashians'<br>on a lot, otherwise R66 was in<br>hair in her room the majority of<br>rmed R66's current care plan<br>erstood activities staff spent<br>room.  |                     |   |                                 |                         |
|                          | stated activity staff<br>room which told sta<br>and stated R6 also<br>her room. AD indica<br>had wanted to bring<br>Adventure activity,<br>during the week, bu<br>attend because she<br>stated R66 used to<br>staff struggled with<br>her wheelchair to a<br>she would like R66<br>it was such a hassle<br>her wheelchair, and<br>or recliner. AD conf<br>stated her care plar<br>stated her care plar | 27 p.m. activities director (AD)<br>had posted a sign in R66's<br>off what TV shows R66 liked<br>had a portable DVD player in<br>ated in the past activities staff<br>of R66 to the Afternoon<br>which was scheduled daily<br>ut struggled to get R66 to<br>be was not in her chair. She<br>get her nails done but activity<br>finding staff to get her up in<br>ttend the activity. She stated<br>to attend music programs but<br>e to find staff to get her up in<br>d R66 was usually in her bed<br>irmed R66's care plan and<br>in could be updated. She<br>in was TV focused and the<br>er also. AD confirmed R66's<br>l stated R66 mostly watched |                     |   |                                 |                         |

|                          | AND PLAN OF CORRECTION (X1) PROVIDER/SUPP<br>IDENTIFICATION   |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED    |                          |
|--------------------------|---|---|---|--|----------------------------------|--------------------------|
|                          |   | 00730   | B. WING                                 |  | 10/24/2016                       |                          |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, ST                        | TATE, ZIP CODE   |                                  |                          |
| FRAZEE                   | CARE CENTER   |   | T MAPLE AVE<br>, MN 56544               | NUE, PO BOX 96   |                                  |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETI<br>DATE |
| 2 555                    | Continued From pa   | age 12  | 2 555                                   |  |                                  |                          |
|                          | R66's care plan had current information   | d not been updated with   |   |  |                                  |                          |
|                          | R29   |   |   |  |                                  |                          |
|                          | identified R29 had  | nary form dated 9/16/16,<br>diagnoses which included<br>malaise, and psychosis.   |   |  |                                  |                          |
|                          | 7/14/16, identified F<br>impairment, and re<br>for bed mobility, tra<br>the unit, dressing a                  | Ainimum Data Set (MDS) dated<br>R29 had severe cognitive<br>quired extensive assistance<br>Insfer, locomotion on and off of<br>and hygiene. The MDS<br>on did not occur for R29 during<br>riod. | f                                       |  |                                  |                          |
|                          | R29 had dementia,<br>memory problems,<br>appeared related to  | AA dated 7/14/16, identified<br>both short term and long term<br>and had poor balance which<br>decreased weight bearing<br>I prior to admission.  |   |  |                                  |                          |
|                          | revealed R29 had a<br>walker with assist<br>ambulation, toileting<br>R29's care plan dire                     | plan revised 10/14/16,<br>an unsteady gait, used a<br>of one and assist with<br>g, and mobility as needed.<br>ected assist of one with front<br>d wheelchair for ambulation.                    |   |  |                                  |                          |
|                          | her wheelchair, at a<br>propelled herself w<br>room towards her r<br>On 10/19/2016, at<br>her wheelchair with | 9:02 a.m. R29 self propelled<br>her feet in the hall. R29<br>ns to her room and then  |   |  |                                  |                          |

| NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |  | CONSTRUCTION          |   | E SURVEY<br>PLETED   |
|--|--|--|-----------------------|---|--|
|  |  | A. BUILDING: _   | A. BOILDING.          |   |  |
|  | 00730  | B. WING  |                       | 10/   | 24/2016  |
| PROVIDER OR SUPPLIER   | STREET AI  | DDRESS, CITY, ST   | TATE, ZIP CODE        |   |  |
| CARE CENTER  |  |  | NUE, PO BOX 96        |   |  |
| SUMMARY STA  |  | ID   |                       |   | (X5)   |
|  |  | PREFIX<br>TAG  | CROSS-REFERENCED TO T | HE APPROPRIATE  | COMPLET<br>DATE  |
| Continued From pa  | ge 13  | 2 555  |                       |   |  |
| desk with a front wh<br>around R29's waist<br>On 10/24/2016, at  | neeled walker and a gait belt<br>9:57 a.m. R29 propelled her   |  |                       |   |  |
| The facility form titled Resident Referral,<br>Interdepartmental Communication dated 8/4/16,<br>to nursing from physical therapy directed R29<br>receive the following: "Recommend Pt (patient)<br>ambulate twice daily with fww (front wheeled<br>walker), gait belt, and CGA (contact guard assist)<br>x (times) 1. Pt has ambulated up to 150' in<br>therapy. Pt may require verbal cues to maintain<br>upright posture and take larger steps." |  |  |                       |   |  |
| through 10/23/16, the<br>received therapy fo<br>not note that reside<br>nursing staff to amb<br>day, nor was there   | he notes identified R29 had<br>r strengthening; however did<br>ent had received the referral for<br>pulate resident two times a<br>documentation that R29 had  |  |                       |   |  |
|  |  |  |                       |   |  |
| assistant (PTA) stat<br>with residents amb<br>programs being cor<br>stated felt there wa<br>the facility to compl<br>maintenance progra  | ted she had serious concerns<br>ulation and maintenance<br>mpleted consistently. PTA<br>s not enough nursing staff in<br>ete ambulation and<br>ams on a routine basis. PTA   |  |                       |   |  |
| receive their ambul<br>On 10/24/2016, at<br>R29 was not on a w<br>indicated R29 would  | ation programs.<br>10:14 a.m. NA-I indicated<br>valking program. NA-I<br>d self transfer and staff would   |  |                       |   |  |
|  | PROVIDER OR SUPPLIER<br>CARE CENTER<br>SUMMARY STA<br>(EACH DEFICIENCY<br>REGULATORY OR L<br>Continued From pa<br>nurse (LPN)-C amb<br>desk with a front will<br>around R29's waist<br>On 10/24/2016, at<br>wheelchair in the ha<br>The facility form title<br>Interdepartmental C<br>to nursing from phy<br>receive the followin<br>ambulate twice dail<br>walker), gait belt, a<br>x (times) 1. Pt has<br>therapy. Pt may rec<br>upright posture and<br>R29's progress not<br>through 10/23/16, t<br>received therapy fo<br>not note that reside<br>nursing staff to amb<br>day, nor was there<br>received ambulatio<br>R29 did not have a<br>the nursing assistant<br>On 10/21/16, at 11:<br>assistant (PTA) sta<br>with residents ambu<br>programs being con-<br>stated felt there wa<br>the facility to compli-<br>maintenance progra-<br>stated residents su<br>receive their ambul<br>On 10/24/2016, at<br>R29 was not on a w<br>indicated R29 woul | 00730PROVIDER OR SUPPLIERSTREET ADCARE CENTERSTREET ADSUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)Continued From page 13nurse (LPN)-C ambulated R29 past the nurses<br>desk with a front wheeled walker and a gait belt<br>around R29's waist.On 10/24/2016, at 9:57 a.m. R29 propelled her<br>wheelchair in the hall with her feet.The facility form titled Resident Referral,<br>Interdepartmental Communication dated 8/4/16,<br>to nursing from physical therapy directed R29<br>receive the following: "Recommend Pt (patient)<br>ambulate twice daily with fww (front wheeled<br>walker), gait belt, and CGA (contact guard assist)<br>x (times) 1. Pt has ambulated up to 150' in<br>therapy. Pt may require verbal cues to maintain<br>upright posture and take larger steps."R29's progress notes were reviewed 6/30/16,<br>through 10/23/16, the notes identified R29 had<br>received therapy for strengthening; however did | O0730         B. WING | O0730         B. WING           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE           CARE CENTER         219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544           SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)         ID<br>PREFIX<br>TAG         PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS.REFERENCE) TO<br>DEFICIENC           Continued From page 13         2 555         PROVIDER'S TAMENT OF DEFICIENCIES<br>(EACH DEFICIENCIES)         D<br>PREFIX           Continued From page 13         2 555         D<br>PROVIDER'S PLAN OF<br>CROSS.REFERENCED TO<br>DEFICIENC         D<br>PREFIX           Continued From page 13         2 555         D<br>PROVIDER'S PLAN OF<br>CROSS.REFERENCED TO<br>DEFICIENC           Continued From page 13         2 555         D<br>PREFIX           Continued From page 13         2 555           Continued From page 13         2 555           Continued From page 14         PACE PROVIDER'S PLAN OF<br>CROSS.REFERENCED TO<br>D<br>PREFIX           Continued From page 13         2 555           Continued From page 13         2 555           Continued From page 14         2 555           Continued From page 13         2 555           Continued From page 14         P Address PLAN<br>Preceive the following: "Recommend PI (patient)<br>ambulate wise data therapy discident R29<br>receive the following: "Recommend PI (patient)<br>antherapy. PI may require verba | O0730         B. WING         10/           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         219 WEST MAPLE AVENUE, PO BOX 96           CARE CENTER         219 WEST MAPLE AVENUE, PO BOX 96         FRAZEE, MN 56544           SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH CORFICIENCY MUST BE PRECEDED BY ULL<br>REGULATORY OF LSCIDENTFYING INFORMATION)         ID<br>PREFIX         PREFIX           Continued From page 13         2 555         CONTINUE (LPN)-C ambulated R29 past the nurses<br>desk with a front wheeled walker and a gait belt<br>around R29's waist.         2 555           Continued From page 13 (D) 24/2016, at 9:57 a.m. R29 propelled her<br>wheelchair in the hall with the retargy directed R29<br>receive the following: "Recommend Pt (patient)<br>ambulate twice daily with fww (front wheeled<br>walker), gait belt, and CGA (contact guard assist)<br>x (times) 1. Pt has ambulated up to 150 in<br>therapy. Pt reay require verbal cues to maintain<br>upright posture and take larger steps."         R29's progress notes were reviewed (A)0/16,<br>through 10/23/16, the notes identified R29 had<br>received therapy for strengthening; however did<br>not note that resident two ifferral for<br>nursing staff to ambulate resident two ifferral for<br>nursing staff to ambulate resident two iffersal<br>day, nor was there documentation that R29 had<br>received ambulation program sheet in<br>the nursing assistant maintenance book.         Not 10/21/16, at 11:20 a.m. physical therapy<br>assistant (PTA) stated she had serious concerns<br>with residents ambulation and maintenance<br>programs being completed consistently. PTA<br>stated resident such as R29 did not routinely<br>receive their ambulation programs.<br>On 102/216, at 10:14 a.m. NA-1 indicated<br>R29 would selt transfer and Staff would |

| Minnesc       | ta Department of He  | alth   |                |  | 1.01.00         | I APPROVE        |
|---------------|--|--|----------------|--|-----------------|------------------|
|               | IT OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIPLE  | CONSTRUCTION   |                 | E SURVEY         |
| AND PLAN      | OF CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILDING:   |  | COMPLETED       |                  |
|               |  | 00730  | B. WING        |  | 10/24/2016      |                  |
| NAME OF I     | PROVIDER OR SUPPLIER   | STREET AD  | DRESS. CITY. S | TATE, ZIP CODE   |                 |                  |
|               |  |  |                | ENUE, PO BOX 96  |                 |                  |
| FRAZEE        | CARE CENTER  |  | MN 56544       |  |                 |                  |
| (X4) ID       |  | TEMENT OF DEFICIENCIES   | ID             | PROVIDER'S PLAN OF   |                 | (X5)             |
| PREFIX<br>TAG |  | YMUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG  | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | THE APPROPRIATE | COMPLETI<br>DATE |
| 2 555         | Continued From pa  | ge 14  | 2 555          |  |                 |                  |
|               | On 10/24/2016, at 10:16 a.m. (NA)-E indicated R29 was not scheduled on a list for an ambulation program.   |  |                |  |                 |                  |
|               | assistant (PTA)-G in<br>reached their goal i<br>from therapy servic<br>ambulation or lower<br>to be completed by<br>to maintain the prog<br>therapy. PTA-G ver<br>therapy in August o<br>currently walking tw<br>PTA-G indicated an  | 10:32 a.m. physical therapy<br>ndicated residnets who had<br>n therapy were discontinued<br>es and then continue with a<br>r extremity exercise program<br>the nursing assistants in order<br>gress which was made in<br>ified R29 was discharged from<br>f 2016, and should be<br>to times a day up to 150 feet.<br>nbulation into the bathroom<br>gh steps to be considered a  |                |  |                 |                  |
|               | (CM)-B indicated R<br>program for one sta<br>hallway with use of<br>was unaware how of<br>verified R29's Resid<br>Interdepartmental C<br>to nursing from phy<br>following: "Recomm<br>twice daily with fww<br>belt, and CGA (care<br>has ambulated up t<br>require verbal cues<br>and take larger step<br>have a form which of<br>program in the NA grou<br>current care plan an | 52 a.m. the clinical manager<br>29 had an ambulation<br>aff to walk the full length of the<br>a gait belt and a walker. CM-B<br>often R29 ambulated. CM-B<br>dent Referral,<br>Communication dated 8/4/16,<br>rsical therapy directed the<br>nend Pt (patient) ambulate<br>r (front wheeled walker), gait<br>e giver assist) x (times) 1. Pt<br>o 150' in therapy. Pt may<br>to maintain upright posture<br>os." CM-B verified R29 did not<br>directed the ambulation<br>maintenance book. CM-B<br>up sheet was part of R29's<br>nd the group sheet did indicate<br>assistance with ambulation |                |  |                 |                  |
|               | two times a day wit  | h CGA of one and a FWW.<br>nout documentation or   |                |  |                 |                  |

| STATEMEN                 | <u>ota Department of He</u><br>NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                           | E CONSTRUCTION  |                                 | E SURVEY<br>PLETED      |
|--------------------------|--|---|---------------------------|---|---------------------------------|-------------------------|
|                          |  | 00730   | B. WING                   |   | 10/24/2016                      |                         |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, S           | TATE, ZIP CODE  |                                 |                         |
| FRAZEE                   | CARE CENTER  |   | T MAPLE AVE<br>, MN 56544 | ENUE, PO BOX 96   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 555                    | Continued From pa  | age 15  | 2 555                     |   |                                 |                         |
|                          | was unaware if R29   | 9's ambulation with staff , she<br>9 had received the referred<br>n two times a day up to 150   |                           |   |                                 |                         |
|                          | R46  |   |                           |   |                                 |                         |
|                          | top of her bed on h<br>small blankets, the<br>grab bar attached t  | 11:00 p.m. R46 was laying on<br>her right side, covered with two<br>call light was secured to the<br>to the side of the bed, and a<br>approximately 3 feet from the<br>ay.  |                           |   |                                 |                         |
|                          |  | rders dated 9/20/16, identified<br>I muscle weakness, syncope   |                           |   |                                 |                         |
|                          | 8/11/16, identified F<br>required extensive<br>locomotion on and<br>toilet use, limited a<br>personal hygiene. | nimum Data Set (MDS) dated<br>R46 had intact cognition, and<br>assistance for transfer,<br>off of the unit, dressing and<br>ssistance for bed mobility and<br>The MDS identified ambulation<br>46 during the assessment |                           |   |                                 |                         |
|                          | 11/9/15, included: (<br>Functional status: /<br>limited assistance (   | ssessment (CAAS) dated<br>Cognitive Patterns- intact.<br>Activities of daily living status-<br>of one staff for transfers,<br>of staff to ambulate in room,<br>dor did not occur.                                       |                           |   |                                 |                         |
| nnesota D                | Interdepartmental (<br>to nursing from phy<br>receive the followin<br>(patient) with RW (                      | ed Resident Referral,<br>Communication dated 11/6/15,<br>/sical therapy directed R46<br>ig: "Please ambulate Pt<br>regular walker), transfer belt,<br>{ (times) daily. Pt. amb.   |                           |   |                                 |                         |

|                          | NT OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         |  |                                 | E SURVEY<br>PLETED      |
|--------------------------|---|---|-------------------------|--|---------------------------------|-------------------------|
|                          |   | 00730   | B. WING                 |  | 10/24/2016                      |                         |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AI   | DDRESS, CITY, S         | TATE, ZIP CODE   |                                 |                         |
| RAZEE                    | CARE CENTER   |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 555                    | Continued From pa   | age 16  | 2 555                   |  |                                 |                         |
|                          | (ambulate) up to 20   | 00' any ? (questions) call."  |                         |  |                                 |                         |
|                          | R46 had an unstea   | plan revised 8/22/16, revieled<br>dy gait and weakness, SBA<br>one for transfer and with  |                         |  |                                 |                         |
|                          | through 10/1/16, d  | tes were reviewed 4/3/16,<br>id not note that R46 had<br>in services with floor staff.  |                         |  |                                 |                         |
|                          |   | ambulation program sheet in nt maintenance book.  |                         |  |                                 |                         |
|                          | R29 was not schect ambulation program   | 10:16 a.m. (NA)-E indicated<br>luled on a list for an<br>n. NA-E stated R29 could pivo<br>couple steps but not walk any   |                         |  |                                 |                         |
|                          | assistant (PTA)-G i<br>reached their goal<br>from therapy servic<br>ambulation or lowe<br>to be completed by<br>to maintain the pro<br>therapy. PTA-G ver<br>from therapy and s<br>times a day up to 2<br>tolerated. PTA-G in<br>to be walking with I<br>program should co<br>a decline, hospitaliz | t 10:32 a.m. physical therapy<br>indicated residnets who had<br>in therapy were discontinued<br>ces and then continued with a<br>r extremity exercise program<br>r the nursing assistants in order<br>gress which was made in<br>rified R46 had been discharged<br>should be currently walking two<br>200 feet or as far as R46<br>indicated she would expect staff<br>R46 in the hall and the<br>ntinue unless the resident had<br>zation or pain. PTA-G indicated |                         |  |                                 |                         |
|                          | be re-screened. PT  | occur the resident should ther<br>A-G indicated ambulation into<br>d not be enough steps to be<br>ng program.   |                         |  |                                 |                         |
|                          | On 10/24/16, at 10<br>repartment of Health  | :52 a.m. the clinical manager   |                         |  |                                 |                         |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         |  |                                  | E SURVEY<br>PLETED      |
|--------------------------|---|---|-------------------------|--|----------------------------------|-------------------------|
|                          |   | 00730   | B. WING                 |  | 10/24/2016                       |                         |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AI   | DRESS, CITY, ST         | ATE, ZIP CODE  |                                  |                         |
| FRAZEE                   | E CARE CENTER   |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 555                    | <ul> <li>(CM)-B indicated sh<br/>ambulate. CM-B in<br/>therapy was received<br/>or other exercise pr<br/>form for the nursing<br/>maintenance book.</li> <li>Referral, Interdepar<br/>11/6/15, to nursing the<br/>following: "Pleas<br/>RW (regular walker<br/>(assist) 2 X (times))<br/>to 200' any ? (quest<br/>did not have a form<br/>program in the NA r<br/>review of R46's cha<br/>ambulation program<br/>months of Decembo<br/>July 2016, but no fu<br/>documentation was<br/>R46's ambulation p<br/>being performed.</li> <li>On 10/24/16, at 11:<br/>nursing staff did not<br/>had not asked her t<br/>walking with the use<br/>PTA-G, R46 stated,<br/>in a while, I can fee<br/>approximately 8 fee<br/>stop a while to rest<br/>minutes, R46 contin<br/>to her room. R46 w<br/>reached her room.</li> <li>On 10/24/16, at 11:<br/>with R46 identified s<br/>walk more; howeve<br/>were very busy and</li> </ul> | ge 17<br>he had never seen R46<br>dicated when a referral from<br>ed for an ambulation program<br>ogram it would be written on a<br>g assistants(NA) in the NA<br>CM-B verified R46's Resident<br>tmental Communication dated<br>from physical therapy directed<br>se ambulate Pt (patient) with<br>), transfer belt, and 1 A<br>daily. Pt. amb. (ambulate) up<br>tions) call." CM-B verified R46<br>which directed the ambulation<br>maintenance book. With<br>urt, CM-B verified the<br>h had been in place for the<br>er 2015, April, May, June and<br>urther ambulation program<br>found. The CM-B verified<br>rogram was not currently<br>11 a.m. R46 verified the<br>t walk with her in the hall and<br>o walk with them. While<br>e of a walker, gait belt and<br>"I can feel I have not walked<br>I ti in my arms." R46 walked<br>et, stopped and requested to<br>her arms. After resting a few<br>nued to walk with PTA-G back<br>as breathing heavily when she<br>24 a.m. a follow up interview<br>she was aware she should<br>r, believed the facility staff<br>she required a lot of<br>x a lot of the staffs time. |                         | DEFICIENC  | Υ)                               |                         |

|                          | NT OF DEFICIENCIES<br>I OF CORRECTION  | Alth<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION   |                                | E SURVEY<br>PLETED      |  |
|--------------------------|--|---|-------------------------|--|--------------------------------|-------------------------|--|
|                          |  | 00730   | B. WING                 |  | 10/                            | 10/24/2016              |  |
| NAME OF                  | PROVIDER OR SUPPLIER   |   | DRESS, CITY, ST         |  |                                |                         |  |
| FRAZEE                   | CARE CENTER  |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC <sup>1</sup> | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 555                    | On 10/24/16, at 2:0<br>(PA)-A indicated shift<br>follow resident care<br>recommended walk<br>prevent resident fur<br>in the residnets qua<br>not providing recorn<br>is not uncommon he<br>R38's significant ch<br>(MDS) 9/26/16, ider<br>cognitive impairmer<br>included degenerati<br>and back pain. The<br>independent in bed<br>wheelchair indepen<br>the MDS identified a<br>turning around and<br>walking and R38 did<br>R38's ADL Care Are<br>9/26/16, indicated F<br>performance and w<br>plan. The CAA did r<br>R38's admission M<br>R38 was not steady<br>human assistance f<br>and facing opposite<br>identified R38 had a<br>assistance from sta | 0 p.m. physician assistant<br>e would expect facility staff to<br>plans and to initiate<br>sing or exercise programs to<br>nctional decline and a decline<br>dity of life. PA-A stated, " Sadly<br>mended restorative exercises<br>ere."<br>ange Minimum Data Set<br>ntified R38 had moderate<br>nt and had diagnoses which<br>ive joint disease, weakness<br>MDS identified R38 was<br>mobility, transfers and used a<br>dently for locomotion. Further,<br>activity did not occur for<br>facing opposite direction while<br>d not walk.<br>ea Assessment (CAA) dated<br>R38 had improved ADL<br>ould be addressed on care<br>not address R38's ambulation.<br>IDS dated 5/24/16, identified<br>y, only able to stabilize with<br>for walking and turning around<br>e direction while walking. The<br>ambulated with limited | 2 555                   |  |                                |                         |  |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                           | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED<br>10/24/2016 |                         |
|--------------------------|---|--|---------------------------|--|---|-------------------------|
|                          |   | 00730  | B. WING                   |  |   |                         |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AL  | DDRESS, CITY, ST          | TATE, ZIP CODE   |   |                         |
| FRAZEE                   | CARE CENTER   |  | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE            | (X5)<br>COMPLET<br>DATE |
| 2 555                    | Continued From pa   | age 19   | 2 555                     |  |   |                         |
|                          |   | CAA dated 5/24/16, identified cooperative with therapies in ne.  |                           |  |   |                         |
|                          | indicated she was<br>and contact guard<br>also indicated R38<br>assist to transfer w<br>wheeled self indep  | plan updated 6/10/16,<br>fully ambulatory with a walker<br>assistance. R38's care plan<br>was receiving therapy and<br>rith one and gait belt, and R38<br>endently in wheelchair. R38's<br>lentify any updates past  |                           |  |   |                         |
|                          | dated 10/17/16, list<br>included R38 was a<br>toileting and ADL's<br>therapy for walking  | Care Plan Group C form,<br>ted various interventions which<br>assist of one for transfers,<br>, and listed R38 received<br>. The form did not list any<br>for R38's ambulation.  |                           |  |   |                         |
|                          | the facility hallway,<br>propelling herself to<br>feet. R38 propelled   | 36 p.m. R38 was observed in<br>seated in a wheelchair,<br>o the activity room with both<br>I herself up to a squared table,<br>ewspaper and began to read  |                           |  |   |                         |
|                          | wheeled herself int<br>to the toilet seat to<br>was able to comple<br>liked to be as indep<br>proceeded to prope<br>utilizing both feet to<br>activity. At 3:08 p.m<br>wheelchair in the a<br>participating in Bing | 88 p.m. R38 indicated she had<br>to the bathroom and slid hersel<br>use the toilet. She stated she<br>bete most cares for herself and<br>bendent as possible. R38<br>el herself out of her room,<br>to the activity room to attend an<br>n. R38 was seated in her<br>ctivity room actively<br>go. R38 was not observed to<br>ne during observations. | f                         |  |   |                         |

| STATEMEN                 | a Department of He<br>FOF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION   |               | E SURVEY<br>PLETED      |
|--------------------------|--|---|-------------------------|--|---------------|-------------------------|
|                          |  | 00730   | B. WING                 |  | 10/24/2016    |                         |
|                          | ROVIDER OR SUPPLIER  | STREET AL   | DRESS, CITY, ST         | ATE, ZIP CODE  |               |                         |
| FRAZEE                   | CARE CENTER  |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |               |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE | (X5)<br>COMPLET<br>DATE |
|                          | and was able to prodestinations. NA-F<br>with all of her personal maintain her independent<br>not think R38 was a assisted R38 to am<br>nursing assistants was a assisted R38 was a and stated she did<br>ambulation program<br>On 10/20/16, at 2:3 not assisted R38 withe past. NA-B state<br>units were responsi<br>programs, after the<br>determined by occu<br>therapies (PT). NA-<br>both PT and OT up<br>months and indicate<br>been placed on the<br>stated she felt R38<br>could R38 ambulate<br>unit often times cou<br>their ambulation program<br>NAs on the floor.<br>On 10/20/16, at 3:1<br>(LPN)-B stated the<br>responsible to amb<br>ambulation program<br>she was unsure if F<br>program at present<br>clinical record, conf<br>PT and OT dated 7<br>to be assisted with<br>walker and one-per | used a wheelchair for mobility<br>opel herself to and from<br>stated R38 was independent<br>onal cares and liked to<br>endence. NA-F stated she did<br>able to walk and had never<br>bulate. NA-F stated the<br>were responsible to ambulate<br>on an ambulation program<br>not think R38 was on an<br>n in the facility.<br>0 p.m. NA-B stated she had<br>ith ambulation at any time in<br>ed the NA on the individual<br>ible for residents walking |                         | DEFICIENC  |               |                         |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                           |   |                                 | E SURVEY<br>PLETED      |
|--------------------------|--|---|---------------------------|---|---------------------------------|-------------------------|
|                          |  | 00730   | B. WING                   |   | 10/24/2016                      |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AI   | DDRESS, CITY, ST          | TATE, ZIP CODE  |                                 |                         |
| RAZEE                    | CARE CENTER  |   | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96  |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 555                    | Continued From pa  | age 21  | 2 555                     |   |                                 |                         |
|                          | (RN)-A stated she<br>ambulation program<br>seen R38 ambulate<br>On 10/21/16, at 111<br>assistant (PTA) sta<br>physical and occup<br>admission to the far<br>stated R38 was dis<br>in July 2016, with a<br>be placed on an an<br>staff. PTA stated R<br>one assist and a fro<br>feet consistently, w<br>PTA stated she had<br>residents' ambulati<br>being completed co<br>there was not enou | 35 a.m. registered nurse<br>was unaware if R38 was on an<br>n and indicated she had not<br>e with staff in the past.<br>20 a.m. physical therapy<br>ted R38 had received both<br>bational therapy upon<br>cility in May of 2016. PTA<br>continued from both therapies<br>referral to nursing for R38 to<br>nbulation program with nursing<br>38 was able to ambulate with<br>ont wheeled walker up to 40<br>then PT and OT were stopped.<br>d serious concerns with<br>on and maintenance programs<br>onsistently. PTA stated felt<br>up nursing staff in the facility<br>ation and maintenance |                           |   |                                 |                         |
|                          | no longer able to w<br>move about the fac<br>walking when she<br>had worked with th<br>stated nursing staff<br>ambulation since th<br>months ago. R38 s<br>which affected her  | 30 a.m. R38 stated she was<br>valk and used a wheelchair to<br>sility. R38 stated she had been<br>was admitted to the facility and<br>erapy for her walking. R38<br>i had not assisted with her<br>herapy had stopped several<br>tated she had bad knees<br>ability to walk, but felt if she<br>ents" she would be able to walk   |                           |   |                                 |                         |
|                          | room, and looked in<br>locations in her roo<br>R38 no longer had   | 36 a.m. PTA entered R38's<br>n her closet and various<br>m for her walker. PTA stated<br>a walker in her room and<br>xpect R38 to have a walker   |                           |   |                                 |                         |

| STATEMEN                 | Dita Department of He<br>NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | CONSTRUCTION  |                                 | E SURVEY<br>PLETED      |
|--------------------------|--|--|-------------------------|---|---------------------------------|-------------------------|
|                          |  | 00730  | B. WING                 |   | 10/24/2016                      |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AI  | DDRESS, CITY, S         | TATE, ZIP CODE  |                                 |                         |
| RAZEE                    | CARE CENTER  |  | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96  |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENCY | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 555                    | Continued From pa  | age 22   | 2 555                   |   |                                 |                         |
|                          | wheeled walker am<br>R38. PTA applied a<br>torso and cued R34<br>up to the walker wh<br>gait belt. R38 was of<br>from the wheelchait<br>R38's knees remait<br>80 degree angle, w<br>or straighten her kr<br>R38 twice more an<br>stand erect or strait<br>she could not stand<br>stood up for a long<br>remember the last<br>PTA asked R38 wh<br>walked and R38 re<br>confirmed the last f<br>was in July, 2016. If<br>the ability to fully st<br>On 10/21/16, at 11<br>interview, PTA state | n briefly, returned with a front<br>d placed the walker in front of<br>a transfer belt around R38's<br>8 to stand from her wheelchair<br>hile PTA pulled upwards on the<br>only able to lift her buttocks<br>ir seat approximately 7 inches.<br>ned bent at approximately an<br>vas unable to stand fully erect<br>nees. PTA attempted to stand<br>d R38 continued to not able to<br>ghten her knees. R38 stated<br>d up all of the way and had not<br>time. R38 stated she could no<br>time she had used a walker.<br>hen the last time she had<br>sponded, "with you." PTA<br>time she had worked with R38<br>PTA confirmed R38 had lost<br>and and to ambulate. |                         |   |                                 |                         |
|                          | 40-60 feet daily wit<br>front wheeled walk<br>referred to an amb<br>and she would hav<br>assistance with wa<br>daily. PTA stated sl<br>problem with the fa   |  |                         |   |                                 |                         |
|                          | ambulation/mainten<br>concerns and state<br>enough NAs to con<br>ambulation/mainten<br>Review of R38's ho  | nance program due to staffing<br>ed she felt there were not<br>nplete resident<br>nance programs.<br>ospital discharge summary   |                         |   |                                 |                         |
| innesota D               | dated 5/17/16, ider  | ospital discharge summary<br>ntified R38 had been treated for<br>at home. The summary  | r                       |   |                                 |                         |

| STATEMEN                 | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | CONSTRUCTION   |                | E SURVEY<br>PLETED      |  |
|--------------------------|---|--|-------------------------|--|----------------|-------------------------|--|
|                          |   | 00730  | B. WING                 |  | 10/            | 10/24/2016              |  |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, ST         | TATE, ZIP CODE   | •              |                         |  |
| FRAZEE                   | CARE CENTER   |  | ۲ MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | Y<br>TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | TION SHOULD BE | (X5)<br>COMPLET<br>DATE |  |
| 2 555                    | •   | -  | 2 555                   |  |                |                         |  |
|                          | walking. The summ   | naving difficulty standing and<br>ary further revealed R38 was<br>or acute rehab due to lower<br>S.  |                         |  |                |                         |  |
|                          | 8/2/16, revealed R3<br>(MD) had seen her<br>revealed R38 had p<br>was ambulating usi<br>revealed R38's dau        | ysician progress note dated<br>38's primary medical doctor<br>at the clinic. The note also<br>lateau in therapy, however,<br>ng a walker. The note further<br>ghter had concerns that R38<br>ssion after therapy was             |                         |  |                |                         |  |
|                          | 10/6/16, revealed R<br>another practitioner<br>a wheelchair for lon<br>and OT during the s                        | ysician progress note dated<br>38 had established care with<br>5. The note revealed R38 used<br>g distances, had received PT<br>spring and summer, and at<br>reased care needs R38 was<br>long term patient.                     |                         |  |                |                         |  |
|                          | Interdepartmental C<br>revealed therapy ha<br>a ambulation progra<br>daily with front walk<br>40 feet. The form a | form titled, Resident Referral<br>Communication dated 7/8/16,<br>ad referred R38 to nursing for<br>am to include ambulation twice<br>er and one assistance up to<br>lso identified R38 has<br>nee pain and if nursing had<br>II. |                         |  |                |                         |  |
|                          | record lacked furthe<br>ambulation status o   | edical record revealed the<br>er documentation of R38's<br>or progress and lacked<br>acility forms maintenance ADL   |                         |  |                |                         |  |
|                          |   | otes were reviewed from<br>6, revealed the following:  |                         |  |                |                         |  |

| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         |  |                                   | E SURVEY<br>PLETED      |  |
|--------------------------|---|---|-------------------------|--|-----------------------------------|-------------------------|--|
|                          |   | 00730   | B. WING                 |  | 10/                               | 10/24/2016              |  |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AI   | DDRESS, CITY, S         | TATE, ZIP CODE   |                                   |                         |  |
| FRAZEE                   | CARE CENTER   |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                   |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 555                    | Continued From pa   | ige 24  | 2 555                   |  |                                   |                         |  |
|                          | On 5/17/16, R38 warequired one assist   | as full weight bearing and ance with ADL's.   |                         |  |                                   |                         |  |
|                          | On 6/10/16, the not with therapy.   | te indicated R38 was working  |                         |  |                                   |                         |  |
|                          | <i>i</i>  | estioned nursing staff on able to return home.  |                         |  |                                   |                         |  |
|                          | On 8/4/16, R38 req  | uired one assist with ADL's.  |                         |  |                                   |                         |  |
|                          |   | ress notes lacked any<br>38's ambulation and decline<br>n status.   |                         |  |                                   |                         |  |
|                          | nursing (ADON) co<br>ambulation/mainter<br>been implemented<br>R38's referral for an<br>program directed s<br>a front wheeled wa<br>ADON stated she w<br>program to be impl | 7 p.m. the assistant director of<br>nfirmed R38's<br>nance program had never<br>in July. ADON confirmed<br>mbulation maintenance<br>taff to ambulate with R38 with<br>lker up to 40 feet twice daily.<br>vould expect R38's ambulation<br>emented to maintain and<br>line her ambulation. |                         |  |                                   |                         |  |
|                          | stated she had und<br>had been assisting<br>stated she was not<br>ambulate. NM-A st   | 27 a.m. nurse manager (NM)-A<br>lerstood the nursing assistants<br>R38 with ambulation. NM-A<br>aware R38 could not longer<br>ated she was not sure why<br>maintenance program had not  |                         |  |                                   |                         |  |
|                          | 4/1/08 identified res<br>admission for a res<br>ambulation. If a am<br>identified need, a p   | d, Restorative Program, dated<br>sidents would be assessed on<br>torative program such as<br>bulation program was an<br>lan would be individualized to<br>ls and goals. The policy further  |                         |  |                                   |                         |  |

| STATEMEN                 | ta Department of He<br>TOF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                           | CONSTRUCTION  |                                | E SURVEY<br>PLETED       |
|--------------------------|--|---|---------------------------|---|--------------------------------|--------------------------|
|                          |  | 00730   | B. WING                   |   | 10/24/2016                     |                          |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AI   | DDRESS, CITY, ST          | TATE, ZIP CODE  |                                |                          |
| FRAZEE                   | CARE CENTER  |   | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96  |                                |                          |
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| 2 555                    | identified residents   | age 25<br>would be supported and their<br>ctioning maintained.  | 2 555                     |   |                                |                          |
|                          | Review of facility po<br>Plans-Comprehens<br>facility would revise   | blicy, Care<br>sive, dated 4/1/08 identified the<br>the resident's comprehensive<br>he resident's mental and<br>s as identified by  |                           |   |                                |                          |
|                          | The director of nurs<br>review and revise p<br>to ensuring the care<br>resident is revised<br>nursing or designed  | THOD OF CORRECTION:<br>sing (DON) or designee could<br>policies and procedures related<br>e plan for each individual<br>and followed. The director of<br>e could develop a system to<br>a monitoring system to ensure<br>e.   |                           |   |                                |                          |
|                          | TIME PERIOD FOR<br>(21) days.  | R CORRECTION: Twenty-one  |                           |   |                                |                          |
| 2 560                    | MN Rule 4658.040<br>Plan of Care; Conte  | 5 Subp. 2 Comprehensive<br>ents   | 2 560                     |   |                                | 11/17/16                 |
|                          | comprehensive pla<br>objectives and time<br>long- and short-terr<br>and mental and psy<br>identified in the con<br>assessment. The c<br>must include the inc | of plan of care. The<br>n of care must list measurable<br>etables to meet the resident's<br>m goals for medical, nursing,<br>ychosocial needs that are<br>nprehensive resident<br>comprehensive plan of care<br>dividual abuse prevention plan<br>ota Statutes, section 626.557,<br>agraph (b). |                           |   |                                |                          |
|                          | This MN Requirem by:   | ent is not met as evidenced   |                           |   |                                |                          |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                          | E CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|---|---|--------------------------|--|--------------------------------|-------------------------|
|                          |   | 00730   | B. WING                  |  | 10/24/2016                     |                         |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AI   | DDRESS, CITY,            | STATE, ZIP CODE  |                                |                         |
| FRAZEE                   | CARE CENTER   |   | T MAPLE AV<br>, MN 56544 | 'ENUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 560                    | Continued From pa   | age 26  | 2 560                    |  |                                |                         |
|                          | review the facility fa<br>which included a th<br>motion (ROM) proc  | ion, interview and document<br>ailed to develop a plan of care<br>herapy recommended range of<br>gram for 1 of 4 residents (R66)<br>decline in her upper  |                          | corrected  |                                |                         |
|                          | 7/13/16, identified I<br>included traumatic<br>and diabetes. The<br>severe cognitive im<br>dependent on staff<br>activities of daily liv<br>identified R66 had<br>of motion on both s<br>extremities, and did<br>or restorative nursi<br>R66's annual MDS | himum Data Set (MDS) dated<br>R66 had diagnoses which<br>brain injury, seizure disorder<br>MDS identified R66 had<br>pairment, and was totally<br>for assistance with all<br>ring (ADLs). R66's MDS<br>functional limitations in range<br>sides, upper and lower<br>d not receive therapy services<br>ng services.<br>dated 1/11/16, identified R66<br>ve impairment, and was totally |                          |  |                                |                         |
|                          | dependent on staff<br>The MDS identified<br>on both sides, uppe   | ve impairment, and was totally<br>for assistance with all ADLs.<br>I R66 had functional limitations<br>er and lower extremities, and<br>rapy services or restorative  |                          |  |                                |                         |
|                          | 1/11/16, identified F all ADLs related to   | ssessment (CAA) dated<br>R66 was dependent on staff for<br>traumatic brain injury over the<br>difficulty with mobility,<br>d cognition.   |                          |  |                                |                         |
|                          | aphasic (non verba<br>and was unable to<br>care plan also iden  | ted 2/18/16, identified R66 was<br>al) due to traumatic brain injury,<br>make her needs known. R66's<br>tified R66 was to wear hand<br>on and 2 hours off during the  |                          |  |                                |                         |

| STATEMEN   | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                             | CONSTRUCTION   |                 | E SURVEY<br>PLETED |  |
|--|--|---|-----------------------------|--|-----------------|--------------------|--|
|  |  | 00730   | <br>B. WING                 |  | 10/             | 10/24/2016         |  |
| NAME OF  | PROVIDER OR SUPPLIER   |   | DRESS, CITY, S <sup>-</sup> | TATE, ZIP CODE   |                 |                    |  |
| FRAZEE CARE CENTER       219 WEST MAPLE AVENUE, PO BOX 96         FRAZEE, MN 56544 |  |   |                             |  |                 |                    |  |
| (X4) ID  |  | TEMENT OF DEFICIENCIES  | ID                          | PROVIDER'S PLAN OF   |                 | (X5)               |  |
| PREFIX<br>TAG  |  | MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG               | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | THE APPROPRIATE | COMPLET<br>DATE    |  |
| 2 560  | Continued From pa  | ge 27   | 2 560                       |  |                 |                    |  |
|  | care plan failed to id<br>and did not identify   | ar the splints all night. R66's<br>dentify R66 had contractures,<br>a ROM or a restorative<br>r R66 to prevent further  |                             |  |                 |                    |  |
|  | 10/17/16, identified<br>with cares and was<br>off every 2 hours du<br>on all night. The Aic<br>R66 had contracture | Care Plan, Group B dated<br>R66 required total assistance<br>to wear hand splints on and<br>uring the day and leave them<br>le Care Plan did not identify<br>es or that she required a ROM<br>ng program to prevent further |                             |  |                 |                    |  |
|  | 12/31/15, indicated<br>non-weight bearing<br>mechanical lift, and<br>R66's Admission As                            | sessment form dated<br>R66 was non verbal, was<br>, transferred with a<br>had elbow contractures.<br>sessment form indicated<br>had not been assessed.  |                             |  |                 |                    |  |
|  | 1/12/16, identified d<br>complete R66's pas<br>to both upper extrem<br>(AROM) to left hand<br>have R66 open and    | Communication form dated<br>lirections for nursing to<br>ssive range of motion (PROM)<br>mities, active range of motion<br>d, and included instruction to<br>I close fingers and to have<br>s hand with her left hand daily |                             |  |                 |                    |  |
|  | therapy dated 2/18/<br>splint wearing sche   | l Resident Referral from<br>16, identified R66's hand<br>dule as for R66 to wear splints<br>off throughout the day and on   |                             |  |                 |                    |  |

| STATEMEN                 | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                              | CONSTRUCTION   |                                 | E SURVEY<br>PLETED      |  |
|--------------------------|---|--|------------------------------|--|---------------------------------|-------------------------|--|
|                          |   | 00730  | 00730 B. WING                |  | 10/                             | 10/24/2016              |  |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, S <sup>-</sup> | TATE, ZIP CODE   |                                 |                         |  |
| FRAZEE                   | CARE CENTER   |  | ST MAPLE AVE<br>, MN 56544   | INUE, PO BOX 96  |                                 |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 560                    | Continued From pa   | age 28   | 2 560                        |  |                                 |                         |  |
|                          |   | R66's progress notes reviewed from 1/3/16 to 10/17/16 identified:  |                              |  |                                 |                         |  |
|                          |   | ed over and grabbed the TV<br>t hand and could hold her TV<br>and.   |                              |  |                                 |                         |  |
|                          | -1/21/16, R66 was remote.   | changing TV channels with  |                              |  |                                 |                         |  |
|                          | techniques and lac  | tes lacked further<br>arding communication skills or<br>ked any documentation of<br>otion, exercises, or decline in  |                              |  |                                 |                         |  |
|                          | Review of R66's pt<br>2/9/16 to 10/16/16  | nysician progress notes from identified:   |                              |  |                                 |                         |  |
|                          | injury in 12/14, had<br>care facility, but far<br>closer to their hom<br>communicate verb<br>did not communica<br>push her call light t | R66 suffered a traumatic brain<br>I been in a former long term<br>mily had requested a transfer<br>e. R66's could not<br>ally. Nursing had reported R66<br>te verbally but was able to<br>button and could change the<br>with her TV remote. |                              |  |                                 |                         |  |
|                          | which involved the physician would ma   | R66 still had some movement<br>left upper extremity, and the<br>ake sure therapy had a<br>nen from a contracture and<br>point for R66.   |                              |  |                                 |                         |  |
|                          | -10/6/16, identified with left hand.  | R66 could squeeze his fingers  | 5                            |  |                                 |                         |  |
|                          | On 10/19/16, obse<br>a.m. were conduct  | rvations from 7:00 a.m. to 9:47<br>ed:   | ,                            |  |                                 |                         |  |

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|--------------------------|---|---|----------------------------|--|---------------------------------|-------------------------|--|
|                          |   | 00730   | B. WING                    | B. WING  |                                 | 10/24/2016              |  |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, ST           | TATE, ZIP CODE   |                                 |                         |  |
| RAZEE                    | CARE CENTER   |   | ST MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                 |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 560                    | Continued From pa   | age 29  | 2 560                      |  |                                 |                         |  |
|                          | back in bed, with h<br>arms were bent at<br>in a fist position on<br>was in a "C" shape<br>and hand slightly ti<br>devices were not o | was observed lying on her<br>er eyes closed. Both R66's<br>the elbow, her right hand was<br>her chest, and her left hand<br>d position with fingers bent<br>lted away from her body. Splin<br>bserved on either of R66's<br>int devices were not observed | t                          |  |                                 |                         |  |
|                          | entered R66's room<br>(artificial opening a<br>confirmed R66 was<br>stated R66 had not<br>recent past becaus                          | I practical nurse (LPN)-A<br>n to provide her trachea<br>t windpipe) site care. She<br>s not wearing hand splints and<br>t been wearing them in the<br>se she thought the splints were<br>R66. LPN-A exited R66's room<br>R66's hand splints.             |                            |  |                                 |                         |  |
|                          | room and immedia station. R66 remain  | se consultant walked in R66's<br>tely walked down to the nurses<br>ned on her back in bed, with<br>is in the same positron, no  | 5                          |  |                                 |                         |  |
|                          | same position with<br>and her hands rest<br>position. No hand s   | mained lying in bed in the<br>R66's arms bent at her elbows<br>ed on her chest in the same<br>splints were observed on R66's<br>were not observed in R66's  |                            |  |                                 |                         |  |
|                          |   | nained in the same position in<br>ts were observed on R66 or<br>om.   |                            |  |                                 |                         |  |
|                          | had not worn hand   | :03 a.m. LPN-A confirmed R66<br>splints and stated R66 did not<br>all." She stated she was not  |                            |  |                                 |                         |  |

|  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |   |   |  | E SURVEY<br>PLETED   |  |
|--|--|---|---|--|--|--|
|  | 00730  | B. WING   |   | 10/  | 24/2016  |  |
| PROVIDER OR SUPPLIER   | STREET AL  | DDRESS, CITY, ST  | TATE, ZIP CODE  |  |  |  |
| FRAZEE CARE CENTER 219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, MN 56544  |  |   |   |  |  |  |
| (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG   | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO                   | TION SHOULD BE   | (X5)<br>COMPLET<br>DATE  |  |
| Continued From pa  | ge 30  | 2 560   |   |  |  |  |
| indicated she thoug  | ht it had been in the distant  |   |   |  |  |  |
| (NA)-E confirmed F<br>hand splints, and st<br>the last time R66 ha<br>provided a copy of<br>confirmed the care<br>wear hand splints. S<br>aware R66 was to w | R66 did not routinely wear<br>tated she could not remember<br>ad worn her splints. NA-E<br>the a NA care sheet and<br>sheet directed for R66 to<br>She stated she had not been<br>wear hand splints. NA-A and  |   |   |  |  |  |
| not aware of how R care for R66. She s   | 66's care plan directed her to stated she was not aware if   |   |   |  |  |  |
| her recliner in her ro<br>on her chest, right h  | oom with both hands resting nand in fist, left hand curled in  |   |   |  |  |  |
| interview, NA-B star<br>receive range of mo  | ted R66 presently did not<br>otion services or presently was   |   |   |  |  |  |
| interview, NA-D sta<br>her hands and was<br>stiffness had gotter<br>not aware if R66 wa  | ted R66 did not routinely use<br>not aware if R66's hand<br>worse. She stated she was<br>as on a restorative program or  |   |   |  |  |  |
|  | SUMMARY STA<br>(EACH DEFICIENCY<br>REGULATORY OR L<br>Continued From para<br>aware when R66 la<br>indicated she thoug<br>past. LPN-A left roo<br>splints to R66.<br>On 10/19/16, at 10:<br>(NA)-E confirmed F<br>hand splints, and st<br>the last time R66 ha<br>provided a copy of<br>confirmed the care<br>wear hand splints. S<br>aware R66 was to v<br>LPN-A exited R66's<br>hand splints.<br>On 10/19/16, at 10:<br>not aware of how R<br>care for R66. She s<br>R66 had hand splint<br>wear them.<br>On 10/19/16, at 12:<br>her recliner in her ro<br>on her chest, right f<br>a "C" shape. R66 d<br>either hand.<br>On 10/20/16, at 9:3<br>interview, NA-B sta<br>receive range of mor<br>not receiving a rest<br>On 10/20/2016, at 9<br>interview, NA-D sta<br>her hands and was<br>stiffness had gotter<br>not aware if R66 was | OF CORRECTION         IDENTIFICATION NUMBER:           00730         00730           PROVIDER OR SUPPLIER         STREET AI           CARE CENTER         219 WES           SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 30           aware when R66 last had worn the splints and<br>indicated she thought it had been in the distant<br>past. LPN-A left room and did not apply hand<br>splints to R66.         On 10/19/16, at 10:33 am nursing assistant<br>(NA)-E confirmed R66 did not routinely wear<br>hand splints, and stated she could not remember<br>the last time R66 had worn her splints. NA-E<br>provided a copy of the a NA care sheet and<br>confirmed the care sheet directed for R66 to<br>wear hand splints. She stated she had not been<br>aware R66 was to wear hand splints. NA-A and<br>LPN-A exited R66's room and did not apply her<br>hand splints.           On 10/19/16, at 10:40 a.m. NA-D stated she was<br>not aware of how R66's care plan directed her to<br>care for R66. She stated she was not aware if<br>R66 had hand splints or if R66 was supposed to<br>wear them.           On 10/19/16, at 12:10 p.m. R66 was seated in<br>her recliner in her room with both hands resting<br>on her chest, right hand in fist, left hand curled in<br>a "C" shape. R66 did not have hand splints on<br>either hand.           On 10/20/16, at 9:30 a.m., during follow up<br>interview, NA-B stated R66 presently did not<br>receive range of motion services or presently was<br>not receiving a restorative nursing program.           On 10/20/2016, at 9:36 a.m., during follow up<br>interview, NA-D stated R66 did not routinely use<br>her hands and was not aware if R66's hand<br>stiffness had gotten worse. She stated she was | OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING: | OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING:       00730     B. WING   PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE   CARE CENTER       219 WEST MAPLE AVENUE, PO BOX 96       FRAZEE, MN 56544   PROVIDER'S PLAN OF (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)       PREDEX     ID       PROVIDER'S PLAN OF   (EACH DEFICIENCY WIST BE PRECEDED BY FULL PRETX TAG Continued From page 30 aware when R66 last had worn the splints and indicated she thought it had been in the distant past. LPN-A left room and did not apply hand splints to R66. On 10/19/16, at 10:33 am nursing assistant (NA-E provided a copy of the a NA care sheet and confirmed R66 did not routinely wear hand splints. She stated she had not been aware R66 was to wear hand splints. NA-A and LPN-A exited R66's room and did not apply her hand splints. On 10/19/16, at 10:40 a.m. NA-D stated she was not are for R66. She stated she was not aware if R66 had hand splints or if R66 was supposed to wear therm. On 10/19/16, at 12:10 p.m. R66 was seated in her recliner in her room with both hands resting on her chest, right hand in fist, left hand curied in a "C's hape. R66 did not have hand splints on either hand. On 10/20/2016, at 9:30 a.m., during follow up interview, NA-B stated R66 for controlling was not receiving a restorative nursing program. On 10/20/2016, at 9:30 a.m., during follow up interview, NA-B stated R66 did not routinely use her hands and was not aware if R66's hand stort receiving a restorative nursing program. On 10/20/2016, at 9:30 a.m., | OF CORRECTION     IDENTIFICATION NUMBER:     A BUILDING:     COM       00730     B. WING     10/       PROVIDER OR SUPPLER     STREET ADDRESS, CITY, STATE, ZIP CODE     219 WEST MAPLE AVENUE, PO BOX 96       CARE CENTER     PROVIDERS PLAN OF CORRECTION<br>IEEACH DEPICENCY MUST BE PROVEDED BY FULL<br>IEEACH CORRECTION SUST BE PROVEDED BY FULL<br>IEEACH CORRECTION TO IS TO EXCEPTION SINCE THE AVENUE, PO BOX 96     PROVIDERS PLAN OF CORRECTION<br>IEEACH CORRECTION SINCE OF PROVIDERS<br>PROVIDERS PLAN OF CORRECTION<br>IEEACH CORRECTION TO IST DEPICIENCIES<br>OF COSS HEFERENCED TO THE SINCE AND THE AVENUE, PO BOX 96       Continued From page 30     2.560       aware when R66 last had worn the splints and<br>indicated she thought it had been in the distant<br>past. LPN-A left room and did not apply hand<br>splints to R66.     2.560       On 10/19/16, at 10:33 am nursing assistant<br>(NA)-E confirmed R66 did not routinely wear<br>hand splints, and stated she could not remember<br>the last time R66 had worn her splints. NA-E<br>provided a copy of the a AN care sheet and<br>confirmed the care sheet directed for R66 to<br>wear hand splints. NA care sheet and<br>confirmed the care sheet directed for R66 to<br>wear hand splints.     NA-D stated she was<br>not aware 166 was to wear hand splints. NA-A and<br>LPN-A exited R66's care plan directed her to<br>care for R66. She stated she was not aware if<br>R66 had hand splints or if R66 was supposed to<br>wear them.     No 10/19/16, at 12:10 p.m. R66 was supposed to<br>wear them.       On 10/20/216, at 9:30 a.m., during follow up<br>interview, NA-B stated R66 did not routinely use<br>her hands.     No 10/20/216, at 9:36 a.m., during follow up<br>interview, NA-B stated R66 did not routinely use<br>her hands and was not aware if R66's hand<br>stiffness had gotten worse. She |  |

| TATEMENT OF  |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |  |                                  | E SURVEY<br>PLETED      |  |
|--|--|--|---------------------|--|----------------------------------|-------------------------|--|
|  |  | 00730  | B. WING             |  | 10/                              | 10/24/2016              |  |
| AME OF PROVI   | DER OR SUPPLIER  | STREET AL  | DRESS, CITY, ST     | TATE, ZIP CODE   |                                  |                         |  |
| RAZEE CAR  | E CENTER   | NUE, PO BOX 96   |                     |  |                                  |                         |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| assi<br>and<br>not<br>mot<br>stat<br>mot<br>On<br>nurs<br>had<br>she<br>india<br>con<br>On<br>(OT<br>time<br>awa<br>con<br>2/18<br>2/18<br>the<br>stat<br>con<br>the<br>con<br>0<br>n<br>(OT<br>time<br>awa<br>con<br>2/18<br>2/18<br>the<br>stat<br>con<br>0<br>On<br>On<br>(OT<br>time<br>awa<br>con<br>2/18<br>2/18<br>the<br>stat<br>con<br>0<br>On<br>(OT<br>time<br>awa<br>con<br>2/18<br>2/18<br>the<br>stat<br>con<br>0<br>On<br>(OT<br>time<br>awa<br>con<br>2/18<br>the<br>stat<br>con<br>0<br>On<br>(OT<br>time<br>awa<br>con<br>2/18<br>the<br>stat<br>con<br>0<br>On<br>(OT<br>time<br>awa<br>con<br>2/18<br>the<br>stat<br>con<br>0<br>On<br>(OT<br>time<br>awa<br>con<br>2/18<br>the<br>stat<br>con<br>0<br>On<br>(OT<br>time<br>awa<br>con<br>2/18<br>the<br>stat<br>con<br>0<br>On<br>(OT<br>time<br>con<br>0<br>On<br>(OT<br>time<br>con<br>2/18<br>con<br>0<br>On<br>(OT<br>time<br>con<br>2/18<br>the<br>stat<br>con<br>0<br>On<br>(OT<br>time<br>con<br>0<br>On<br>(OT<br>time<br>con<br>2/18<br>con<br>0<br>On<br>(OT<br>time<br>con<br>0<br>Stat<br>con<br>0<br>On<br>(OT<br>time<br>con<br>0<br>Stat<br>Con<br>Stat<br>Con<br>Stat<br>Con<br>Stat<br>Con<br>Stat<br>Con<br>Stat<br>Con<br>Stat<br>Con<br>Stat<br>Con<br>Stat<br>Stat<br>Con<br>Stat<br>Stat<br>Con<br>Stat<br>Stat<br>Con<br>Stat<br>Stat<br>Stat<br>Stat<br>Stat<br>Stat<br>Stat<br>Sta | stated she felt<br>current, and R6<br>ion services and<br>e the screen wa<br>ed she was sure<br>ion when they d<br>10/20/16, at 9:4<br>sing stated she<br>been discontine<br>questioned if th<br>cated she felt R<br>tracted than whe<br>10/20/16, at 10:<br>)-A stated R66 lad<br>of admission, a<br>ure if R66 had co<br>firmed R66's the<br>8/16, and indical<br>8/16, was completed<br>tractures had no<br>facility did not h<br>sult. She stated<br>eline for her cor<br>include measure<br>of the ROM and<br>ommended for F<br>tracture and dis<br>A stated the fact<br>viding ROM serving<br>a book of recor-<br>grams at the nut | book at the nursing station<br>R66's therapy screening was<br>6 did not need range of<br>d did not need to wear splints<br>as old (February 2016) She<br>e R66 got enough range of |                     | DEFICIENC  | τ,                               |                         |  |

| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | CONSTRUCTION   |                | E SURVEY<br>PLETED      |  |
|--------------------------|--|---|---------------------|--|----------------|-------------------------|--|
|                          |  | 00730   | B. WING             | B. WING  |                | 10/24/2016              |  |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AL   | DRESS, CITY, ST     | TATE, ZIP CODE   |                |                         |  |
|                          |  |   |                     | NUE, PO BOX 96   |                |                         |  |
| FRAZEE                   | CARE CENTER  |   | MN 56544            |  |                |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE | (X5)<br>COMPLET<br>DATE |  |
| 2 560                    | Continued From pa  | age 32  | 2 560               |  |                |                         |  |
|                          | was slightly limited,<br>limitations were wit<br>she felt R66's hand<br>high tone. She cont<br>splints were recom-<br>high tone. She state<br>wear the splints all<br>off every 2 hours th<br>12/31/15, and shou<br>services since 1/12  | r, and flexion and extension<br>, and stated she felt R66's<br>hin normal limits. She stated<br>ls weren't contracted but had<br>firmed the ROM and the<br>mended treatments for R66's<br>ed she would expect R66 to<br>night and alternating on and<br>proughout the day since<br>and have received ROM<br>2/16. |                     |  |                |                         |  |
|                          | At approximately 10:10 a.m., NA<br>room and OT-A asked her to loc<br>splints. NA-B looked in R66's be<br>locations and found them on R6<br>underneath blankets and equipm<br>R66 should have been wearing<br>according to the schedule to pre<br>functional decline. NA-B stated I<br>the hand splints in awhile, and s<br>sure why R66 had not been wea | ked her to locate R66's hand<br>d in R66's bedroom in various<br>d them on R66's wheelchair<br>ts and equipment. OT-A stated<br>een wearing her hand splints<br>hedule to prevent further<br>NA-B stated R66 had not worn<br>awhile, and stated she was not   |                     |  |                |                         |  |
|                          | R66's care plan did<br>program or ROM th<br>confirmed R66's ca<br>services were not c  | 35 a.m. LPN-A stated she felt<br>I not include a restorative<br>hat she knew of. She<br>are plan and stated that ROM<br>on R66's care plan. She stated<br>d hand splints, and she felt<br>about the same."  |                     |  |                |                         |  |
|                          | therapy assistant (C<br>stated their usual p<br>ROM program for r<br>therapy screen and<br>recommended ROI<br>manager (CM.) She<br>the plan she was ex   | rocess for implementing a esidents was to complete a  |                     |  |                |                         |  |

| STATEME  | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | CONSTRUCTION   |                                  | E SURVEY<br>PLETED      |
|--|---|---|---------------------|--|----------------------------------|-------------------------|
|  |   | 00730   | B. WING             |  | 10/24/2016                       |                         |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, ST     | TATE, ZIP CODE   |                                  |                         |
| FRAZEE CARE CENTER       219 WEST MAPLE AVENUE, PO BOX 96         FRAZEE, MN 56544 |   |   |                     |  |                                  |                         |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 560  | ADL Worksheet," in<br>ROM provided. Sh<br>documentation that<br>for R66 in her medi<br>She confirmed R66<br>services since 1/12<br>explain why she ne<br>On 10/20/16, at 10:<br>R66's stiffness had<br>were more stiff now<br>was more stiff when<br>they really had to m<br>put her shirts on.<br>On 10/20/16, at 11:<br>elbow ROM while F<br>physically picked up<br>manipulated both a<br>right elbow lacked 2<br>R66 was a little tigh<br>movements, and cc<br>with movement. Sh<br>pain and grimaced<br>and R66's left elbow<br>extension.<br>On 10/20/2016 at 1<br>sometimes R66 wa<br>extremities, and sta<br>more depending on<br>her.<br>On 10/21/16, at 10:<br>totally dependent of<br>stated she was uns<br>program , but stated<br>stated she knew R6<br>than her left arm. S | ge 33<br>the NA Book for documenting<br>e confirmed there was no<br>ROM services were provided<br>cal record or in the NA Book.<br>should have received ROM<br>/16, and stated she could not<br>ver received ROM services.<br>40 a.m. NA-B stated she felt<br>gotten worse and her arms<br>/. She stated she noticed R66<br>in they dressed her, and stated<br>hanipulate her arms when they<br>45 a.m. OT evaluated R66's<br>R66 was awake in her bed. OT<br>b R66's right arm and after she<br>rms, she confirmed R66's<br>25% extension. She confirmed<br>it with initial right side<br>onfirmed R66 grimaced in pain<br>he confirmed R66 also had<br>with movement of her left arm,<br>w lacked about 10% for<br>2:00 p.m. NA-D stated<br>s a little more stiff in her upper<br>aff had to manipulate her arms<br>the shirt they were putting on<br>14 a.m. NA-A stated R66 was<br>n staff for all of her cares. She<br>ure if R66 was on a ROM<br>d she felt R66 should be. She<br>S6's right arm was more stiff<br>he stated R66 just started<br>is to both hands today and | 2 560               | DEFICIENC  |                                  |                         |

|                          | ta Department of He<br>T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | CONSTRUCTION  |                                | E SURVEY<br>PLETED       |
|--------------------------|--|--|-------------------------|---|--------------------------------|--------------------------|
|                          |  | 00730  | B. WING                 |   | 10/24/2016                     |                          |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AI  | DDRESS, CITY, S         | TATE, ZIP CODE  |                                |                          |
| RAZEE                    | CARE CENTER  |  | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96  |                                |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETI<br>DATE |
| 2 560                    | Continued From pa  | ge 34  | 2 560                   |   |                                |                          |
|                          | stated she had nev splints until today.  | er seen R66 wear see hand  |                         |   |                                |                          |
|                          | her back in bed with<br>right hand in a fist,<br>splints were observ<br>8.5 X 11" white pie<br>instructions and ha<br>was observed poste   | 6 p.m. R66 was observed on<br>h both arms resting on chest,<br>left hand in a "C" shape. No<br>red on either of R66's hands. A<br>ce of paper with both typed<br>nd-written notes, dated 8/3/16,<br>ed on R66's bedroom wall<br>cliner and identified R66's TV   |                         |   |                                |                          |
|                          | pathologist (SLP) s<br>with R66 on commu-<br>assessed her ability<br>in the past. SLP rep<br>assessment of R66<br>SLP held "Yes and<br>chest. SLP instructor<br>answered her ques<br>motion hand toward<br>use her eyes to loo<br>questions. R66 was<br>assessment at all. I<br>ended assessment<br>success today, whe | 5 p.m. speech language<br>tated she had been working<br>unication techniques and<br>y to use her hands and elbows<br>beated her functional<br>5. R66 was reclined in bed and<br>No" flash cards above R66's<br>ed R66 to point at the card that<br>tions. R66 unable to point or<br>d cards. SLP instructed R66 to<br>k at either card to answer her<br>s unable to participate in the<br>R66 began crying and SLP<br>. SLP confirmed R66 had 0%<br>ere R66 responded correctly to<br>ns during a past assessment. | t                       |   |                                |                          |
|                          | she was not aware  | 0 a.m. NA-B stated at present<br>if R66 could use her call light ,<br>not know if R66 could hold a   |                         |   |                                |                          |
|                          | might be able to us  | 14 a.m. NA-D stated R66<br>e her call light or TV remote if<br>hand, but wasn't sure.  |                         |   |                                |                          |
|                          | On 10/24/16, at 10:<br>epartment of Health   | 38 a.m. registered nurse   |                         |   |                                |                          |

| STATEMEN      | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                 |  |               | E SURVEY<br>PLETED |  |
|---------------|--|---|-----------------|--|---------------|--------------------|--|
|               |  | 00730   | B. WING         | B. WING  |               | 10/24/2016         |  |
| NAME OF       | PROVIDER OR SUPPLIER   | STREET AL   | DRESS, CITY, ST | TATE, ZIP CODE   |               |                    |  |
| RAZEE         |  |   |                 |  |               |                    |  |
| (X4) ID       | SUMMARY STA  |   | MN 56544        | PROVIDER'S PLAN OF   | CORRECTION    | (X5)               |  |
| PREFIX<br>TAG |  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG   | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE | COMPLET            |  |
| 2 560         | Continued From pa  | ge 35   | 2 560           |  |               |                    |  |
|               | impairment and wa<br>all cares. She state<br>on a ROM program<br>today, or had declir<br>extremities. She sta<br>ROM and wore her<br>therapy recomment<br>was not on R66's c<br>On 10/24/16, at 103<br>(CM)-A stated R66<br>impairment, and wa<br>cares. She indicate<br>contractures on add<br>remember where the<br>side of R66's body<br>remembered talking<br>past about R66's co<br>and stated she told<br>remote in her room | 53 a.m. clinical manager<br>had severe cognitive<br>as dependent on staff for<br>d she thought R66 had<br>mission, but stated she did not<br>he contractures were, or which<br>was affected. CM-A stated she<br>g to the physician in the distant<br>pontractures after admission<br>him she saw R66 use her TV |                 |  |               |                    |  |
|               | since 1/12/16, and<br>and off during the c<br>stated she expecte<br>according to the sc<br>services from the N<br>no documentation i<br>the NA book that R<br>services since adm<br>services were not c  |   |                 |  |               |                    |  |
|               | while she was awal<br>COTA picked up Re<br>and put her call ligh<br>adjusted her fingers<br>fingers were very w  | :00 p.m. COTA evaluated R66<br>se and sat in her recliner.<br>66's right arm by her elbow<br>it in between R66's finger and<br>s to hold call light. R66's<br>reak and her fingers and hand<br>e call light fell on her lap. COTA   |                 |  |               |                    |  |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE<br>A. BUILDING: _ | CONSTRUCTION   |                                | E SURVEY<br>PLETED       |
|--------------------------|---|---|---------------------------------|--|--------------------------------|--------------------------|
|                          |   | 00730   | B. WING                         |  | 10/24/2                        |                          |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AL   | DRESS, CITY, ST                 | TATE, ZIP CODE   |                                |                          |
| RAZEE                    | CARE CENTER   |   | T MAPLE AVE<br>MN 56544         | NUE, PO BOX 96   |                                |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC <sup>1</sup> | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETI<br>DATE |
| 2 560                    | picked up R66's lef<br>call light between F<br>and fingers did not<br>were very weak and<br>hand and R66 coul<br>light. COTA also er<br>TV remote. COTA a<br>remote in R66's rig<br>R66's arm by her e<br>the TV remote at a<br>COTA lifted R66's I<br>put the remote betw<br>remote slipped in F<br>the ceiling. R66 wa<br>towards her TV or a<br>left hand and finger<br>R66 declined in her<br>On 10/24/16, at 12<br>(AD) confirmed act<br>in R66's room at th<br>listed TV shows R6 | it arm by the elbow, placed her<br>R66's fingers. R66's left hand<br>move. R66 hand and fingers<br>d call light just sat loose in her<br>d not grasp or activate her call<br>valuated R66 for holding her<br>attempted to place R66's TV<br>ht hand while she supported<br>lbow. R66 was unable to hold<br>ll with her right hand or fingers.<br>eft arm up by the elbow and<br>ween R66's left fingers. The TV<br>R66's hand and pointed up to<br>s unable to hold the remote<br>activate the remote with her<br>rs. She stated she was sure<br>r upper extreme ROM.<br>:27 p.m. Activities Director<br>ivity staff had posted a paper<br>e time of admission, which<br>S6 like to watch. AD indicated<br>was originally posted, R66 |                                 |  |                                |                          |
|                          | channel surf on the<br>shows she liked to<br>On 10/24/16, at 1:4<br>stated she felt if R6<br>remote or call light<br>it was evidence of a<br>stated the failure to<br>not a new concern   | the remote, and liked to<br>TV and would stop on the<br>watch.<br>5 p.m. nurse practitioner (NP)<br>66 was unable to use her<br>now, and could on admission,<br>a functional decline. She<br>provide ROM services was<br>for her and stated she had<br>ms to administration in the  |                                 |  |                                |                          |
|                          | past, but continued<br>in the facility.<br>On 10/25/16, at 5:0  | to be a long standing problem<br>5 p.m. family member (FM)-A<br>rst got to the facility she could   |                                 |  |                                |                          |

|                          | ota Department of He<br>NT OF DEFICIENCIES<br>N OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                               |                         | CONSTRUCTION  |                                | E SURVEY<br>PLETED      |
|--------------------------|---|---|-------------------------|---|--------------------------------|-------------------------|
|                          |   |   | A. BUILDING             |   |                                |                         |
|                          |   | 00730   | B. WING                 |   | 10/24/2016                     |                         |
| NAME OF                  | PROVIDER OR SUPPLIER  |   | DRESS, CITY, ST         |   |                                |                         |
| FRAZEE                   | E CARE CENTER   |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96  |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 560                    | Continued From particles of the stated when Refacility R66 could all arms in the arm hole stated R66 could need and indicated she for cried. She stated R affected by her brais visited R66 over the noticed staff were moticed staff were stated R66 received admission to this far asked facility staff were crises and state they felt her brain withem to do that. Review of facility produced 4/1/08 identified assessed on admiss such as ROM. If a Fidentified need, a pimeet resident need identified residents highest level of function states and revise pito ensuring the care resident is revised a nursing or designed. |   | 2 560                   |   |                                |                         |

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                        | E CONSTRUCTION (  | X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|---|------------------------|---|------------------------------|
|                          |  | 00730   | B. WING                |   | 10/24/2016                   |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                        | STATE, ZIP CODE   |                              |
| RAZEE                    | CARE CENTER  |   | T MAPLE AV<br>MN 56544 | ENUE, PO BOX 96   |                              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLET                   |
| 2 560                    | Continued From pa  | ge 38   | 2 560                  |   |                              |
|                          | TIME PERIOD FOR<br>(21) days.  | R CORRECTION: Twenty-one  |                        |   |                              |
| 2 565                    | MN Rule 4658.0409<br>Plan of Care; Use   | 5 Subp. 3 Comprehensive   | 2 565                  |   | 11/17/16                     |
|                          |  | omprehensive plan of care<br>I personnel involved in the<br>t.  |                        |   |                              |
|                          | by:<br>Based on observation<br>review the facility factor<br>plan interventions we<br>preferences for 1 or<br>for choices, ambulation<br>implemented and re-<br>residents (R44) revealed<br>addition the facility<br>plan interventions we<br>assessed reposition<br>for 1 of 1 resident for<br>incontinence and for | ent is not met as evidenced<br>ion, interview and document<br>ailed to ensure resident care<br>vere implemented for bathing<br>f 3 residents (R61) reviewed<br>ation programs were<br>outinely followed for 1 of 4<br>viewed for ambulation. In<br>failed to ensure resident care<br>vere implemented for<br>oning, personal cares needs<br>(R18) reveiwed for urinary<br>or repositioning for 2 of 2<br>66) at risk for development of |                        | corrected   |                              |
|                          | Findings include:  |   |                        |   |                              |
|                          | Bathing Preference   | S:  |                        |   |                              |
|                          |  | rrent care plan revised<br>R61 required assistance of one   |                        |   |                              |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                            | CONSTRUCTION   |                                 | E SURVEY<br>PLETED      |
|--------------------------|---|---|----------------------------|--|---------------------------------|-------------------------|
|                          |   | 00730   | B. WING                    |  | 10/                             | 24/2016                 |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, ST           | TATE, ZIP CODE   |                                 |                         |
| RAZEE                    | CARE CENTER   |   | ST MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa   | age 39  | 2 565                      |  |                                 |                         |
|                          | Review of nursing assistant care sheet provided<br>by the facility, dated 10/17/16, directed staff to<br>assist R61 with a bath 3 times a week, Monday,<br>Wednesday and Fridays.<br>On 10/19/16, at 1:26 p.m. R61 stated she had not<br>received her bath on Monday 10/17/16, due to not<br>enough staff on the floor. R61 stated she had<br>been told the staff would try to help her with<br>bathing on 10/18/16, though due to not enough<br>staff on the floor, she had not received assistance<br>with a bath. R61 stated the nursing assistants<br>(NA) do not have enough time during the day to<br>give baths, so she had changed to before bed.<br>R61 stated she was scheduled to have 3 baths a<br>week, Monday, Wednesday and Fridays and was<br>still not able to get 3 baths a week due to not<br>enough staff on the floor. R61 stated it had been<br>"months" since she had received 3 baths a week,<br>and indicated she understood it was due to the<br>lack of nursing staff. |   |                            |  |                                 |                         |
|                          |   |   | t<br>e                     |  |                                 |                         |
|                          | understood R61 wa   | 52 a.m. NA-F stated she<br>as supposed to receive 2 baths<br>ings and was not sure if R61<br>routinely.                       | 5                          |  |                                 |                         |
|                          | had met with R61 of   | :02 a.m. ADON indicated she<br>on 10/20/16 and confirmed R61<br>nely receiving her 3 baths a<br>ned.                          | 1                          |  |                                 |                         |
|                          | interview, ADON s to routinely comple   | 37 p.m. during a follow up<br>tated she felt staff were unable<br>ete the number of baths based<br>rence, such as R61, due to |                            |  |                                 |                         |
|                          |   | 31 a.m. nurse manager (NM)-A<br>aware R61's baths were not  |                            |  |                                 |                         |

| STATEMEN                 | ota Department of He<br>NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | CONSTRUCTION   |                                  | E SURVEY<br>PLETED      |
|--------------------------|---|--|-------------------------|--|----------------------------------|-------------------------|
|                          |   | 00730  | B. WING                 |  | 10/24/2016                       |                         |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AI  | DDRESS, CITY, ST        | TATE, ZIP CODE   |                                  |                         |
| FRAZEE                   | CARE CENTER   |  | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa   | ge 40  | 2 565                   |  |                                  |                         |
|                          | getting done 3 time<br>care plan should be  | s a week. She stated R61's<br>e followed.  |                         |  |                                  |                         |
|                          | 9/25/15, revealed F<br>mobility in a wheeld<br>with ambulation wit  | rrent care plan updated<br>A44 was independent with<br>chair and required assistance<br>h use of a walker. R44's care<br>o offer to walk with R44 to all   |                         |  |                                  |                         |
|                          | 10/17/16, listed var<br>included R44 was a<br>directed staff to ass   | e Plan Group C form, dated<br>ious interventions which<br>assist one for ADL's and<br>sist R44 with ambulation twice<br>th a rear wheeled walker and   |                         |  |                                  |                         |
|                          | standard wheelcha<br>dining room and wh<br>table. R44 verbalize<br>obtained her food a<br>a.m. R44 had eater    | 6 a.m. R44 was seated in a<br>ir, propelling herself into the<br>neeled herself up to a circular<br>ed her breakfast order,<br>and ate independently. At 8:34<br>n 100% of her meal and at that<br>elf out of the dining room. |                         |  |                                  |                         |
|                          | Worksheet from Ap<br>identified R44's was<br>twice a day (BID) Ic<br>with a walker and tr<br>also indicated R44 | form titled Maintenance ADL<br>oril 2016, to October 2016,<br>s on an ambulation program<br>ong distances in the hallways<br>ransfer belt. The worksheet<br>was to be assisted to<br>feet (ft.) R44's worksheets<br>ing:       |                         |  |                                  |                         |
|                          | R44 had received h  | April 2016, worksheet identified<br>her ambulation program 16 out<br>n hours and 25 out of 31 days   |                         |  |                                  |                         |

| STATEMEN                 | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                            | CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|--|---|----------------------------|--|--------------------------------|-------------------------|
|                          |  | 00730   | B. WING                    |  | 10/                            | 24/2016                 |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, ST           | TATE, ZIP CODE   |                                |                         |
| FRAZEE                   | CARE CENTER  |   | ST MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa  | age 41  | 2 565                      |  |                                |                         |
|                          | identified R44 had program 13 out of 3   | -Review of R44's May 21016, worksheet<br>identified R44 had received her ambulation<br>program 13 out of 31 days in the am and 20 days<br>out of 31 in the pm.        |                            |  |                                |                         |
|                          | R44 had received I   | une 2016, worksheet identified<br>her ambulation program 8 out<br>m and 24 out of 30 days in the  |                            |  |                                |                         |
|                          | R44 had received I   | uly 2016, worksheet identified<br>her ambulation program 7 out<br>m and 12 out of 30 days in the  |                            |  |                                |                         |
|                          | identified R44 had   | ugust 2016, worksheet<br>received her ambulation<br>1 days in the am and pm.  |                            |  |                                |                         |
|                          | identified R44 had   | September 2016, worksheet<br>received her ambulation<br>ut of 30 in the am and 8 days   |                            |  |                                |                         |
|                          | identified R44 had   | October 2016, worksheet<br>received her ambulation<br>It of 17 in the the am and 0<br>It pm.  |                            |  |                                |                         |
|                          | assessment dated<br>discharged from th<br>placed on the nurs<br>program) and was | pational Therapy (OT)<br>3/12/15, revealed R44 was<br>erapy services and had been<br>ing gait list (ambulation<br>to ambulate with a front<br>th stand by assistance. |                            |  |                                |                         |
|                          | (NA)-F stated R44  | 59 p.m. nursing assistant<br>was able to complete most<br>NA-F stated R44 required  |                            |  |                                |                         |

|                          | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                            | CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|--|--|----------------------------|--|--------------------------------|-------------------------|
|                          |  | 00730  | B. WING                    |  | 10/                            | 24/2016                 |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, ST           | TATE, ZIP CODE   |                                |                         |
| RAZEE                    | CARE CENTER  |  | ST MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa  | age 42   | 2 565                      |  |                                |                         |
|                          | assistance to ambulate in the hallways and was<br>on an ambulation program for twice a day in the<br>am and in the pm. NA-F stated there were days<br>when R44 was not assisted to ambulate due to<br>not enough nursing staff on the floor.<br>On 10/20/16, at 2:34 p.m. NA-B stated R44<br>required limited assistance with ADL's of dressing<br>and ambulation. NA-B stated R44 was on an |  |                            |  |                                |                         |
|                          | residents ambulation<br>were not getting do<br>enough staff and th<br>On 10/20/16, at 3:2  | 24 p.m. licensed practical nurse   |                            |  |                                |                         |
|                          | program for twice a stated R44 liked to  | 4 was on a ambulation<br>a day in the am and pm. LPN-E<br>walk and felt the times R44<br>ith ambulation was due to not<br>e floor.   | 3                          |  |                                |                         |
|                          | on a walking progra<br>walk twice a day. F<br>to 3 times a day an<br>was walked once a<br>told her they were t<br>not receive her am<br>that had been happ<br>several months. R  | :08 a.m. R44 stated she was<br>am which she was supposed to<br>R44 stated she used to walk up<br>id stated she was lucky if she<br>a day. R44 stated the staff had<br>too busy on the days she did<br>bulation program. R44 stated<br>bening routinely for the last<br>44 stated she was able to walk<br>lock (200 feet square |                            |  |                                |                         |
|                          | perimeter around the<br>time would get a bi-<br>like she should. R4<br>was not as steady<br>R44 stated she fea   | he nursing station,) but at the<br>t winded due to not walking<br>4 stated she felt as though she<br>on her legs as she used to be.<br>ared she would lose her ability<br>ot continue with her ambulation  |                            |  |                                |                         |
|                          | On 10/21/16, at 10   | :18 a.m. registered nurse  |                            |  |                                |                         |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                            | CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|--|--|----------------------------|--|--------------------------------|-------------------------|
|                          |  | 00730  | B. WING                    |  | 10/24/2016                     |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, ST           | TATE, ZIP CODE   |                                |                         |
| FRAZEE                   | CARE CENTER  |  | ST MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa  | age 43   | 2 565                      |  |                                |                         |
|                          | program twice daily<br>walker and gait bel<br>R44 was routinely r<br>program and stated<br>answer the questio<br>On 10/21/16, at 10<br>therapy assistant (0<br>been referred to nu<br>program last year a<br>daily to 200 feet wit<br>walker.<br>On 10/21/16, at 11:<br>nursing (ADON) co<br>consistently receivi<br>ADON stated she e | <ul> <li>R44 was on an ambulation<br/>y to 200 feet with assist of one,<br/>t. RN-A did not comment if<br/>receiving her ambulation<br/>d R44 would be best person to<br/>in.</li> <li>:38 a.m. certified occupational<br/>COTA) confirmed R44 had<br/>ursing for an ambulation<br/>and was to be ambulated twice<br/>th one assist, gait belt and</li> <li>:13 a.m. assistant director of<br/>onfirmed R44 was not<br/>ing her ambulation program.<br/>expected staff to routinely<br/>on/maintenance programs for</li> </ul> |                            |  |                                |                         |
|                          | Repositioning/perse  | onal cares:  |                            |  |                                |                         |
|                          | 10/7/16, revealed F<br>was unable to com<br>totally dependent or<br>repositioning needs<br>incontinent of bowe<br>incontinent brief. T<br>interventions which<br>and reposition ever<br>clean and dry and a<br>wheelchair. The ca  | s and was frequently<br>el and bladder and wore an<br>The care plan listed<br>n included to assist R18 to turn<br>ry 2 hours and prn, keep skin  |                            |  |                                |                         |
|                          |  | 7:03 a.m. to 10:39 a.m.,<br>ations of R18 revealed the   |                            |  |                                |                         |

STATE FORM

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE<br>A. BUILDING: _ |   |                                | E SURVEY<br>PLETED      |
|--------------------------|---|--|---------------------------------|---|--------------------------------|-------------------------|
|                          |   | 00730  | B. WING                         |   | 10/24/2016                     |                         |
| NAME OF F                | PROVIDER OR SUPPLIER  |  | DDRESS, CITY, S                 | TATE, ZIP CODE  |                                |                         |
| RAZEE                    | CARE CENTER   |  |                                 | NUE, PO BOX 96  |                                |                         |
|                          |   |  | , MN 56544                      |   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa   | age 44   | 2 565                           |   |                                |                         |
|                          | On 10/19/16, at 7:03 a.m. R18 was seated in a gel cushioned wheelchair, fully dressed in her room. R18's bed was stripped of its linens which were balled into a bundle on her bed. R18's head was hung forward in a chin to chest position and her eyes were closed.<br>-at 7:38 a.m. the call light to R18's room was on by R18's roommate, staff were observed to enter the room to assist R18's roommate. At that time, housekeeping staff entered R18's room and made R18's bed while she remained seated in the wheelchair. At 7:41 a.m. the housekeeping staff member wheeled R18 to the dining room. R18 had remained with her eyes closed and her head was in a chin to chest position. Housekeeping staff wheeled R18 to a table in the dining room and placed a clothing protector around her neck, at that time R18 covered her face with the clothing protector. |  |                                 |   |                                |                         |
|                          | wheelchair in the d<br>(DA)brought R18 h<br>plate on the table i<br>At that time nursin<br>approached R18, p<br>and verbally promp<br>opened her eyes a<br>R18 to begin eating<br>R18 ate 100% of h<br>independently whil   | remained seated in the<br>lining room. A dietary aid<br>her breakfast plate, left the<br>n front of her and walked away<br>ng assistant (NA)-G<br>blaced a hand on her shoulder<br>bted her to wake up. R18<br>and NA-G verbally prompted<br>g and handed her a spoon.<br>her breakfast foods<br>e seated in the wheelchair.<br>ted in the wheelchair at the |                                 |   |                                |                         |
|                          | wheelchair at the c   | remained seated in her<br>Jining room table, had made no<br>om the table. R18 had  |                                 |   |                                |                         |

| STATEMEN                 | ota Department of He<br>NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                           |  |                | E SURVEY<br>PLETED      |
|--------------------------|---|---|---------------------------|--|----------------|-------------------------|
|                          |   | 00730   | B. WING                   |  | 10/24/2016     |                         |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AI   | DDRESS, CITY, S           | TATE, ZIP CODE   |                |                         |
| FRAZEE                   | CARE CENTER   |   | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |                           | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | TION SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | completed her mea<br>juice and water in fr<br>attempt to reach fo<br>spoon, and would r<br>the lipped edge of h<br>her spoon.<br>-at 9:01 a.m. R18 r<br>wheelchair in the di<br>attempts to leave th<br>R18 and asked how<br>respond, NA-H wal<br>repeatedly run her<br>of the plate, while s | al, had a glass of milk orange<br>ront of her though made no<br>r them. R18 held onto her<br>epeatedly run the spoon over<br>her plate, periodically licking<br>emained seated in her<br>ining room, having made no<br>he table. NA-H approached<br>w her day was, R18 did not<br>ked away. R18 continued to<br>spoon around the lipped edge<br>the periodically licked her | 2 565                     |  |                |                         |
|                          | fluids.<br>-at 9:18 a.m. R18 r<br>wheelchair in the di<br>spoon on the table,<br>Shortly after R18's  | ade no attempts to drink her<br>emained seated in her<br>ining room. R18 had set the<br>and had closed her eyes.<br>head dropped forward in a<br>on. No staff had offered to<br>ositioning.   |                           |  |                |                         |
|                          | wheelchair in the di<br>her eyes, looked ar<br>protector and cover<br>attempt to move av<br>face covered with th  | emained seated in her<br>ining room. R18 had opened<br>round, took her clothing<br>red her face it. R18 made no<br>vay from the table and held her<br>he clothing protector.  | r                         |  |                |                         |
|                          | awoke R18 and off<br>awake, removed th<br>face and allowed N<br>juice. R18 drank 50<br>handed R18 her gla<br>independently dran   | entered the dining room,<br>ered R18 her fluids. R18<br>e clothing protector from her<br>A-D to assist her to drink her<br>0% of her juice. NA-D then<br>ass of water and R18<br>k the water. NA-D left R18<br>lchair and exited the dining   |                           |  |                |                         |

| STATEMEN                 | ta Department of He<br>T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                              | CONSTRUCTION   |                                 | E SURVEY<br>PLETED      |
|--------------------------|--|---|------------------------------|--|---------------------------------|-------------------------|
|                          |  | 00730   | B. WING                      |  | 10/24/2016                      |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   |   | DDRESS, CITY, S <sup>-</sup> |  |                                 |                         |
| FRAZEE                   | CARE CENTER  |   | ST MAPLE AVE<br>, MN 56544   | NUE, PO BOX 96   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa  | age 46  | 2 565                        |  |                                 |                         |
|                          |  | room. NA-D was not observed to offer R18 assistance with cares, repositioning or toileting needs.   |                              |  |                                 |                         |
|                          | her to drink her ren<br>remained seated ir<br>removed the clothi   | approached R18 and assisted<br>naining fluids, while R18<br>her wheelchair. NA-H<br>ng protector from R18's neck,<br>shirt and covered her face with<br>ition.  |                              |  |                                 |                         |
|                          | room while seated<br>to her room and ha<br>NA-H attached the<br>and left R18's roon  | assisted R18 out of the dining<br>in her wheelchair, brought her<br>anded R18 a stuffed bear.<br>call light to R18's wheelchair<br>n. NA-H was not observed to<br>cares, including repositioning  |                              |  |                                 |                         |
|                          |  | D was observed to walk past<br>It look in or stop in R18's room.  |                              |  |                                 |                         |
|                          | hallway from R18's   | E exited a room across the room, briefly looked into mediately walked away down   |                              |  |                                 |                         |
|                          | (ADON) was notified<br>her wheelchair for a<br>minutes. At that tim<br>required assistance<br>checking and chan<br>confirmed R18 was<br>ADON went to R18 | stant director of nursing<br>ed R18 had remained seated ir<br>an observed 3 hours and 36<br>ne the ADON confirmed R18<br>e with repositioning and<br>uging every 2 hours. ADON<br>s at risk for skin breakdown.<br>3's room while requesting<br>her nursing staff via walkies |                              |  |                                 |                         |
|                          |  | E entered R18's room and the bathroom. NA-E donned a  |                              |  |                                 |                         |

| STATEMEN                 | DIT DEPARTMENT OF HE  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                       |  |                                | E SURVEY<br>PLETED      |
|--------------------------|---|--|---------------------------|--|--------------------------------|-------------------------|
|                          |   | 00730  | B. WING                   |  | 10/24/2016                     |                         |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, S           | TATE, ZIP CODE   |                                |                         |
| FRAZEE                   | CARE CENTER   |  | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIV<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | gait belt across R1<br>assisted R18 to sta<br>ambulate to the ba<br>slacks and incontin<br>amount of urine in<br>amount of bowel. A<br>buttocks surface w<br>had deep blush pin<br>surrounding her pe<br>blanchable. NA-E a<br>complete toileting r<br>back in her wheelc<br>R18 had remained<br>of 3 hours and 36 r<br>staff were observed<br>repositioning.<br>On 10/19/16, at 10<br>thought R18 was la<br>a.m. and had state<br>helping others with<br>repositioning and to<br>R18 was supposed<br>checked and chang<br>needed. NA-E state<br>verbalize hers and<br>R18's needs.<br>On 10/20/16. at 2:3<br>needs must be ant<br>dependent on 2 sta<br>repositioning and to<br>required routine ev<br>toileting. NA-B state | 8's torso, NA-E and ADON<br>and from the wheelchair,<br>throom and removed R18's<br>nent brief. R18 had a moderate<br>her brief as well as a small<br>ADON confirmed R18's entire<br>hich had contact with the brief<br>ak creases and was moist<br>pri-rectal area, though was<br>and ADON assisted R18 to<br>needs and assisted R18 to<br>needs and assisted R18 to<br>sit hair.<br>in a seated position for a total<br>minutes, during that time no<br>d to offer R18 assistance with<br>:39 a.m. NA-E stated she<br>ast repositioned around 6:45<br>d she had been too busy<br>cares to assist R18 with<br>oileting needs. NA-E stated<br>d to be repositioned and<br>ged every 2 hours and as<br>ed R18 was not able to<br>staff needed to anticipate<br>aff for her needs, including<br>oileting. NA-B stated R18<br>icipated and was totally<br>aff for her needs, including<br>oileting. NA-B stated R18<br>ery 2 hour repositioning and<br>ed R18's buttocks would get<br>ould not recall any recent open |                           |  | 1                              |                         |
| nnesota D                |   | 28 p.m. licensed practical nurse<br>8 was totally dependent on   | e                         |  |                                |                         |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | • •                        | CONSTRUCTION   |                                  | E SURVEY<br>PLETED     |
|--------------------------|---|---|----------------------------|--|----------------------------------|------------------------|
|                          |   | 00730   | B. WING                    |  | 10/24/2016                       |                        |
| AME OF F                 | PROVIDER OR SUPPLIER  |   | DDRESS, CITY, SI           | TATE, ZIP CODE   |                                  |                        |
| RAZEE                    | CARE CENTER   |   | ST MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                  |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLE<br>DATE |
| 2 565                    | Continued From pa   | age 48  | 2 565                      |  |                                  |                        |
|                          | staff of for all of he<br>was at risk for skin<br>incontinence and ir   |   |                            |  |                                  |                        |
|                          | interview ADON sta<br>to routinely repositi<br>timely manner, suc<br>shortages. ADON s<br>able to fill in for sicl  | B7 p.m. during a follow up<br>ated she felt staff were unable<br>oning and toilet residents in a<br>h as R18, due to staffing<br>stated they were not always<br>c calls and there were times<br>are unable to fill holes in the   |                            |  |                                  |                        |
|                          | Hand splints  |   |                            |  |                                  |                        |
|                          | aphasic (non verba<br>and was unable to<br>care plan also iden<br>splints for 2 hours of<br>day, and was to we<br>care plan failed to i<br>and did not identify | ted 2/18/16, identified R66 was<br>I) due to traumatic brain injury<br>make her needs known. R66's<br>tified R66 was to wear hand<br>on and 2 hours off during the<br>ear the splints all night. R66's<br>dentify R66 had contractures,<br>a ROM or a restorative<br>r R66 to prevent further | ,                          |  |                                  |                        |
|                          | 10/17/16, identified<br>with cares and was<br>off every 2 hours d<br>on all night. The Aid<br>R66 had contracture   | Care Plan, Group B dated<br>R66 required total assistance<br>to wear hand splints on and<br>uring the day and leave them<br>de Care Plan did not identify<br>res or that she required a ROM<br>ng program to prevent further  |                            |  |                                  |                        |
|                          | On 10/19/16, obser<br>a.m. were conducte  | rvations from 7:00 a.m. to 9:47<br>ed:  | ,                          |  |                                  |                        |
|                          |   | was observed lying on her<br>er eyes closed. Both R66's   |                            |  |                                  |                        |

|                          | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | CONSTRUCTION   |               | E SURVEY<br>PLETED      |
|--------------------------|--|--|-------------------------|--|---------------|-------------------------|
|                          |  | 00730  | B. WING                 |  | 10/           | 24/2016                 |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AL  | DRESS, CITY, ST         | TATE, ZIP CODE   |               |                         |
| FRAZEE                   | CARE CENTER  |  | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |               |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | ION SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | arms were bent at t<br>in a fist position on<br>was in a "C" shaped<br>and hand slightly til<br>devices were not of<br>hands, and the split<br>in her room.<br>-7:49 a.m. licensed<br>entered R66's room<br>(artificial opening at<br>confirmed R66 had not<br>recent past becaus<br>uncomfortable for F<br>and did not apply R<br>-8:03 a.m. the nurs<br>room and immediat<br>station. R66 remain<br>her hands and arms<br>splints observed.<br>-8:20 a.m. R66 rem<br>same position with<br>and her hands reste<br>position. No hand s<br>hands and splints w<br>room.<br>-9:47 a.m. R66 rem<br>bed, no hand splints<br>present in R66's roo<br>On 10/19/16, at 10:<br>had not worn hand<br>wear the splints "at<br>aware when R66 la | the elbow, her right hand was<br>her chest, and her left hand<br>d position with fingers bent<br>ted away from her body. Splint<br>beerved on either of R66's<br>int devices were not observed<br>practical nurse (LPN)-A<br>in to provide her trachea<br>t windpipe) site care. She<br>is not wearing hand splints and<br>been wearing them in the<br>e she thought the splints were<br>R66. LPN-A exited R66's room<br>66's hand splints.<br>See consultant walked in R66's<br>tely walked down to the nurses<br>hed on her back in bed, with<br>is in the same positron, no<br>hained lying in bed in the<br>R66's arms bent at her elbows<br>ed on her chest in the same<br>plints were observed on R66's<br>were not observed in R66's<br>the same position in<br>is were observed on R66's |                         | DEFICIENC  | ΥΥ)<br>       |                         |

Minnesota Department of Health STATE FORM

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| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                            | CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|--|---|----------------------------|--|--------------------------------|-------------------------|
|                          |  | 00730   | B. WING                    |  | 10/24/2016                     |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, ST           | TATE, ZIP CODE   |                                |                         |
| FRAZEE                   | CARE CENTER  |   | ST MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC <sup>1</sup> | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa  | age 50  | 2 565                      |  |                                |                         |
|                          | splints to R66.  |   |                            |  |                                |                         |
|                          | (NA)-E confirmed I<br>hand splints, and s<br>the last time R66 h<br>provided a copy of<br>confirmed the care<br>wear hand splints.<br>aware R66 was to | :33 am nursing assistant<br>R66 did not routinely wear<br>tated she could not remember<br>ad worn her splints. NA-E<br>the a NA care sheet and<br>e sheet directed for R66 to<br>She stated she had not been<br>wear hand splints. NA-A and<br>s room and did not apply her |                            |  |                                |                         |
|                          | not aware of how F care for R66. She   | :40 a.m. NA-D stated she was<br>R66's care plan directed her to<br>stated she was not aware if<br>nts or if R66 was supposed to   |                            |  |                                |                         |
|                          | her recliner in her r<br>on her chest, right   | :10 p.m. R66 was seated in<br>room with both hands resting<br>hand in fist, left hand curled in<br>did not have hand splints on   |                            |  |                                |                         |
|                          | interview, NA-B sta<br>receive range of m  | 30 a.m., during follow up<br>ated R66 presently did not<br>otion services or presently was<br>torative nursing program.   | 5                          |  |                                |                         |
|                          | nursing stated she<br>had been discontin<br>she questioned if the<br>indicated she felt F  | 45 a.m. assistant director of<br>was not aware if R66's splints<br>nued in the past and indicated<br>he splints bothered R66 and<br>R66 was not anymore<br>nen she was admitted.  |                            |  |                                |                         |
|                          | (RN-A) stated R66  | :38 a.m. registered nurse<br>had severe cognitive<br>as totally dependent on staff for  | r                          |  |                                |                         |

| STATEMEN      | ta Department of He<br>T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                                |  |                | E SURVEY<br>PLETED |  |  |
|---------------|--|--|--------------------------------|--|----------------|--------------------|--|--|
|               |  | 00730  | B. WING                        |  | 10/            | 10/24/2016         |  |  |
| NAME OF I     | PROVIDER OR SUPPLIER   | STREET AD  | ADDRESS, CITY, STATE, ZIP CODE |  |                |                    |  |  |
| FRAZEE        | CARE CENTER  |  | T MAPLE AVE<br>MN 56544        | NUE, PO BOX 96   |                |                    |  |  |
| (X4) ID       | SUMMARY STA  |  | ID ID                          | PROVIDER'S PLAN OF   | COBBECTION     | (X5)               |  |  |
| PREFIX<br>TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | PREFIX<br>TAG                  | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | TION SHOULD BE | COMPLET<br>DATE    |  |  |
| 2 565         | Continued From pa  | ige 51   | 2 565                          |  |                |                    |  |  |
|               | on a ROM program<br>today, or had declin<br>extremities. She sta<br>ROM and wore her<br>therapy recomment<br>was not on R66's c<br>PRESSURE ULCE<br>R66's care plan dat<br>at risk for developin<br>fragile skin, not bein<br>immobile and was b<br>plan also identified<br>the bed or wear she<br>feet, and was to be<br>according to her tur<br>care plan further ide<br>and was to be check<br>hours. | R<br>ted 2/18/16, identified R66 was<br>ng pressure ulcers related to<br>ng able to turn herself, was<br>bed and chair bound. The care<br>R66 was to suspend heels off<br>eepskin boots to protect her<br>turned and repositioned<br>rning and positioning plan. The<br>entified R66 was incontinent<br>cked and changed every 2 |                                |  |                |                    |  |  |
|               | 10/17/16, identified with cares, was to b  | Care Plan, Group B, dated<br>R66 required total assistance<br>be turned and repositioned<br>was to float heels off the bed<br>boots.   |                                |  |                |                    |  |  |
|               | dark, and her door<br>dressed in a hospit<br>her back in bed. Re<br>and her body was o<br>legs were straight,<br>on her mattress. Sh<br>boots. R66's sheep   | 20 a.m. R66's bedroom was<br>was fully open. R66 was<br>al gown, and was asleep on<br>66's arms rested on her chest<br>covered with a blanket. R66's<br>and her heels rested directly<br>he was not wearing sheep skin<br>iskin boots were observed to<br>'s dresser across the room. At   |                                |  |                |                    |  |  |
|               | 7:19 a.m. R66 was  | in the same position in her<br>now open, continued with  |                                |  |                |                    |  |  |

| STATEME                  | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED<br><b>10/24/2016</b> |                         |
|--------------------------|--|---|-------------------------|--|--|-------------------------|
|                          |  | 00730   | B. WING                 |  |  |                         |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AI   | DDRESS, CITY, ST        | ATE, ZIP CODE  |  |                         |
| FRAZEE                   | CARE CENTER  |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN           (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE           REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED  |                         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE                  | (X5)<br>COMPLET<br>DATE |
| 2 565                    | loud mouth breathin<br>the mattress and w<br>boots. At 7:39 a.m.<br>in her bed with her<br>continued to be dire<br>wearing her sheeps<br>At 7:49 a.m. license<br>entered R66's room<br>were not free floate<br>sheep skin boots. I<br>heels were, "kind o<br>her mattress. LPN-<br>to approximately or<br>however it did not li<br>LPN-A laid R66's he<br>immediately left the<br>At 8:03 a.m. the reg<br>walked in to R66's he<br>immediately left the<br>At 8:03 a.m. the reg<br>walked in to R66's no<br>out, towards the nu<br>remained in the sar<br>asleep. R66 remain<br>heels floated, or sh<br>a.m.<br>At 10:03 a.m. LPN<br>developing pressur<br>think R66 had press<br>stated R66 sometin<br>and sometimes the<br>bed. LPN-A stated<br>pressure mattress a<br>repositioned and ch<br>hours. LPN-A confit<br>been repositioned v<br>that morning. At 10<br>observation (3 hour | ng and heels rested directly on<br>as not wearing her sheep skin<br>R66 was in the same position<br>eyes closed. R66's heels<br>ectly on her bed and was not<br>skin boots.<br>ed practical nurse (LPN)-A<br>n. LPN-A stated R66's heels<br>d and she was not wearing<br>LPN-A stated she felt R66's<br>f," floated by the bubbles in<br>A then pulled a flat pillow dowr<br>he inch under R66's calves<br>ft R66's heels off the mattress<br>eels directly on the bed, and |                         | DEFICIENC  | ντ)<br>  |                         |

| STATEMEN                 | DTA Department of He<br>NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                              | CONSTRUCTION   |                                 | E SURVEY<br>PLETED      |  |
|--------------------------|---|---|------------------------------|--|---------------------------------|-------------------------|--|
|                          |   | 00730   | B. WING                      |  | 10/                             | 10/24/2016              |  |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, S <sup>-</sup> | TATE, ZIP CODE   |                                 |                         |  |
| RAZEE                    | CARE CENTER   |   | ST MAPLE AVE<br>, MN 56544   | NUE, PO BOX 96   |                                 |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 565                    | Continued From pa   | age 53  | 2 565                        |  |                                 |                         |  |
|                          |   | vere intact. NA-E entered<br>ssisted LPN-A with R66's   |                              |  |                                 |                         |  |
|                          | last time R66 was in<br>was supposed to be<br>checked and chang<br>she would have to<br>see when she report<br>taking care of R66<br>felt R66 was was a<br>ulcers, but she didr<br>problems. NA-E sta<br>bed because R66 hand had an air bed<br>didn't wear her she<br>her current care sh<br>sheepskin boots. No<br>room after R66 was | E stated she didn't know the<br>repositioned. NA-E stated R66<br>be turned and repositioned,<br>ged every 2 hours. She stated<br>check with partner NA-D to<br>ositioned R66 as they were<br>for the day. NA-E stated she<br>t risk for developing pressure<br>n't think R66 had any skin<br>ated R66 heels could be on the<br>had no breakdown at this time<br>. NA-E further stated R66<br>be skin boots. NA-E confirmed<br>ueet did not direct the use of<br>IA-E and LPN-A left R66's<br>s in her recliner with her heels<br>on the footrest of the recliner. | •                            |  |                                 |                         |  |
|                          | didn't know if R66 w<br>pressure ulcers, or<br>her to do for R66's<br>special mattress, a<br>would be at risk. Na<br>R66 had a history of<br>aware of any sheep<br>stated she did not n<br>and stated she thou  | :40 a.m. NA-D stated she<br>was at risk for developing<br>what R66's care plan directed<br>skin. She stated R66 had a<br>nd stated she assumed R66<br>A-D stated she didn't know if<br>of pressure ulcers and wasn't<br>o skin boots for R66. NA-D<br>reposition R66 this morning,<br>ught the last time R66 had<br>was at approximately 630 a.m.   |                              |  |                                 |                         |  |
|                          | recliner in front of h<br>heels floated on a  | :10 p.m. R66 was seated in<br>her TV. R66 did not have her<br>pillow and was not wearing her<br>R66's heels rested directly on<br>recliner.   |                              |  |                                 |                         |  |

| STATEMEN      | ota Department of He<br>NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                       | CONSTRUCTION   |                | E SURVEY<br>PLETED |  |
|---------------|--|---|-----------------------|--|----------------|--------------------|--|
|               |  |   | A. BUILDING:          |  |                |                    |  |
|               |  | 00730   | B. WING               |  | 10/            | 10/24/2016         |  |
| NAME OF       | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S        | TATE, ZIP CODE   |                |                    |  |
| FRAZEE        | CARE CENTER  |   | MAPLE AVE<br>MN 56544 | INUE, PO BOX 96  |                |                    |  |
| (X4) ID       |  | TEMENT OF DEFICIENCIES  | ID                    | PROVIDER'S PLAN OF   |                | (X5)               |  |
| PRÉFIX<br>TAG |  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG         | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | HE APPROPRIATE | COMPLET<br>DATE    |  |
| 2 565         | Continued From pa  | uge 54  | 2 565                 |  |                |                    |  |
|               | back, legs straight directly on her bed.   | 1 p.m. R66 laid in bed on her<br>out with her heels resting<br>R66 did not have her heels<br>, and was not wearing sheep  |                       |  |                |                    |  |
|               | totally dependent o<br>she wasn't sure of<br>she didn't think R66<br>ulcers, and didn't ku<br>ulcers in the past. N<br>rested directly on h<br>wearing sheepskin<br>Aide Care Sheet ar<br>had sheepskin boo<br>sheet, but R66's he | 4 p.m. NA-B stated R66 was<br>n staff for cares, and stated<br>R66's cognition. She stated<br>6 was at risk for pressure<br>now if R66 had pressure<br>NA-B confirmed R66's heels<br>er bed and she was not<br>boots. NA-B confirmed R66's<br>nd stated she didn't know R66<br>ts as they weren't on her<br>eels were supposed to floated<br>posed to be repositioned every |                       |  |                |                    |  |
|               | (RN)-A stated R66<br>pressure ulcers bed<br>herself. She stated<br>had ever had any s<br>R66's heels were s  | 38 a.m. registered nurse<br>was at risk for developing<br>cause she couldn't reposition<br>she didn't remember if R66<br>kin problems. She stated<br>upposed to be floated off of<br>A's were supposed reposition   |                       |  |                |                    |  |
|               | stated R66 had sev<br>was dependent on<br>was supposed to be<br>her heels were sup<br>bed, or R66 was to<br>had a history of pre   | 53 a.m. Unit Manager (UM-A)<br>vere cognitive impairment and<br>staff for cares. She stated R66<br>e repositioned every 2 hours,<br>posed to be floated off of her<br>wear sheepskin boots. R66<br>essure ulcers. She stated she<br>had a blister on her heel in  |                       |  |                |                    |  |

| STATEME                  | Dta Department of He<br>NT OF DEFICIENCIES<br>NOF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED  |                         |
|--------------------------|---|---|-------------------------|---|--------------------------------|-------------------------|
|                          |   | 00730   | B. WING                 |   | 10/                            | 24/2016                 |
| NAME OF                  | PROVIDER OR SUPPLIER  |   | DRESS, CITY, ST         |   |                                |                         |
| FRAZEE                   | CARE CENTER   |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96  |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | February from a pro<br>and that's when the<br>implemented floatin<br>confirmed R66's me<br>directed staff to floa<br>wear sheep skin bo<br>R66 every 2 hours.<br>to follow R66's care<br>apply sheep skin bo<br>reposition R66 ever<br>ulcers. She stated s<br>needed more educa<br>floating of heels.<br>A facility policy titleo<br>4/1/08, identified re<br>admission and as m<br>program including a<br>identified residents<br>highest level of fund<br>A facility policy titleo<br>Management dated<br>facility's policy to er<br>or bladder incontine<br>treatment and servi<br>functioning. The po<br>an individual toiletim<br>residents and noted<br>SUGGESTED MET<br>The director of nurs<br>review and revise p<br>to ensuring the care<br>resident is followed<br>designee could dev | ge 55<br>biologic of the splint she wore,<br>ey discontinued the boot and<br>and R66's heels. UM-A<br>bost recent care plan which<br>at R66's heels off the bed or<br>bots, and turn and reposition<br>She stated she expected staff<br>e plan and float her heels or<br>bots to R66's feet, and<br>cy 2 hours to prevent pressure<br>she felt nursing assistants<br>ation on repositioning and<br>d, Restorative Program, dated<br>sidents would be assessed on<br>beeded for a restorative<br>ambulation. The policy further<br>would be supported and their<br>ctioning maintained.<br>d Bowel and Bladder<br>1 4/1/08, revealed it was the<br>hsure each resident with bowel<br>ence would receive appropriate<br>tees to maintain normal<br>licy directed staff to develop<br>ng schedule for all incontinent<br>d on resident care plans.<br>CHOD OF CORRECTION:<br>sing (DON) or designee could<br>policies and procedures related<br>e plan for each individual<br>. The director of nursing or<br>relop a system to educate staff<br>ystem to ensure ongoing |                         |   |                                |                         |

|               | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                        | E CONSTRUCTION   |               | E SURVEY<br>IPLETED |  |
|---------------|--|--|------------------------|--|---------------|---------------------|--|
|               |  | 00730  | B. WING                |  |               | 10/24/2016          |  |
| NAME OF F     | PROVIDER OR SUPPLIER   |  | DRESS, CITY, S         | STATE, ZIP CODE  |               |                     |  |
| FRAZEE        | CARE CENTER  |  | T MAPLE AV<br>MN 56544 | ENUE, PO BOX 96  |               |                     |  |
| (X4) ID       |  | TEMENT OF DEFICIENCIES   | ID ID                  | PROVIDER'S PLAN OF CO  |               | (X5)                |  |
| PREFIX<br>TAG |  | / MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG          | (EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI<br>DEFICIENCY) | E APPROPRIATE | COMPLET<br>DATE     |  |
| 2 565         | Continued From pa  | ge 56  | 2 565                  |  |               |                     |  |
|               | TIME PERIOD FOR<br>(21) days.  | R CORRECTION: Twenty-one   |                        |  |               |                     |  |
| 2 690         | MN Rule 4658.0465<br>and Death   | 5 Subp. 3 Transfer, Discharge,   | 2 690                  |  |               | 11/17/16            |  |
|               | another health care<br>nursing home must<br>compiled according<br>information about th<br>and sufficient inform<br>care prior to or at th<br>discharge to the oth<br>program. Additionat<br>for the resident's im<br>the new health care | transferred or discharged to<br>a facility or program, the<br>send the discharge summary<br>to subpart 2, and pertinent<br>he resident's immediate care<br>nation to ensure continuity of<br>he time of the transfer or<br>her health care facility or<br>al information not necessary<br>mediate care may be sent to<br>be facility or program at the<br>transfer or discharge. |                        |  |               |                     |  |
|               | by:<br>Based on interview<br>facility failed to ens<br>inappropriately disc  | ent is not met as evidenced<br>and document review, the<br>ure residents are not<br>harged from the facility for 1<br>hts reviewed for discharge   |                        | corrected  |               |                     |  |
|               | Findings include:  |  |                        |  |               |                     |  |
|               | diagnoses which in<br>liver with ascites, he<br>induced insomnia, i  | gnoses list identified<br>cluded, alcohol cirrhosis of the<br>epatic encephalopathy, alcohol<br>uncontrolled diabetes and<br>pulmonary disease (COPD).   |                        |  |               |                     |  |
|               | 10/20/16, identified   | Assessment form dated<br>R103 was alert, oriented and<br>R103's assessment also  |                        |  |               |                     |  |

| STATEMEN      | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION   |                 | E SURVEY<br>PLETED |  |
|---------------|---|---|-------------------------|--|-----------------|--------------------|--|
|               |   | 00730   | -<br>B. WING            | B. WING  |                 | 10/24/2016         |  |
| NAME OF       | PROVIDER OR SUPPLIER  | STREET AL   | DDRESS, CITY, ST        | TATE, ZIP CODE   | •               |                    |  |
| FRAZEE        | CARE CENTER   |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                 |                    |  |
| (X4) ID       | SUMMARY STA   | TEMENT OF DEFICIENCIES  | ID ID                   | PROVIDER'S PLAN OF   | CORRECTION      | (X5)               |  |
| PRÉFIX<br>TAG | (EACH DEFICIENCY  | YMUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG           | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO ⊺<br>DEFICIENC | THE APPROPRIATE | COMPLET<br>DATE    |  |
| 2 690         | Continued From pa   | ge 57   | 2 690                   |  |                 |                    |  |
|               | revealed R103 was independent in mobility and<br>was full weight bearing.<br>R103's Individual Resident Care Plan dated<br>10/20/16, identified R103 was alert and oriented<br>and was independent with activities of daily living<br>(ADL's) including ambulation. |   |                         |  |                 |                    |  |
|               |   |   |                         |  |                 |                    |  |
|               |   | urses progress notes from<br>6 revealed the following:  |                         |  |                 |                    |  |
|               | facility, was indeper   | o.m. R103 was admitted to the<br>ndent with ambulation, had<br>the facility and was forgetful at  |                         |  |                 |                    |  |
|               |   | . R103 was alert, asked and<br>s appropriately and ate poorly<br>l.   |                         |  |                 |                    |  |
|               | short periods of tim<br>stomach ache and  | a.m. R103 had only slept for<br>e. R103 requested Tums for a<br>Melatonin (supplement used<br>ad been up to the bathroom 3<br>yht.  |                         |  |                 |                    |  |
|               | attempted to reach<br>had left a message<br>had been wandering<br>been fluctuating. R<br>consultant and had<br>the staff member at<br>had verbally threate<br>been sitting on a dir<br>occupied by other r<br>the facility. The note<br>nurse spoke with R          | .m. nursing staff had<br>R103's medical doctor, and<br>with the MD's nurse. R103<br>g constantly and his mood had<br>103 had yelled at a nurse<br>physically hit the door when<br>ttempted to assist him. R103<br>ened to kill the nurse and had<br>hing room table which was<br>esidents, threatening others in<br>e identified at 8:40 a.m. the<br>103's MD and an order was<br>103 back to the hospital. |                         |  |                 |                    |  |

| STATEME                  | ota Department of He<br>NT OF DEFICIENCIES<br>N OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION   |                                 | E SURVEY<br>PLETED      |
|--------------------------|---|---|-------------------------|--|---------------------------------|-------------------------|
|                          |   | 00730   | B. WING                 |  | 10/24/2016                      |                         |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AI   | DDRESS, CITY, ST        | TATE, ZIP CODE   |                                 |                         |
| FRAZEE                   | E CARE CENTER   |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | ) ID SUMMARY STATEMENT OF DEFICIENCIES<br>EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FU  |   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 690                    | <ul> <li>10/21/16, late entry<br/>been up wandering<br/>redirected to return<br/>R103 was observed<br/>room, made the sta<br/>somewhere." R103<br/>own and stated to t<br/>took all of his a.m. i<br/>and he was all done<br/>towards the nurse,<br/>had reported to the<br/>the bruises on his a<br/>from the nurses hitt<br/>the facility nurse ha<br/>room to stop hitting<br/>R103's room. R103<br/>escalate and act er<br/>arrived at 9:00 a.m.<br/>the emergency roor<br/>and shoes sent with<br/>Review of R103 sor<br/>10/20/16, R103 ha<br/>following a 3 month<br/>an altered mental s<br/>with various relative<br/>R103 had orders fo<br/>had not been detern<br/>declined to complet<br/>he requested to pla</li> <li>-10/21/16, at 3:30 p<br/>the emergency roor<br/>R103 acting erratic<br/>staff and residents.<br/>Immediate Dischard</li> </ul> | ry at 10:00 a.m. R103 had<br>since 6:00 a.m. and had been<br>to his room to watch TV.<br>d lying in the hallway by his<br>atement, "I gotta sleep<br>got up off of the floor on his<br>he nurse he was sick. R103<br>medications, stated that was it<br>e. R103 became threatening<br>stated he would kill her. R103<br>nurse the day prior that all of<br>arms were not from IV's but<br>ting him. The note revealed<br>ad heard R103 yelling in his<br>him, though no person was in<br>b's behavior continued to<br>ratically, the ambulance<br>. and R103 was transported to<br>m with his clothing, glasses<br>h him.<br>cial services notes from<br>6 revealed the following:<br>ad been admitted to the facility<br>hospital stay which was for<br>tatus. R103 had been living<br>es in the last year and a half.<br>or therapy and length of stay<br>mined at that time. R103 had<br>te the admission paperwork as |                         | DEFICIENC  | Y)                              |                         |

| STATEMEN      | Dia Department of He<br>NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | CONSTRUCTION  |                | E SURVEY<br>PLETED |  |
|---------------|---|--|-------------------------|---|----------------|--------------------|--|
|               |   | 00730  | B. WING                 |   | 10/            | 10/24/2016         |  |
| NAME OF I     | PROVIDER OR SUPPLIER  | STREET AL  | DRESS, CITY, ST         | TATE, ZIP CODE  |                |                    |  |
| FRAZEE        | CARE CENTER   |  | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96  |                |                    |  |
| (X4) ID       |   | TEMENT OF DEFICIENCIES   | ID                      | PROVIDER'S PLAN OF (  |                | (X5)               |  |
| PREFIX<br>TAG |   | / MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG           | (EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC | HE APPROPRIATE | COMPLET<br>DATE    |  |
| 2 690         | Continued From pa   | ge 59  | 2 690                   |   |                |                    |  |
|               | guardian several wi<br>manager from Whit<br>R103 was a member<br>contacted Hennepin<br>open case) and Wr<br>admission and disc<br>Review of R103's p<br>telephone order dat<br>the hospital by amb<br>R103's medical rec<br>documentation by F<br>On 10/24/16, at app<br>telephone interview<br>(HSW), she stated<br>from the nursing ho<br>10/21/16. The nurs<br>personal belonging<br>arrived the facility h<br>via fax from the nur<br>sheet had instructe<br>HSW stated R103 I<br>acute complications<br>presented to the EF<br>was now alert, coop<br>himself without diffi<br>discharge from the<br>had been in contac<br>recently, 10/24/16,<br>not be accepting R<br>HSW indicated she<br>would not take him<br>threat to himself an<br>had told her he was | hysician orders, revealed a<br>ted 10/21/16, to send R103 to<br>pulance.<br>ord did not have any futher<br>R103's physician.<br>proximately 3:00 p.m., during<br>with hospital social worker<br>R103 had been transferred<br>ome to the hospital on<br>ing home had sent his<br>s with him and shortly after he<br>had sent a Notice of Discharge<br>rsing home. The fax cover<br>d to give the notice to R103.<br>had been admitted because of<br>s from liver problems,<br>R "sedated" and with treatment<br>perative and ambulating<br>culty and was ready for<br>hospital. She indicated she<br>t with the nursing home, most<br>and was told the facility would<br>103 back to the nursing home.<br>had been told the facility<br>back due to R103 being a<br>d others. HSW stated R103<br>s looking forward to returning |                         |   |                |                    |  |
|               |   | ad told her he liked the staff in<br>looking forward to playing  |                         |   |                |                    |  |
|               | bingo.  |  |                         |   |                |                    |  |

Minnesota Department of Health STATE FORM

6899

|               | ta Department of He                                 | alth  |                   |   |            |                    |
|---------------|---|---|-------------------|---|------------|--------------------|
|               | IT OF DEFICIENCIES<br>OF CORRECTION                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:       |                   | CONSTRUCTION                                  |            | E SURVEY<br>PLETED |
|               | of oormeonom  | IDENTITION TON NOMBER.                                      | A. BUILDING:      |   | 001        |                    |
|               |   | 00730   | B. WING           |   | 10/24/2016 |                    |
| NAME OF I     | PROVIDER OR SUPPLIER                                | STREET AD   | DRESS, CITY, S    | TATE, ZIP CODE                                |            |                    |
|               |   | 219 WES   | MAPLE AVE         | ENUE, PO BOX 96                               |            |                    |
| FRAZEE        | CARE CENTER   |   | MN 56544          | ,   |            |                    |
| (X4) ID       |   |   | ID PROVIDER'S PLA |   |            | (X5)               |
| PREFIX<br>TAG |   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG     | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T |            | COMPLETE<br>DATE   |
| inte          |   |   |                   | DEFICIENC                                     |            |                    |
| 2 690         | Continued From pa                                   | nge 60  | 2 690             |   |            |                    |
|               |   | .90 00  |                   |   |            |                    |
|               | Poviow of an untitle                                | ed Frazee Care Center form,                                 |                   |   |            |                    |
|               |   | vealed a Notice to Discharge                                |                   |   |            |                    |
|               |   | sota Statutes 144.651, subd.                                |                   |   |            |                    |
|               |   | 369 r. had been issued to                                   |                   |   |            |                    |
|               | R103 via fax from the facility. A letter head cover |   |                   |   |            |                    |
|               | sheet timed 10:20 a                                 | a.m., was attached to the                                   |                   |   |            |                    |
|               |   | ne hospital emergency room                                  |                   |   |            |                    |
|               |   | er the notice to R103. The                                  |                   |   |            |                    |
|               |   | 03 had been immediately                                     |                   |   |            |                    |
|               |   | e facility due to the safety of                             |                   |   |            |                    |
|               |   | n endangered and R103 had ne life of other residents and    |                   |   |            |                    |
|               |   | cility. The notice also revealed                            |                   |   |            |                    |
|               |   | luals in the facility would be                              |                   |   |            |                    |
|               |   | otice was signed by the facility                            |                   |   |            |                    |
|               | administrator (FM.)                                 |   |                   |   |            |                    |
|               | Review of B103's f                                  | acility discharge summary                                   |                   |   |            |                    |
|               |   | vealed R103 was discharged to                               |                   |   |            |                    |
|               |   | wandering, placing self on the                              |                   |   |            |                    |
|               |   | occupied dining room tables.                                |                   |   |            |                    |
|               |   | aled R103 had been sent to                                  |                   |   |            |                    |
|               |   | pulance with all belongings                                 |                   |   |            |                    |
|               | sent with.  |   |                   |   |            |                    |
|               | Review of the hosp                                  | ital discharge planning                                     |                   |   |            |                    |
|               |   | 10/24/16, revealed R103 had                                 |                   |   |            |                    |
|               |   | a diagnosis of hepatic                                      |                   |   |            |                    |
|               |   | d had exhibited no behavioral                               |                   |   |            |                    |
|               |   | he had arrived at the hospital.                             |                   |   |            |                    |
|               |   | R103 had requested to return                                |                   |   |            |                    |
|               |   | note revealed no information                                |                   |   |            |                    |
|               |   | reatening behavior had been                                 |                   |   |            |                    |
|               |   | he emergency room. The note                                 |                   |   |            |                    |
|               |   | 03 had not received a 30 day<br>lity regarding an intent to |                   |   |            |                    |
|               |   | nospital social worker would                                |                   |   |            |                    |
|               |   | ice of Ombudsman for Long                                   |                   |   |            |                    |
|               | Term Care.  |   |                   |   |            |                    |
| nonoto D      | epartment of Health                                 |   | li i              |   |            | 1                  |

Minnesota Department of Health STATE FORM

| STATEMENT OF DEFICIENCIES (X1)<br>AND PLAN OF CORRECTION |   | Alth<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION |  |                 | E SURVEY<br>PLETED |
|--|---|--|----------------------------|--|-----------------|--------------------|
|  | of connection   | DERTH IONTION NOMBER.  | A. BUILDING: _             |  | 001             |                    |
|  |   | 00730  | B. WING                    |  | 10/24/2016      |                    |
| NAME OF I  | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, ST            | TATE, ZIP CODE   |                 |                    |
| FRAZEE   | CARE CENTER   |  | T MAPLE AVE<br>MN 56544    | NUE, PO BOX 96   |                 |                    |
| (X4) ID  | SUMMARY STA   | TEMENT OF DEFICIENCIES   | ID                         | PROVIDER'S PLAN OF                                       | CORRECTION      | (X5)               |
| PREFIX<br>TAG  |   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG              | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | THE APPROPRIATE | COMPLET<br>DATE    |
| 2 690  | Continued From pa   | ge 61  | 2 690                      |  |                 |                    |
|  | stated he was awar<br>the hospital as well<br>discharged from the<br>stated he had been<br>uncooperative, lying<br>the dining room tab<br>had also threatened<br>added he had spok<br>service worker at th<br>was not the best pla<br>make sure R103 was<br>care. Administrator<br>operations was com<br>morning R103 was<br>room and had mad<br>R103 from the facility | 2 p.m. the administrator<br>re of R103 being transferred to<br>as being subsequently<br>e facility. The administrator<br>told R103 was extremely<br>g on the floors and standing on<br>les. Administrator stated R103<br>d staff and other residents, and<br>en with the hospital social<br>nat time and had felt the facility<br>ace for R103 and wanted to<br>as going to receive the best<br>stated the regional director of<br>usulted on 10/21/16, the<br>transferred to the emergency<br>e the decision to discharge<br>ity and not to re-admit R103<br>ess resolved.<br>2 p.m. the social worker (SW) |                            |  |                 |                    |
|  | stated she had bee<br>admitted on 10/20/<br>complete all of his a<br>wanted to attend bin<br>was acting out of so<br>evening. SW stated   | n with R103 when he was<br>16. SW stated R103 would not<br>admission paperwork as he<br>ngo. SW stated she felt R103<br>orts but felt he settled in for the<br>I when she arrived to the   |                            |  |                 |                    |
|  | the hallway by staff<br>staff and residents<br>SW stated it had ta<br>to de-escalate R103   | /21/16, she had been met in<br>stating R103 was threatening<br>as well being uncooperative.<br>ken several nurse managers<br>3 and get him off of the dining<br>ated others residents had  |                            |  |                 |                    |
|  | been fearful of R10<br>with the director of<br>note (due to violence  | 3 so she had spoken directly operations and a discharge ce) was sent to the hospital   |                            |  |                 |                    |
|  | in which R103 had vulnerable adult rep  | as well as 3 different counties<br>resided and the local<br>porting agency. SW stated<br>h R103's daughter and had   |                            |  |                 |                    |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         |  | (X3) DATE SURVEY<br>COMPLETED   |                         |  |
|--------------------------|--|--|-------------------------|--|---------------------------------|-------------------------|--|
|                          |  | 00730  | B. WING                 |  | 10/                             | 10/24/2016              |  |
| IAME OF I                | PROVIDER OR SUPPLIER   | STREET AL  | DDRESS, CITY, ST        | TATE, ZIP CODE   |                                 |                         |  |
| RAZEE                    | CARE CENTER  |  | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                 |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 690                    | Continued From pa  | ge 62  | 2 690                   |  |                                 |                         |  |
|                          | for 6 months and he<br>before his last hosp<br>the previous hospits<br>sending R103 to the<br>physical and occup<br>R103 was independ<br>On 10/24/16, at 4:1<br>stated she had com<br>paperwork and had<br>stated R103's cogn<br>behavior would also<br>inappropriate. NM-0<br>very well the night be<br>hospital and the mo-<br>hospital he had bed<br>staff and residents.<br>operations told ther | ehavior had been escalating<br>e had been acting strangely<br>bitalization. SW stated she felt<br>al had dumped on them by<br>e facility with orders for<br>ational therapies as a guise as<br>dent with all mobility.<br>2 p.m. nurse manager (NM)-C<br>apleted R103's admission<br>worked with him. NM-C<br>ition had fluctuated and his<br>o fluctuate from appropriate to<br>C stated R103 did not sleep<br>before he was sent to the<br>come very threatening towards<br>NM-C stated the director of<br>n to call 911 and apparently<br>sion to discharge R103. |                         |  |                                 |                         |  |
|                          | nursing (DON) or d<br>medical director to<br>procedures for whe<br>the new placement<br>the resident's imme<br>information to ensu<br>could educate staff<br>also perform audits   | of Correction: The director of<br>esigee could work with the<br>update policies and<br>n to notify the resident(s) and<br>of pertinent information about<br>ediate care and sufficient<br>re continuity of care, and then<br>. The DON or designee could<br>of resident records to<br>idents had been notified as  |                         |  |                                 |                         |  |
|                          | Time Period for Co   | rrection: Thirty (30) days.  |                         |  |                                 |                         |  |
| 2 800                    | MN Rule 4658.0510<br>Staffing requirement  | ) Subp. 1 Nursing Personnel;<br>hts  | 2 800                   |  |                                 | 11/17/16                |  |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                           | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED<br>10/24/2016 |                         |
|--------------------------|---|--|---------------------------|---|---|-------------------------|
|                          |   | 00730  | B. WING                   |   |   |                         |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY,             | STATE, ZIP CODE   |   |                         |
| RAZEE                    | CARE CENTER   |  | 6T MAPLE A\<br>, MN 56544 | ENUE, PO BOX 96   |   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY) | ON SHOULD BE                                | (X5)<br>COMPLET<br>DATE |
| 2 800                    | Continued From pa   | age 63   | 2 800                     |   |   |                         |
|                          | home must have of<br>number of qualified<br>registered nurses,<br>nursing assistants<br>residents at all nurs<br>in all buildings if mo   | g requirements. A nursing<br>n duty at all times a sufficient<br>I nursing personnel, including<br>licensed practical nurses, and<br>to meet the needs of the<br>ses' stations, on all floors, and<br>ore than one building is<br>udes relief duty, weekends,<br>cements.  |                           |   |   |                         |
|                          | by:<br>Based on observat<br>interview and docu<br>to ensure sufficient<br>resident needs rela<br>ambulation (R38, F<br>motion (ROM) serv<br>pressure ulcers (R<br>prevention (R78) cl<br>services (R61.) The<br>potential to affect a<br>residing in the facili | ent is not met as evidenced<br>ion, resident, staff and family<br>ment review the facility failed<br>staffing was available to meet<br>ted to assistance with<br>R44, R29, R46), range of<br>vices for (R66), prevention of<br>18) personal cares (R18) fall<br>hoices and provision of<br>e deficient practice had the<br>II 52 residents currently<br>ity. Because of the deficient<br>v caused actual harm for R38, |                           | corrected   |   |                         |
|                          | Findings include:   |  |                           |   |   |                         |
|                          |   | e any ambulation services as<br>due to insufficient staffing,  |                           |   |   |                         |
|                          |   | e timely repositioning and directed by care plan, see  |                           |   |   |                         |
|                          |   | did not receive ambulation<br>d by therapy, see F311.  |                           |   |   |                         |

|  | TEMENT OF DEFICIENCIES<br>PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION         A. BUILDING:  |  | <u> </u>   | (X3) DATE S<br>COMPL  |  |
|--|---|--|--|---|--|
| 00730  |   | B. WING  |  | 10/24/2016  |  |
| ROVIDER OR SUPPLIER  | STREET ADI  | DRESS, CITY, ST  | TATE, ZIP CODE   |   |  |
| CARE CENTER  | 219 WEST  | MAPLE AVE  | NUE, PO BOX 96   |   |  |
|  | FRAZEE,   | MN 56544   |  |   |  |
| (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL  | ID<br>PREFIX<br>TAG  | (EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH   | N SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLET<br>DATE  |
| Continued From pa  | ge 64   | 2 800  |  |   |  |
| related to a pattern   | of multiple falls due to  |  |  |   |  |
| assistant (PTA) stat<br>residents had not b<br>programs including<br>insufficient staffing.<br>some residents lose<br>in ambulation and F<br>due to not receiving<br>stated she had voic<br>management in we<br>which both the facil<br>of nursing (DON) w<br>had been told by bo<br>DON they were wor<br>she had voiced con<br>last 4-5 months and  | ted she had concerns<br>een receiving restorative<br>ROM and ambulation due to<br>PTA stated she had seen<br>their abilities and/or decline<br>ROM including R66 and R38<br>restorative services. PTA<br>ed her concerns to facility<br>ekly medicare meetings,<br>ity administrator and director<br>ould attend. PTA stated she<br>oth the administrator and the<br>king on staffing. PTA stated<br>cerns about staffing for the<br>had not seen any   |  |  |   |  |
| nursing (ADON) sta<br>working on staffing<br>ADON stated the ac<br>nursing (DON) and<br>been working on sta<br>ADON stated she h<br>meetings as she ha<br>that role due to hav<br>another registered of<br>felt call ins were a p<br>number of staff as a<br>facility had used nu<br>September, howeve<br>staff from any agen<br>half. ADON stated s | ated the facility had been<br>concerns since last year.<br>dministrator, director of<br>human resources (HR) had<br>affing with weekly meetings.<br>ad not been attending those<br>ad been trying to back out of<br>ing to work nights along with<br>hurse (RN.) ADON stated she<br>problem as well as not enough<br>a whole. ADON stated the<br>rsing pool staff last in<br>er they had been unable to find<br>cy in the last month and a<br>she felt there were times the   |  |  |   |  |
|  | SUMMARY STA<br>(EACH DEFICIENCY<br>REGULATORY OR LE<br>Continued From pa<br>R78 did not receive<br>related to a pattern<br>nsufficient staffing,<br>On 10/21/16, at 11::<br>assistant (PTA) stat<br>residents had not b<br>orograms including<br>nsufficient staffing.<br>some residents lose<br>n ambulation and F<br>due to not receiving<br>stated she had voice<br>management in we<br>which both the facil<br>of nursing (DON) w<br>had been told by bo<br>DON they were wor<br>she had voiced con<br>ast 4-5 months and<br>mprovement with s<br>On 10/21/16, at 1:4<br>nursing (ADON) stated<br>mursing (DON) and<br>peen working on staffing<br>ADON stated the ad<br>nursing (DON) and<br>peen working on staffing<br>ADON stated the ad<br>nursing (DON) and<br>peen working on staffing<br>ADON stated she h<br>meetings as she hat<br>that role due to hav<br>another registered n<br>felt call ins were a p<br>number of staff as a<br>facility had used nu<br>September, however<br>staff from any agen<br>half. ADON stated she | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)<br>Continued From page 64<br>R78 did not receive accurate assessments<br>related to a pattern of multiple falls due to<br>nsufficient staffing, see F323.<br>On 10/21/16, at 11:20 a.m. physical therapy<br>assistant (PTA) stated she had concerns<br>residents had not been receiving restorative<br>orograms including ROM and ambulation due to<br>nsufficient staffing. PTA stated she had seen<br>some residents lose their abilities and/or decline<br>n ambulation and ROM including R66 and R38<br>due to not receiving restorative services. PTA<br>stated she had voiced her concerns to facility<br>management in weekly medicare meetings,<br>which both the facility administrator and director<br>of nursing (DON) would attend. PTA stated she<br>had been told by both the administrator and the<br>DON they were working on staffing. PTA stated<br>she had voiced concerns about staffing for the<br>ast 4-5 months and had not seen any<br>mprovement with staffing.<br>On 10/21/16, at 1:43 p.m. the assistant director of<br>nursing (ADON) stated the facility had been<br>working on staffing concerns since last year.<br>ADON stated the administrator, director of<br>nursing (DON) and human resources (HR) had<br>been working on staffing with weekly meetings.<br>ADON stated she had not been attending those<br>meetings as she had been trying to back out of<br>that role due to having to work nights along with<br>another registered nurse (RN.) ADON stated she<br>felt call ins were a problem as well as not enough<br>number of staff as a whole. ADON stated the<br>facility had used nursing pool staff last in | FRAZEE, MN 56544         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       ID<br>PREFIX<br>TAG         Continued From page 64       2 800         R78 did not receive accurate assessments<br>related to a pattern of multiple falls due to<br>nsufficient staffing, see F323.       2 800         On 10/21/16, at 11:20 a.m. physical therapy<br>assistant (PTA) stated she had concerns<br>residents had not been receiving restorative<br>programs including ROM and ambulation due to<br>nsufficient staffing. PTA stated she had seen<br>some residents lose their abilities and/or decline<br>n ambulation and ROM including R66 and R38<br>due to not receiving restorative services. 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ADON stated the<br>facility had used nursing pool staff last in<br>September, however they had been unable to find<br>staff from any agency in the last month and a<br>naif. ADON stated she felt there were times the<br>VA were unable to complete tasks in a timely | HAZEE, MN 56544         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       ID<br>PREFIX<br>TAG       ID<br>PREFIX<br>CROSS-REFRENCED TO TH<br>DEFICIENCY)         Continued From page 64       2 800         R78 did not receive accurate assessments<br>related to a pattern of multiple falls due to<br>nsufficient staffing, see F323.       2 800         On 10/21/16, at 11:20 a.m. physical therapy<br>assistant (PTA) stated she had concerns<br>residents had not been receiving restorative<br>orgrams including ROM and ambulation due to<br>nsufficient staffing. PTA stated she had seen<br>some residents lose their abilities and/or decline<br>n ambulation and ROM including R66 and R33<br>due to not receiving restorative services. PTA<br>stated she had voiced her concerns to facility<br>management in weekly medicare meetings,<br>which both the facility administrator and director<br>of nursing (DON) would attend. PTA stated she<br>had been told by both the administrator and the<br>DON they were working on staffing. PTA stated<br>she had voiced concerns about staffing for the<br>ast 4-5 months and had not seen any<br>mprovement with staffing.         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ADON stated the<br>facility had used nursing pool staff last in<br>September, however they had been unable to find<br>staff from any agency in the last month and<br>a | FRAZEE, WN 55544         SUMMARY STATEMENT OF DEFICIENCES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       ID<br>PREFIX<br>TAG       PROVIDER'S PLAN OF CORRECTION<br>(EACH ORPROPRIATE<br>TAG         Continued From page 64       2 800         R78 did not receive accurate assessments<br>related to a pattern of multiple falls due to<br>nsufficient staffing, see F323.         On 10/21/16, at 11:20 a.m. physical therapy<br>assistant (PTA) stated she had concerns<br>residents had not been receiving restorative<br>programs including ROM and ambulation due to<br>nsufficient staffing, TA stated she had seen<br>some residents lose their abilities and/or decline<br>n ambulation and ROM including R66 and R38<br>Jue to not receiving restorative services. 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| STATEME                  | Dta Department of He<br>NT OF DEFICIENCIES<br>NOF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE (<br>A. BUILDING: | CONSTRUCTION   |                                 | E SURVEY<br>PLETED      |
|--------------------------|--|---|---------------------------------|--|---------------------------------|-------------------------|
|                          |  | 00730   | B. WING                         |  | 10/24/2016                      |                         |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AL   | DRESS, CITY, ST                 | ATE, ZIP CODE  |                                 |                         |
| RAZEE                    | CARE CENTER  |   | T MAPLE AVEN<br>MN 56544        | NUE, PO BOX 96   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 800                    | insufficient staffing.<br>the other nurse mai<br>provide oversight of<br>according to care p<br>ADON stated she fe<br>care plans were not<br>a consistent basis of<br>ADON stated she h<br>residents and staff<br>ADON stated NA ha<br>cares were not con-<br>staffing concerns. A<br>together in an atten<br>however was difficu<br>ADON stated she w<br>restorative program<br>implemented or sta<br>complete the requir<br>basis. ADON stated she w<br>restorative program<br>implemented or sta<br>complete the requir<br>basis. ADON stated the fa<br>admissions though<br>look at acuity.<br>R27's annual MDS<br>was cognitively inta<br>assistance Activities<br>including transfers,<br>personal hygiene.<br>On 10/17/16, at 6:4<br>believed the facility<br>because she had to<br>go to the bathroom<br>have had to wait an | ADON stated she felt she and<br>nagers (NM) were unable to<br>f cares to ensure cares were<br>lans and completed timely.<br>elt resident assessments and<br>t completed and/or updated on<br>due to insufficient staffing.<br>ad routine complaints from<br>regarding sufficient staffing.<br>ad reported to her resident<br>sistently completed due to<br>ADON stated the staff worked<br>npt to meet residents needs,<br>alt due to insufficient staffing.<br>vas aware the facility<br>is had not been consistently<br>rted due to not enough staff to<br>red programs on a routine<br>d she felt there had been in<br>shes due to insufficient staffing.<br>acility continued to take<br>would screen residents to<br>dated 8/17/16, identified R27<br>ct, required extensive<br>s of Daily Living (ADL's,)<br>dressing, toileting and<br>7 p.m. R27 indicated she<br>did not have enough staff<br>o wait for staff to get to her.<br>often waited for assistance to<br>or go to bed. R27 stated,"I<br>hour or more." R27 indicated<br>bout the long wait times for |                                 |  |                                 |                         |

| STATEMEN      | ota Department of He<br>NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                                |  |                                  | E SURVEY<br>PLETED |  |
|---------------|---|---|--------------------------------|--|----------------------------------|--------------------|--|
|               |   | 00730   | B. WING                        |  | 10/24/2016                       |                    |  |
| NAME OF       | PROVIDER OR SUPPLIER  | STREET AL   | ADDRESS, CITY, STATE, ZIP CODE |  |                                  |                    |  |
| FRAZEE        | CARE CENTER   |   | T MAPLE AVE<br>MN 56544        | NUE, PO BOX 96   |                                  |                    |  |
| (X4) ID       | SUMMARY STA   |   |                                | PROVIDER'S PLAN OF   | CORRECTION                       | (X5)               |  |
| PREFIX<br>TAG | (EACH DEFICIENC)  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG                  | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | COMPLET<br>DATE    |  |
| 2 800         | Continued From pa   | ige 66  | 2 800                          |  |                                  |                    |  |
|               | R27 stated,"it make   | e long wait for assistance.<br>e me feel miserable;" however<br>ow it made her feel.  |                                |  |                                  |                    |  |
|               | 7/24/16, identified F<br>had diagnoses whic<br>diabetes, congestiv<br>anxiety. The MDS i<br>extensive assistance  | imum Data Set (MDS) dated<br>R61 was cognitively intact and<br>ch included, insulin dependent<br>re heart failure (CHF) and<br>dentified R61 required<br>ce from staff with dressing.<br>tified R61 received insulin  |                                |  |                                  |                    |  |
|               | had concerns and r<br>only use her call lig<br>working. R61 stated<br>(NA) would walk pa<br>was on and others<br>shut the light off an<br>be back. R61 stated<br>return. R61 stated s<br>about her call light,<br>staff at her care con | 03 a.m. R61 stated when she<br>needed assistance she would<br>ht when certain staff were<br>d some nursing assistants<br>ast her room when the call light<br>would come into her room,<br>d leave stating that they would<br>d most of the time they did not<br>she had voiced her concerns<br>baths and blood sugars to<br>inferences and her son and<br>had spoken with staff.                  |                                |  |                                  |                    |  |
|               | nurse (LPN)-C state<br>census was 52. LP<br>usual staff schedule<br>and five nursing as<br>there were four NA<br>indicated the facility<br>staffing and as rece<br>short staffing on bo<br>LPN-C indicated sh<br>incidents of short st  | 8:50 a.m. licensed practical<br>ed at that time the facility<br>N-C indicated the day shift<br>e included three floor nurses,<br>sistants (NA), however today<br>'s. At 9:17 a.m. LPN-C<br>y did not have sufficient<br>ent as last weekend there was<br>th the day and the night shift.<br>he had reported the recent<br>taffing to the facility scheduler<br>c stated the facility had a lot of |                                |  |                                  |                    |  |

| STATEMEN      | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION   |                 | E SURVEY<br>PLETED |
|---------------|--|---|-------------------------|--|-----------------|--------------------|
|               |  | 00730   | B. WING                 |  | 10/24/2016      |                    |
| NAME OF       | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, ST         | ATE, ZIP CODE  |                 |                    |
| RAZEE         | CARE CENTER  |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                 |                    |
| (X4) ID       |  | TEMENT OF DEFICIENCIES  | ID                      | PROVIDER'S PLAN OF   |                 | (X5)               |
| PREFIX<br>TAG |  | / MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG           | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | THE APPROPRIATE | COMPLET<br>DATE    |
| 2 800         | Continued From pa  | ge 67   | 2 800                   |  |                 |                    |
|               | in for scheduled shi   | staff did not consistently come<br>ifts. LPN-C stated she was<br>Iministration had planned for  |                         |  |                 |                    |
|               | On 10/19/2016, at 1:01:33 p.m. house keeping<br>staff (HC)-A indicated at that time the nursing<br>assistants (NA) were working short. HC-A stated<br>when there were not enough staff to answer call<br>lights, she would answer them and inform the<br>residents the NA were busy and would have to<br>wait longer. HC-A stated she felt when the facility<br>was short staffed it took longer to attend to<br>resident needs. |   |                         |  |                 |                    |
|               | (NM)-B indicated s<br>past year. NM-B sta<br>the floor and was u<br>managerial work. N<br>to continue to work<br>time, they would ge<br>lack of staff on the   | 10:11 a.m. nurse manager<br>taffing had not improved in the<br>ated she was often working on<br>nable to routinely complete her<br>IM-B stated she felt if staff had<br>under the conditions at that<br>t burned out. NM-B stated the<br>floor must have had<br>th the large amount of resident   |                         |  |                 |                    |
|               | had lost staff left ar<br>NA-F stated she did<br>staff in the facility to<br>needs on a consiste<br>had heard staff, fan<br>about staffing short<br>noticed an increase<br>incontinence and be<br>staff were burning of<br>hours. NA-F stated  | 0 p.m. NA-F stated the facility<br>ad right the last 5 months.<br>d not feel there was sufficient<br>o routinely meet resident<br>ent basis. NA-F stated the she<br>nily and residents complain<br>ages. NA-F stated she had<br>e in resident falls, skin rashes,<br>ehaviors. NA-F stated she felt<br>but due to working too many<br>she felt residents who<br>ist (such as R18, R26, R15, |                         |  |                 |                    |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | Ealth<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         |  |                                 | E SURVEY<br>PLETED      |
|--------------------------|--|---|-------------------------|--|---------------------------------|-------------------------|
|                          |  | 00730   | B. WING                 |  | 10/24/201                       |                         |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET AL   | DRESS, CITY, ST         | TATE, ZIP CODE   |                                 |                         |
| RAZEE                    | CARE CENTER  |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 800                    | Continued From pa  | age 68  | 2 800                   |  |                                 |                         |
|                          |  | ds (R61) were the residents ely received the cares they   |                         |  |                                 |                         |
|                          | the facility had a ch<br>had been going on<br>she felt it was impor-<br>residents needs du<br>stated the facility has<br>basis and often we<br>NA-B stated she fe<br>routine repositionin<br>and bathing, such a<br>R44, and R61. NA-<br>the interim DON ap<br>about insufficient si<br>been told it was like<br>to just work togethe<br>had gotten so bad | A3 p.m. NA-B stated she felt<br>pronic insufficient staffing which<br>for the last year. NA-B stated<br>possible to routinely meet<br>ue to insufficient staffing. NA-B<br>ad call-ins on at least a weekly<br>re not able to replace the staff.<br>It residents were not receiving<br>ug, toileting, ambulation, ROM<br>as R27, R37, R18, R47, R66,<br>B stated she had spoken with<br>pproximately ago a month<br>taffing. NA-B stated she had<br>that everywhere and they had<br>e that everywhere and they had<br>er. NA-B stated she felt staffing<br>there were times R51 would<br>e floor to get staffs attention. |                         |  |                                 |                         |
|                          | assistant (PTA) sta<br>with residents amb<br>programs being co<br>stated felt there wa<br>the facility to compl<br>maintenance progr<br>confirmed a decline<br>stated residents su   | 20 a.m. physical therapy<br>ted she had serious concerns<br>ulation and maintenance<br>mpleted consistently. PTA<br>is not enough nursing staff in<br>lete ambulation and<br>ams on a routine basis. PTA<br>in ambulation for R38 and<br>ch as R44 and R29 did not<br>eir ambulation programs.  |                         |  |                                 |                         |
|                          | interview, NA-B sta increase in skin irri  | 1:35 p.m. during a follow up<br>ted she felt R37 had an<br>tation from incontinence due to<br>routinely because of short  |                         |  |                                 |                         |
|                          | On 10/21/2016, at  | 2:17 p.m. NA-J stated she felt  |                         |  |                                 |                         |

| STATEMEN                 | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                                | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED  |                         |  |
|--------------------------|--|---|--------------------------------|---|--------------------------------|-------------------------|--|
|                          |  | 00730   | B. WING                        |   | 10/24/2016                     |                         |  |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AL   | ADDRESS, CITY, STATE, ZIP CODE |   |                                |                         |  |
| RAZEE                    | CARE CENTER  |   | T MAPLE AVE<br>MN 56544        | NUE, PO BOX 96  |                                |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG            | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENC <sup>1</sup> | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 800                    |  | age 69<br>dequate amount of staff to  | 2 800                          |   |                                |                         |  |
|                          | meet resident need<br>had not been suffice<br>needs for the last s<br>there were times w<br>working for the even<br>be 5 on the shift. N<br>weekly. NA-J states<br>done in a timely ma<br>repositioning, amb<br>consistent basis. N<br>administrator and I<br>needs not being ma | ds. NA-J stated she felt there<br>sient staff to meet residents<br>several months. NA-J stated<br>then only 3 NA's would be<br>ening shift when there were to<br>A-J stated that would occur<br>d routine cares would not get<br>anner such as toileting,<br>ulation and baths on a<br>A-J stated she felt the<br>DON were aware of resident<br>et consistently, but was<br>tions the admininstrator or |                                |   |                                |                         |  |
|                          | felt staffing was ge<br>would routinely wor<br>were supposed to I<br>stated she felt resid<br>and repositioning w<br>or timely. NA-A sta<br>call light to alert sta<br>however due to ins<br>get assistance time<br>NA-A also stated sh  | s 2:32 p.m. NA-A stated she<br>tting "tough." NA-A stated they<br>rk with 3 or 4 NA's when they<br>have 5-6 NA's on a shift. NA-A<br>dents cares such as toileting<br>vere not being done routinely<br>ted she felt R46 would use her<br>aff of her toileting needs,<br>ufficient staffing R46 would not<br>ely and would be incontinent.<br>he felt R44 did not receive<br>r care planned ambulation   |                                |   |                                |                         |  |
|                          | representative of fa<br>felt there was not e<br>meet all of the resid<br>was at the facility e<br>residents call lights<br>long periods of time  | 53 p.m. a family member and<br>amily council (FM)-B stated she<br>enough staff in the facility to<br>dents needs. FM-B stated she<br>every day and often saw other<br>a had gone unanswered for<br>e. FM-B stated has recent as a<br>amily members bedding had  |                                |   |                                |                         |  |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         |  | (X3) DATE SURVE<br>COMPLETED   |                         |  |
|--------------------------|---|--|-------------------------|--|--------------------------------|-------------------------|--|
|                          |   | 00730  | B. WING                 |  | 10/                            | 10/24/2016              |  |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AI  | DDRESS, CITY, ST        | TATE, ZIP CODE   |                                |                         |  |
| RAZEE                    | CARE CENTER   |  | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC <sup>1</sup> | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 800                    | been soiled and co<br>stated she continue<br>nursing staff about<br>of her family memb<br>staff cut corners to<br>concerns at a famil<br>2016. FM-B stated<br>not the place to voi<br>had been directed to<br>FM-B stated she be<br>of staff. FM-B state<br>concerns about suf<br>conference for her<br>told again the faciliti<br>stated she felt she<br>members linens an<br>daily basis.<br>On 10/24/16, at 9:3<br>not heard any receive<br>residents or family<br>had been working r<br>nursing position.<br>On 10/24/16, at 1:<br>worker (LSW) state<br>complaints regarding<br>members or staff. I<br>when a complaint v<br>to write a grievance<br>facility had met the<br>staffing. LSW state | vered with a blanket. FM-B<br>ad to reported concerns to the<br>soiled linens and wheelchair<br>ber. FM-B stated she felt the<br>save time had verbalized her<br>y council meeting in August,<br>she had been told that was<br>ce concerns about staffing and<br>to fill out a grievance form.<br>Seen told the facility had "plenty"<br>d she had also voiced her<br>ficient staffing in the last care<br>family member and had been<br>ty had plenty of staff. FM-B<br>had to make sure her family<br>d wheelchair were clean on a<br>25 a.m. NM-A stated she had<br>nt staffing complaints from<br>members. NM-A stated she<br>hights due to an unfilled night<br>15 p.m. the Licensed social<br>ed she could not recall any<br>ng staffing by residents, family<br>_SW stated her usual process<br>vas brought forward would be<br>a form. LSW stated she felt the<br>"state requirements," for<br>d there were times when staff |                         | DEFICIENC  | Y)                             |                         |  |
|                          | to write a grievance<br>facility had met the<br>staffing. LSW state<br>would be tied up wi<br>(who required 3 sta<br>there were sufficier<br>on a routine basis.<br>On 10/24/16, at 1:3   | e form. LSW stated she felt the<br>"state requirements," for   |                         |  |                                |                         |  |

| STATEMEN                 | ta Department of He<br>T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                                |  |                                 | E SURVEY<br>PLETED      |  |  |
|--------------------------|--|--|--------------------------------|--|---------------------------------|-------------------------|--|--|
|                          |  | 00730  | B. WING                        |  | 10/                             | 24/2016                 |  |  |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET AL  | ADDRESS, CITY, STATE, ZIP CODE |  |                                 |                         |  |  |
| RAZEE                    | CARE CENTER  |  | T MAPLE AVE<br>MN 56544        | NUE, PO BOX 96   |                                 |                         |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG            | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |  |
| 2 800                    | DM stated she had<br>insufficient nursing<br>director, NM's, DOI<br>few months. DM st<br>was aware of staffi<br>though, has not see<br>On 10/24/16, at 2:0<br>Registered Nurse/O<br>Practitioner(NP)-A<br>facility staff to asse<br>to identify a pattern<br>attempt to minimize<br>she would expect ff<br>care plans and pro-<br>and exercise. NP-A<br>recommended rest<br>uncommon here."<br>On 10/24/16, at 2:4<br>(MR)-B staff indical<br>scheduled is detern<br>for the shift. If there<br>number of staff to s<br>the administrator. M<br>52 residents in hou<br>five NA's for the da<br>evening shift, and t<br>Review of the facilii<br>from 9/5/16 to 10/2<br>varied number of s<br>consistently have th<br>had identified as ap<br>inconsistencies we<br>- the day shift did n | ring meals on a weekly basis.<br>verbalized concerns about<br>staff from residents to the HR<br>N and administrator in the last<br>ated she felt the administrator<br>ng concerns in the facility<br>en any improvement.<br>00 p.m. Advanced Practice<br>Certified Nurse<br>indicated she expected the<br>ss falls routinely and attempt<br>or reason for the falls in an<br>e further falls. NP-A indicated<br>loor staff to follow resident<br>vide restorative ambulation<br>a stated," Sadly not providing<br>orative exercises is not<br>0 p.m. the medicals records<br>ted the number of staff<br>nined by the resident census<br>a is a question regarding the<br>schedule MR-B would consult<br>AR-B indicated at this time with<br>se she attempted to schedule<br>ay shift, five NA's for the<br>wo NA's for the overnight shift.<br>ties daily assignments sheets<br>0/16, revealed the facility had<br>taff scheduled and did not<br>ne staffing ratios the facility<br>poropriate. The following<br>re found: |                                | DEFICIENC  | Y)                              |                         |  |  |
|                          |  | did not have the staffing  |                                |  |                                 |                         |  |  |

| Image: Definition of the second state of the shift.     Definition of the second state of the shift.       00730     B. WING  | STATEME | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                 | CONSTRUCTION                                  |                | E SURVEY<br>PLETED |
|---|---------|--|--|-----------------|---|----------------|--------------------|
| TRAZEE CARE CENTER       219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, NN 56544         (X4) ID<br>PREFIX<br>TAG       SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       ID<br>PREFIX<br>TAG       PROVIDER'S PLAN OF CORRECTION ACTION SHOLD BE<br>CROSS-REFERENCED TO THE APPROPRIATE       COMPLET<br>DATE         2 800       Continued From page 72       2 800       2 800       determined by the administrator for 14 out of 48 days,<br>on these two night shifts one nursing assistant<br>was scheduled rather than two for 55 residents-<br>and then 56 residents.       2 800       -       -         -9/26/16, one NA to care for 55 residents-<br>and then 56 residents.       -9/26/16, one At ocare for 55 residents-no<br>increase in licensed staff for the shift.       On 10/24/16, at 3:03 p.m. during a follow up<br>interview, LSW stated she attended the facility's<br>family council meetings when they had attendees.<br>LSW stated the facility's routine family council<br>members had quit going to the meeting<br>and had been directed to fill out a grievance form<br>versus discussing the concern at the meeting.<br>LSW stated she kept a log of all grievances and<br>the family member idn on tifl out a grievance       He staff she the form                |         |  | 00730  | B. WING         |   | 10/24/2016     |                    |
| HAZEE CARE CENTER       FRAZEE, MN 56544         (X4) ID<br>PREFIX<br>TAG       SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICENCY WILTS DE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       ID<br>PREFIX<br>TAG       PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)       COMPLET<br>DATE         2 800       Continued From page 72       2 800       2 800         determined by the administrator for 14 out of 48<br>days<br>- the night shift did not have the staffing<br>determined by the administrator for 2 of 48 days,<br>on these two night shifts one nursing assistant<br>was scheduled rather than two for 55 residents<br>and then 56 residents.       -9/26/16, one NA to care for 55 residents-no<br>increase in licensed staff for the shift.         On 10/24/16, at 3:03 p.m. during a follow up<br>interview, LSW stated she attended the facility's<br>family council meetings when<br>they did not want to volunteer for remodeling or<br>decorating. LSW stated a family member had<br>started to complain about staffing at one meeting<br>and had been directed to fill out a grievance form<br>versus discussing the concern at the meeting.<br>LSW stated she kept a log of all grievance sond<br>the family member did not fill out a grievance | NAME OF | PROVIDER OR SUPPLIER   | STREET AL  | DRESS, CITY, ST | TATE, ZIP CODE                                |                |                    |
| (X4) ID<br>PREFIX<br>TAG       SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       ID<br>PREFIX<br>TAG       PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)       (X5)<br>COMPLET<br>DEFICIENCY         2 800       Continued From page 72       2 800         determined by the administrator for 14 out of 48<br>days<br>- the night shift did not have the staffing<br>determined by the administrator for 2 of 48 days,<br>on these two night shifts one nursing assistant<br>was scheduled rather than two for 55 residents<br>and then 56 residents.<br>-9/26/16, one NA to care for 55 residents-no<br>increase in licensed staff for the shift.       On 10/24/16, at 3:03 p.m. during a follow up<br>interview, LSW stated she attended the facility's<br>family council meetings when<br>they did not want to volunteer for remodeling or<br>decorating. LSW stated a family member had<br>started to complain about staffing at one meeting<br>and had been directed to fill out a grievance form<br>versus discussing the concern at the meeting.<br>LSW stated she kept a log of all grievances       Hereing   | FRAZEE  | CARE CENTER  |  |                 | NUE, PO BOX 96                                |                |                    |
| determined by the administrator for 14 out of 48<br>days<br>- the night shift did not have the staffing<br>determined by the administrator for 2 of 48 days,<br>on these two night shifts one nursing assistant<br>was scheduled rather than two for 55 residents<br>and then 56 residents.<br>-9/26/16, one NA to care for 55 residents-no<br>increase in licensed staff for the shift.<br>On 10/24/16, at 3:03 p.m. during a follow up<br>interview, LSW stated she attended the facility's<br>family council meetings when they had attendees.<br>LSW stated the facility's routine family council<br>members had quit going to the meetings when<br>they did not want to volunteer for remodeling or<br>decorating. LSW stated a family member had<br>started to complain about staffing at one meeting<br>and had been directed to fill out a grievance form<br>versus discussing the concern at the meeting.<br>LSW stated she kept a log of all grievances and<br>the family member did not fill out a grievance   | PRÉFIX  | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL   | PREFIX          | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1 | TION SHOULD BE | COMPLET            |
|   | 2 800   | determined by the a<br>days<br>- the night shift did<br>determined by the a<br>on these two night<br>was scheduled rath<br>and then 56 resider<br>-9/26/16, one NA to<br>increase in licensed<br>On 10/24/16, at 3:0<br>interview, LSW stat<br>family council meet<br>LSW stated the fac<br>members had quit<br>they did not want to<br>decorating. LSW st<br>started to complain<br>and had been direct<br>versus discussing t<br>LSW stated she ke | administrator for 14 out of 48<br>not have the staffing<br>administrator for 2 of 48 days,<br>shifts one nursing assistant<br>her than two for 55 residnets<br>nts.<br>o care for 55 residents-no<br>d staff for the shift.<br>13 p.m. during a follow up<br>ted she attended the facility's<br>tings when they had attendees.<br>illity's routine family council<br>going to the meetings when<br>o volunteer for remodeling or<br>rated a family member had<br>about staffing at one meeting<br>ted to fill out a grievance form<br>he concern at the meeting.<br>pt a log of all grievances and |                 |   |                |                    |

| STATEME       | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                                | CONSTRUCTION   |                | E SURVEY<br>PLETED |  |
|---------------|--|--|--------------------------------|--|----------------|--------------------|--|
|               |  | 00730  | B. WING                        |  | 10/24/2016     |                    |  |
| NAME OF       | PROVIDER OR SUPPLIER   | STREET AI  | ADDRESS, CITY, STATE, ZIP CODE |  |                |                    |  |
| RAZEE         | CARE CENTER  |  | T MAPLE AVE<br>, MN 56544      | NUE, PO BOX 96   |                |                    |  |
| (X4) ID       | SUMMARY STA  | TEMENT OF DEFICIENCIES   | ID                             | PROVIDER'S PLAN OF   | CORRECTION     | (X5)               |  |
| PRÉFIX<br>TAG |  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG                  | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | HE APPROPRIATE | COMPLET<br>DATE    |  |
| 2 800         | Continued From pa  | ge 73  | 2 800                          |  |                |                    |  |
|               | completed and had<br>DON also stated sh<br>for a call light to be<br>DON further stated<br>complaints from resistaff regarding insu-<br>staff performance.<br>would be the one to<br>and unlicensed state<br>On 10/24/16, at 3:4<br>stated he had been<br>Monday (when he sist<br>meet with the clinic<br>resident acuity. He<br>staffing in the facilit<br>administrator stated<br>adequate number of<br>problem was with fu-<br>stated the facility has<br>open, 4 NA position<br>that time he had no<br>plans for staffing, th<br>recruitment plan fro-<br>to work on employed<br>implemented at that<br>On 10/24/16, at 4:0<br>(AD) stated she bro-<br>from resident count<br>meetings to all dep-<br>concerns were alwas<br>quality assurance in<br>sometimes she fille<br>Concern Follow-up<br>nursing, or put the fille | 1 p.m. the administrator<br>n working on staffing since last<br>started,) and had planned to<br>al managers to identify<br>stated he was unsure if the<br>y was sufficient. The<br>d he felt the facility had an<br>of staff and stated he felt the<br>ull and part time ratios. He<br>ad 4 licensed nursing positions<br>is at that time. FA stated at<br>t implemented any action<br>hough had just received a staff<br>om HR. FM stated he planned<br>are relations, though had not | ;                              |  |                |                    |  |

|                          | TATEMENT OF DEFICIENCIES<br>ND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |  | (X2) MULTIPLE<br>A. BUILDING: | CONSTRUCTION   |                                  | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|-------------------------------|--|----------------------------------|-------------------------------|--|
|                          |   | 00730  | B. WING                       | B. WING  |                                  | 24/2016                       |  |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AL  | DDRESS, CITY, S               | TATE, ZIP CODE   |                                  |                               |  |
| FRA7FF                   | CARE CENTER   |  |                               | NUE, PO BOX 96   |                                  |                               |  |
|                          | 1   |  | MN 56544                      |  |                                  |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE       |  |
| 2 800                    | Continued From pa   | ge 74  | 2 800                         |  |                                  |                               |  |
|                          | stated she had new<br>with R66 for her ha<br>didn't know if they e<br>received ROM all th<br>this facility. She sta<br>why R66 did not ge<br>she had been told b<br>not working enough<br>stated she R66 cou<br>could before she ca<br>one full calander ye<br>light, the TV remote<br>word mom. FM-A si<br>enough staff in the<br>were routinely met.<br>Review of resident<br>July 2016, to Septe<br>following:<br>- resident council m<br>revealed 8 resident<br>and a concern over<br>hours was voiced. | 5 p.m. family member (FM)-A<br>er seen staff do any exercises<br>nds and arms, and stated she<br>ever had. She stated R66<br>he time before admission to<br>ted she had asked facility staff<br>t ROM exercises and stated<br>by staff they felt her brain was<br>n for them to do that. FM-A<br>ild no longer do things she<br>ame to the facility (less than<br>ear ago,) such as using her call<br>e and write her name and the<br>tated she felt there were not<br>facility to ensure R66's needs<br>council meeting minutes from<br>mber 2016, revealed the<br>hinutes dated 7/27/16,<br>s had attended the meeting<br>call light wait time of up to 2<br>An undated and unsigned<br>sponse note revealed nursing |                               |  |                                  |                               |  |
|                          | and there had been<br>response also reve<br>educated, the FA ar<br>been notified of the<br>- resident council m<br>revealed 11 residen  | ninutes dated 8/31/16,<br>nts had attended the meeting<br>ns over call light wait time. The  |                               |  |                                  |                               |  |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                           | CONSTRUCTION   |                                 | E SURVEY<br>PLETED      |  |
|--------------------------|--|---|---------------------------|--|---------------------------------|-------------------------|--|
|                          |  | 00730   | -<br>В. WING              | B. WING  |                                 | 10/24/2016              |  |
| NAME OF                  | PROVIDER OR SUPPLIER   |   | DDRESS, CITY, ST          | TATE, ZIP CODE   |                                 |                         |  |
| RAZEE                    | CARE CENTER  |   | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                 |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 800                    | <ul> <li>resident council n<br/>revealed 10 resider<br/>and voiced concern<br/>averaged 30 to 60<br/>occurred at all hour<br/>response from nurs<br/>10/6, and 10/7/16,<br/>completed regardir<br/>placement. The no<br/>regional director has<br/>concern.</li> <li>Review of facility fa<br/>from July, 2016 to<br/>concerns related to</li> </ul> | ninutes dated 9/28/16,<br>nts had attended the meeting<br>ns over call light wait times had<br>minute wait time which had<br>rs of the day. An undated<br>sing form revealed on 10/5,<br>call light audits had been<br>ng response and call light<br>te further revealed FA and<br>ad been informed of the<br>umily council meeting minutes<br>September 2016, revealed no                                    |                           |  |                                 |                         |  |
|                          | The DON and adm<br>staffing patterns an<br>residents in the fac<br>implement a restor<br>would be responsit<br>and range of motio<br>The DON could pro<br>staff on policies an<br>resident cares. The<br>all residents are re-<br>appropriate care. T<br>assurance committe<br>compliance.   | THOD FOR CORRECTION:<br>inistrator could review the<br>id the acuity levels of the<br>ility. The administrator could<br>ative nursing program who<br>ole for completing ambulation<br>n programs for the residents.<br>ovide training for all appropriate<br>d procedures related to<br>e DON could monitor to assure<br>ceiving adequate and<br>the quality assessment and<br>the could audit care to ensure |                           |  |                                 |                         |  |
|                          | TIME PERIOD FO<br>(21) Days.   | R CORRECTION: Twenty-one  | ;                         |  |                                 |                         |  |

|                          | <u>ota Department of He</u><br>NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                          | LE CONSTRUCTION (>  | (3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|--|--------------------------|---|------------------------------|
|                          |   | 00730  | B. WING                  |   | 10/24/2016                   |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AL  | DDRESS, CITY,            | STATE, ZIP CODE   |                              |
| RAZEE                    | CARE CENTER   |  | T MAPLE AV<br>, MN 56544 | 'ENUE, PO BOX 96  |                              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE COMPLET                   |
| 2 830                    | Continued From pa   | ge 76  | 2 830                    |   |                              |
| 2 830                    | MN Rule 4658.0520<br>Proper Nursing Ca  | 0 Subp. 1 Adequate and<br>re; General  | 2 830                    |   | 11/17/16                     |
|                          | individual needs an<br>the comprehensive<br>plan of care as des<br>4658.0405. A nurs<br>of bed as much as<br>written order from t   | supervision based on<br>d preferences as identified in<br>resident assessment and<br>scribed in parts 4658.0400 and<br>ing home resident must be out<br>possible unless there is a<br>he attending physician that the<br>in in bed or the resident<br>bed.   |                          |   |                              |
|                          | by:<br>Based on observative<br>review, the facility for assess a resident's<br>new interventions is to decrease the risk<br>residents (R78) reverting the facility of the facility of the facility implementation of the facility of the facility implementation of | ent is not met as evidenced<br>ion, interview and document<br>ailed to comprehensively<br>falls to determine whether<br>hould have been implemented<br>of further falls for 1 of 3<br>iewed for accident hazards.<br>ice resulted in harm for R78<br>of fracture with a fall. In<br>failed to ensure consistent<br>outine medical treatments of<br>a for 1 of 2 resident (R61)<br>insulin dependent. |                          | corrected   |                              |
|                          | Findings include:   |  |                          |   |                              |
|                          | (MDS) dated 7/24/1<br>cognitively intact ar<br>included, insulin de   | arterly Minimum Data Set<br>6, identified R61 was<br>and had diagnoses which<br>pendent diabetes, congestive<br>and anxiety. The MDS   |                          |   |                              |

STATE FORM

LSCM11

If continuation sheet 77 of 165

| STATEMEN      | ta Department of He<br>TOF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION   |                 | E SURVEY<br>PLETED |  |
|---------------|--|---|-------------------------|--|-----------------|--------------------|--|
|               |  | 00730   | B. WING                 |  | 10/             | 10/24/2016         |  |
| NAME OF I     | PROVIDER OR SUPPLIER   | STREET AL   | DRESS, CITY, ST         | TATE, ZIP CODE   |                 |                    |  |
| FRAZEE        | CARE CENTER  |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                 |                    |  |
| (X4) ID       | SUMMARY STA  | TEMENT OF DEFICIENCIES  | ID                      | PROVIDER'S PLAN OF                                       | CORRECTION      | (X5)               |  |
| PRÉFIX<br>TAG |  | / MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG           | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | THE APPROPRIATE | COMPLET            |  |
| 2 830         | Continued From pa  | ge 77   | 2 830                   |  |                 |                    |  |
|               |  | ired extensive assistance from<br>The MDS also identified R61<br>ections daily.   |                         |  |                 |                    |  |
|               | (CAA) dated 1/22/1<br>diagnoses of depre<br>grateful for anything<br>was content to stay<br>others. The CAA fu<br>to feel self pity in ge<br>R61 had a diagnosi<br>requiring insulin and<br>checked 4 times a of<br>related to erratic lev<br>R61 received Lantu<br>insulin accordingly. | nual Care Area Assessment<br>6, revealed R61 had<br>ssion and anxiety, was<br>g that was done for her and<br>r in her room with visits from<br>rther revealed R61 "appeared<br>eneral." The CAA revealed<br>is of diabetes mellitus,<br>d R61's blood sugars were<br>day and as needed (prn)<br>vels. The CAA further revealed<br>is insulin and a sliding scale                            |                         |  |                 |                    |  |
|               | 1/27/16, did not add   | dress R61's diagnosis of<br>par monitoring or use of insulin.   |                         |  |                 |                    |  |
|               | wheelchair in her ro<br>face (evident by, fu<br>jaw line). R61 state<br>that morning. R61 s<br>blood sugar checke<br>R61 stated she felt<br>blood sugar checke<br>sleeping all night. F<br>blood sugar a few t<br>had frightened her,  | 8 p.m. R61 was seated in her<br>bom, with a tense affect on her<br>rrowed brow, tight lips, tight<br>d she had a horrible morning<br>stated she did not have her<br>ed that day until 11:30 a.m.<br>it was important to have her<br>ed in the morning after<br>R61 stated she had a very low<br>imes in the morning, stated it<br>though it had been a long<br>occurred. R61 stated she had |                         |  |                 |                    |  |
|               | worried for most of<br>whether to sit and c<br>answer her call ligh<br>tray had come arou<br>to eat just in case h   | the morning and did not know<br>ery or see if someone would<br>t. R61 stated her breakfast<br>and 9:15, so she had decided<br>her blood sugar had been on<br>tated she had difficulty getting   |                         |  |                 |                    |  |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                       |  |                                 | E SURVEY<br>PLETED      |  |
|--------------------------|--|--|---------------------------|--|---------------------------------|-------------------------|--|
|                          |  | 00730  | B. WING                   |  | 10/                             | 10/24/2016              |  |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, S           | TATE, ZIP CODE   |                                 |                         |  |
| RAZEE                    | CARE CENTER  |  | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                 |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 830                    |  | age 78<br>nely check her morning blood   | 2 830                     |  |                                 |                         |  |
|                          | sugars. R61 stated<br>during her last care<br>few months ago, an<br>improvement. R61       | I she had voiced her concern<br>e conference which had been a<br>nd had not seen an<br>stated she had been<br>II the nurses knew her routine   | ı                         |  |                                 |                         |  |
|                          |  | Review of R61's current physician orders signed 10/6/16, revealed the following orders:  |                           |  |                                 |                         |  |
|                          | 11:30 a.m., 5:00 p.  | od sugar checks) 730 a.m.,<br>m., 9:00 p.m. call if blood<br>0 or greater than 300 as a<br>start dated 9/3/14.   |                           |  |                                 |                         |  |
|                          | inject per sliding sc<br>= 1 unit; 201-250 =<br>301-350 = 4 units;<br>units, > than 400 ca | 100 units/ml (insulin aspart)<br>cale: if 0-150 = 0 unit; 151-200<br>2 units; 251-300 = 3 units;<br>351-400 = 5 units; 401-500 = 6<br>all MD, sq 3 times a say for<br>ugar lower than 100 or greater<br>ern call MD. |                           |  |                                 |                         |  |
|                          |  | 100 units/ml (insulin aspart,<br>inject 8 units one time a day   |                           |  |                                 |                         |  |
|                          | insulin) inject 22 ur  | nsulin glargine, long acting<br>hits subcutaneous (sq) one<br>to diabetes, order was start   |                           |  |                                 |                         |  |
|                          |  | nsulin glargine,) inject 8 units<br>ed to diabetes, order was start  |                           |  |                                 |                         |  |
|                          |  | edication administration<br>n August 2016, to October  |                           |  |                                 |                         |  |

STATE FORM

If continuation sheet 79 of 165

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                           | CONSTRUCTION   |                                 | E SURVEY<br>PLETED      |
|--------------------------|--|--|---------------------------|--|---------------------------------|-------------------------|
|                          |  | 00730  | B. WING                   |  | 10/                             | 24/2016                 |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AI  | DDRESS, CITY, ST          | TATE, ZIP CODE   |                                 |                         |
| FRAZEE                   | CARE CENTER  |  | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 830                    | Continued From pa  | ge 79  | 2 830                     |  |                                 |                         |
|                          | 2016, revealed the   | following:   |                           |  |                                 |                         |
|                          | sugar results were<br>11:30 a.m. results v   | aled R61's 7:30 a.m. blood<br>blank on 7 out of 31 days<br>vere blank on 8 out of 31 days<br>Its were blank 10 out of 31   |                           |  |                                 |                         |
|                          | blood sugar results 11:30 a.m. results v   | revealed R61's 7:30 a.m.<br>were blank 7 out of 30 days,<br>vere blank 9 out of 30 days,<br>ere blank 8 out of 30 days.  |                           |  |                                 |                         |
|                          | sugar results were a.m. results were b   | realed R61' s 7:30 a.m. blood<br>blank 13 out of 21 days, 11:30<br>lank 10 out of 21 days, 5:30<br>lank 7 out of 21 days.  |                           |  |                                 |                         |
|                          | sheet dated 9/20/16<br>accu check had not  | form titled, Diabetic Flow<br>6, to 10/20/16, revealed R61's<br>t been completed as<br>ut of the 30 days R61's blood<br>led.   |                           |  |                                 |                         |
|                          | revealed R61 had "<br>and how staff chang<br>regarding the timing<br>revealed R61 had c                        | cial service note dated 8/7/16,<br>ruminated" about diagnoses<br>ges had impacted her care<br>g of the med pass. The note<br>chronic temperaments and<br>s on medical conditions and<br>surance.                       |                           |  |                                 |                         |
|                          | revealed R61 was of<br>chronic melancholy<br>her medical issues<br>exclusion of all else<br>expressed distress | service note dated 7/24/16,<br>cognitively intact and had a<br>r temperament and focused on<br>and limitations to the<br>e. The note revealed R61 had<br>when there was a staff<br>ing, even if it did not affect her. |                           |  |                                 |                         |

| STATEME                  | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED<br>10/24/2016 |                         |
|--------------------------|---|---|-------------------------|--|---|-------------------------|
|                          |   | 00730   | B. WING                 |  |   |                         |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AL   | DRESS, CITY, ST         | ATE, ZIP CODE  |   |                         |
| FRAZEE                   | CARE CENTER   |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE                               | (X5)<br>COMPLET<br>DATE |
| 2 830                    | concerns that a new<br>the routine of seaso<br>medication adminis<br>R61 was given reas<br>worker (SW) that st<br>orientation and carn<br>note revealed R61<br>intent to consider the<br>reiterate her worry of<br>note also revealed<br>her medical concern<br>children.<br>On 10/20/16, at 9:3<br>(LPN)-B stated she<br>supposed to have he<br>times a day. LPN-B<br>brittle diabetic and the<br>have her blood sug<br>LPN-B stated R61 with<br>sugars and felt R61<br>she did not have her<br>routine.<br>On 10/20/16, at 9:4<br>nursing (ADON) state<br>blood sugars were<br>on a consistent base<br>expected R61's phy<br>as well as R61's car<br>On 10/20/16, at 9:4<br>Practitioner (CNP) with R61 for 5 years<br>R61's medical concern<br>stated R61 required<br>as it had been diffic<br>sugars and required | <ul> <li>w staff person would not follow oned staff regarding stration. The note revealed seurance by the facility social taff received the appropriate he with verified skill levels. The had listened but not with any he information, as she would or bring up a new one. The staff should distract R61 from ns by asking about her</li> <li>6 a.m. licensed practical nurse understood R61 was her blood sugars checked 3 is stated R61 was kind of a felt it was very important to ars checked consistently. worried about her blood would become distressed if er blood sugar done per her</li> <li>3 a.m. assistant director of ated she was not aware R61's not being routinely monitored sis. The ADON stated she vsician orders to be followed</li> </ul> |                         | DEFICIENC  | ·Y)   |                         |

| STATEMEN      | ota Department of He<br>NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | CONSTRUCTION   |                 | E SURVEY<br>PLETED |
|---------------|--|--|-------------------------|--|-----------------|--------------------|
|               |  | 00730  | B. WING                 |  | 10/24/2016      |                    |
| NAME OF I     | PROVIDER OR SUPPLIER   | STREET AL  | DRESS, CITY, ST         | TATE, ZIP CODE   |                 |                    |
| FRAZEE        | CARE CENTER  |  | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                 |                    |
| (X4) ID       | SUMMARY STA  |  | ID                      | PROVIDER'S PLAN OF   | CORRECTION      | (X5)               |
| PREFIX<br>TAG |  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG           | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | THE APPROPRIATE | COMPLET<br>DATE    |
| 2 830         | Continued From pa  | age 81   | 2 830                   |  |                 |                    |
|               | basis. CNP stated I controlled with med  | R61 had anxiety which was<br>lication.   |                         |  |                 |                    |
|               | reported to her that<br>answered, she did<br>blood sugars were<br>NA-B stated she fe<br>she reported her co                          | 27 p.m. NA-B stated R61 had<br>ther call light was not routinely<br>not receive her baths and her<br>not being checked routinely.<br>It R61 appeared anxious when<br>oncerns to her. NA-B stated<br>261's concern to a nurse about                   |                         |  |                 |                    |
|               | interview, ADON co<br>August, September<br>amount" of blanks i<br>blood sugar results<br>say for sure R61's I<br>checked on those of | 202 a.m. during a follow up<br>onfirmed R61's MAR for<br>r and October had a "fair<br>in the documentation of R61's<br>ADON stated she could not<br>blood sugars had not been<br>days, though did state if it was<br>he could not prove it was done. |                         |  |                 |                    |
|               | stated she was una not routinely check   | 1 a.m. nurse manager (NM)<br>aware R61's blood sugars were<br>ed. NM stated she expected<br>s to be routinely checked and<br>ould be followed.   | •                       |  |                 |                    |
|               | stated R61 was a c<br>focus on her medic<br>R61 had reported to<br>that not all the nurs<br>SW stated she did                        | 21 a.m. social worker (SW)<br>chronic worrier and tended to<br>cal concerns. SW confirmed<br>o her on in July and August<br>ses were following her routine.<br>not check to see if R61's   |                         |  |                 |                    |
|               | followed. SW stated<br>times she was afra<br>working, though did<br>she felt it was just s   | hents or care plan was being<br>d R61 had reported to her at<br>id when new staff were<br>d not probe further. SW stated<br>staff turnover that was  |                         |  |                 |                    |
|               |  | R61 was an "anxious person."<br>I told R61 if she did not like   |                         |  |                 |                    |

| STATEMEN                 | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                           | CONSTRUCTION   |                                 | E SURVEY<br>PLETED      |  |
|--------------------------|---|--|---------------------------|--|---------------------------------|-------------------------|--|
|                          |   | 00730  | B. WING                   | B. WING  |                                 | 10/24/2016              |  |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AI  | DDRESS, CITY, S           | TATE, ZIP CODE   |                                 |                         |  |
| RAZEE                    | CARE CENTER   |  | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                 |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 830                    | Continued From pa   | age 82   | 2 830                     |  |                                 |                         |  |
|                          | should tell that nurs<br>stated her usual pr<br>nurse regarding re-<br>medications and tr<br>SW stated R61 ten      | oing something that R61<br>se she was uncomfortable. SW<br>actice would be to talk to the<br>sident concerns with<br>eatments and thought she did.<br>ided to ruminate over things<br>n underlying mental health                                     | ,                         |  |                                 |                         |  |
|                          | April 1, 2008, revea<br>directed staff to ch  | d Insulin Administration, dated<br>aled a facility policy which<br>eck resident physician orders<br>inistration and to check blood<br>or ordered.  |                           |  |                                 |                         |  |
|                          | 1, 2008, revealed a<br>included the right to<br>with reasonable ac<br>needs and preferen<br>residents right to cl   | d Resident Rights, dated April<br>a list of resident rights which<br>o receive services in the facility<br>commodation of individual<br>nces. The policy also revealed<br>hoose activities, schedules,<br>nsistent with interests,<br>plans of care. | ,                         |  |                                 |                         |  |
|                          | 6/14/16, identified<br>included Alzheimer<br>atrial fibrillation. Th<br>moderate cognitive<br>assist to transfer, v | nimum Data Set (MDS) dated<br>R78 had diagnoses which<br>s disease, unspecified fall, and<br>e MDS identified R78 had<br>e impairment, required limited<br>valking, toilet use and was<br>inent of urine, continent of<br>on a toileting plan.       |                           |  |                                 |                         |  |
|                          | R78 had intact cog assistance to trans  | DS dated 9/14/16, identified<br>nition, required limited<br>fer, walk, toilet and for<br>was occasionally incontinent of   |                           |  |                                 |                         |  |

| STATEMEN                 | DIT DEPARTMENT OF HE  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                           | CONSTRUCTION   |                                  | E SURVEY<br>PLETED      |  |
|--------------------------|---|---|---------------------------|--|----------------------------------|-------------------------|--|
|                          |   | 00730   | B. WING                   |  | 10/                              | 10/24/2016              |  |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AI   | DDRESS, CITY, S           | TATE, ZIP CODE   |                                  |                         |  |
| RAZEE                    | CARE CENTER   |   | T MAPLE AVE<br>, MN 56544 | ENUE, PO BOX 96  |                                  |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 830                    | Continued From pa   | age 83  | 2 830                     |  |                                  |                         |  |
|                          | urine, continent of l<br>toileting plan.  | bowel and was not on a  |                           |  |                                  |                         |  |
|                          | identified R78 had<br>impairment, was to<br>transfers, dressing   | nange MDS dated 10/3/16,<br>moderate cognitive<br>tally dependent upon staff for<br>and toileting, was occasionally<br>e, continent of bowel and was<br>an.   | ,                         |  |                                  |                         |  |
|                          | 10/3/16, identified I<br>disorientation, forge<br>reassurance, remin<br>things. The CAA id-<br>a decline in conditionand<br>and surgical interver-<br>was receiving thera<br>established for toile<br>impulsive leading to<br>had a history of fall | ssessment (CAA) dated<br>R78 had confusion,<br>etfulness and needed<br>nders to help make sense of<br>entified R78 had experienced<br>on related to fall with fracture<br>ention and incontinence. R78<br>apy services with goal<br>eting transfers. R78 had been<br>o poor safety awareness and<br>s and experienced a fall<br>ure with surgical intervention. |                           |  |                                  |                         |  |
|                          | had a self care defi<br>unsteady gait and t<br>related to history of<br>incontinence and p<br>dementia. The care<br>urinal at night per h<br>mattress related to<br>with hoyer (full bod  | vised 9/28/16, indicated R78<br>icit related to cognitive loss,<br>transfers, was at risk for falls<br>f falls, unsteady gait,<br>oor judgment related to<br>e plan indicated R78 used a<br>his request, App (concave)<br>decreased mobility, transfer<br>y lift) and two staff, floor mats<br>nge room to allow extra room                                     |                           |  |                                  |                         |  |
|                          | dated 10/17/16, dir<br>one staff for ADL's<br>falls, used a mecha   | ed Aide Care Plan Group B,<br>ected R78 required assist of<br>(activity of daily living), had<br>anical lift for transfers, would<br>id required assist of one for  |                           |  |                                  |                         |  |

| STATEMEN      | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                                | CONSTRUCTION  |                                 | E SURVEY<br>PLETED |  |
|---------------|--|--|--------------------------------|---|---------------------------------|--------------------|--|
|               |  | 00730  | B. WING                        |   | 10/24/2016                      |                    |  |
| NAME OF       | PROVIDER OR SUPPLIER   | STREET A   | ADDRESS, CITY, STATE, ZIP CODE |   |                                 |                    |  |
| RAZEE         | CARE CENTER  |  | T MAPLE AVE<br>, MN 56544      | NUE, PO BOX 96  |                                 |                    |  |
| (X4) ID       | SUMMARY STA  |  |                                | PROVIDER'S PLAN OF (  | COBBECTION                      | (X5)               |  |
| PREFIX<br>TAG | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG                  | (EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | COMPLET<br>DATE    |  |
| 2 830         | Continued From pa  | uge 84   | 2 830                          |   |                                 |                    |  |
|               | toileting.   |  |                                |   |                                 |                    |  |
|               | the room was dark<br>R78's bed a thin gra<br>the right side a thin<br>square white perso<br>grab bar attached t                        | 5 a.m. R78 was lying in bed,<br>and quiet. On the left side of<br>ay fall mat on the floor and on<br>brown fall mat was present. A<br>nal alarm was secured to the<br>o the right side of R78's bed<br>as attached to the grab bar                             |                                |   |                                 |                    |  |
|               | nurse (LPN)-A prop<br>in a wheel chair, the  | 9 a.m. licensed practical<br>belled R78 to the dining room<br>e white square personal alarm<br>back of R78's wheel chair.  |                                |   |                                 |                    |  |
|               | independently ate t  | 8:27 a.m. to 8:40 a.m. R78<br>he breakfast meal seated in a<br>e personal alarm secured to<br>eel chair.   |                                |   |                                 |                    |  |
|               | wheelchair in the h<br>watching the activit  | 2:33 a.m. R78 was seated in a hall outside of his room y of staff and other residents, was secured to the back of  |                                |   |                                 |                    |  |
|               |  | linical record revealed the<br>ented falls since R78 was<br>7, 2016:   |                                |   |                                 |                    |  |
|               | beside his bed. Res<br>stated,"I was going<br>placed a bed alarm<br>(IDT) reviewed the<br>following the fall). T<br>"Resident attempts | .m. R78 was found on floor<br>sident interview indicated R78<br>to the bathroom." Staff initially<br>. The interdisciplinary team<br>fall on 3/18/16 (10 days<br>The post fall findings identified,<br>to self transfer to BRM<br>ervention to be implemented: |                                |   |                                 |                    |  |

|                          | ota Department of He  | (X1) Provider/Supplier/Clia   |                     | CONSTRUCTION   |                | ESURVEY                 |  |
|--------------------------|---|---|---------------------|--|----------------|-------------------------|--|
|                          | OF CORRECTION   | IDENTIFICATION NUMBER:  | A. BUILDING:        |  |                | PLETED                  |  |
|                          |   | 00730   | B. WING             | B. WING  |                | 10/24/2016              |  |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AL   | DRESS, CITY, S      | TATE, ZIP CODE   |                |                         |  |
| FRAZEE                   | CARE CENTER   |   |                     | NUE, PO BOX 96   |                |                         |  |
|                          |   |   | MN 56544            |  |                |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ITEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | TION SHOULD BE | (X5)<br>COMPLET<br>DATE |  |
| 2 830                    | Continued From pa   | ge 85   | 2 830               |  |                |                         |  |
|                          | staff to R78's room<br>next to bed. R78 su<br>elbow 1 cm (centim<br>note identified R78<br>tried to get up. Inter<br>as a result of the as<br>mat, urinal placed.<br>on 3/17/16 (8 days<br>information/interver<br>staff along with cha<br>included: floor mat<br>and not a new inter | . alarm sounded and alerted<br>. R78 was found on floor mat<br>istained a skin tear to the right<br>neter) by 0.8 cm. The incident<br>needed to use bathroom and<br>rventions to be implemented<br>sessment: Bed alarm, floor<br>The IDT team reviewed the fal<br>following the fall). Additional<br>ntions to be communicated to<br>inges to the care plan<br>(which was currently in use<br>vention).<br>.m. R78 was found lying face |                     |  |                |                         |  |
|                          | down on floor with I<br>Resident interview<br>was getting up to ge<br>sustained a lacerati<br>long and a lacerati<br>nose 0.4 cm. The ir<br>was on the floor ne<br>got up he had bare<br>The IDT reviewed<br>following the fall). Ir<br>implemented as a r                            | head against night stand.<br>indicated R78 had stated he<br>o to the bathroom. R78<br>ion to the right eyebrow 2.5 cm<br>on to the left side bridge of his<br>ncident note identified a mat<br>xt to R78's bed, when resident<br>feet and slipped on the mat.<br>the fall on 3/14/16 (2 days  |                     |  |                |                         |  |
|                          | the floor mat on floo<br>indicated he was go<br>chair. The nursing a<br>bathroom and to ge<br>note indicated R78<br>mat by the bed was<br>indicated R78 had a<br>awareness, recently<br>recommendations   | n. R78 was found sitting on<br>or next to bed. R78 had<br>bing to get up and into wheel<br>assistant assisted R78 to the<br>et dressed for the day. The<br>indicated he slipped on the<br>s bare footed. The note<br>a problem with safety<br>y completed therapy and<br>were to continue to receive<br>ply and continues to attempt  |                     |  |                |                         |  |

| STATEMEN                 | ta Department of He<br>TOF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                           | CONSTRUCTION   |                              | E SURVEY<br>PLETED      |
|--------------------------|--|---|---------------------------|--|------------------------------|-------------------------|
|                          |  | 00730   | B. WING                   |  | 10/24/2016                   |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, S           | TATE, ZIP CODE   |                              |                         |
| FRAZEE                   | CARE CENTER  |   | T MAPLE AVE<br>, MN 56544 | ENUE, PO BOX 96  |                              |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 830                    | self transfer.<br>(5) 7/15/16- 3:00 a<br>room and it was un<br>prior to the fall. The<br>transferring without<br>the call light. Interv<br>a result of the asse<br>light and wait for as<br>identified R78 was<br>Resident was unab<br>doing. The nurses<br>reviewed the fall or<br>should use call ligh<br>will add a lipped map<br>perimeters.<br>(6) 7/27/16- 6:20 p<br>residents room and<br>in bed. The form id | age 86<br>.m. R78's fall occurred in his<br>aknown what R78 was doing<br>e fall occurred when R78 was<br>t assistance and did not use<br>entions to be implemented as<br>essment: Reminded to use call<br>ssist. The nurse's notes<br>found lying on floor near bed.<br>ble to identify what he had beer<br>notes also indicated the IDT<br>n 7/15/16, did not remember he<br>ht to alert staff for assistance,<br>attress to bed to define<br>.m. R78's fall occurred in<br>d prior to the fall R78 was lying<br>lentified alarms had been<br>fall. The note did not include | ı                         |  |                              |                         |
|                          | IDT on 8/2/16 (6 da<br>(7) 9/19/16-5:20 a.<br>occurred in room a<br>sleeping. The note<br>identified-found lyin<br>bathroom door, res<br>The notes indicated<br>forgetful and had a<br>awareness. The not<br>interventions to be<br>fall for R78. The ID<br>on 9/27/16 (8 days<br>(8) 9/22/16-8:15 a.  | m. indicated R78's fall<br>and prior to the fall, had been<br>faxed to the physician<br>ng on floor in room in front of<br>sident stated he had slipped.<br>d R78 was confused at times,<br>history of falls, lack of safety<br>otes lacked documentation of<br>implemented as a result of the<br>T team had reviewed the fall<br>later)<br>m. indicated staff were alerted   |                           |  |                              |                         |
|                          | to room by roomma<br>sideways on floor o   | ate. R78 was found sitting<br>of BR (bathroom) states<br>stood up and slipped. The  |                           |  |                              |                         |

| STATEMEN                 | ta Department of He<br>TOF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                           | CONSTRUCTION  |                                | E SURVEY<br>PLETED      |
|--------------------------|--|---|---------------------------|---|--------------------------------|-------------------------|
|                          |  | 00730   | B. WING                   |   | 10/24/2016                     |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AI   | DDRESS, CITY, ST          | TATE, ZIP CODE  |                                |                         |
| FRAZEE                   | CARE CENTER  |   | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96  |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 830                    | note indicated R78'<br>underneath resider<br>Further, the incider<br>have BM (bowel me<br>prior to fall. The po-<br>identified R78 comp<br>motion of left leg ar<br>be shorter than the<br>called to transport I<br>R78's hospital disc<br>for readmission to t<br>9/26/16, indicated F<br>fixation and nailing<br>the left hip fracture<br>Review of R78's Fa<br>dated 3/7/16, identi<br>week, was weak, ir<br>walker and was abl<br>independently.<br>Review of R78's Fa<br>dated 6/23/16, indic<br>remained current w<br>changes: "Has had<br>Is reminded to use<br>The Fall Risk Asset<br>to comprehensively<br>include but not limit<br>factors that may be<br>effectiveness of inte<br>No Further Fall Ris<br>R78's record<br>Review of R78's Bo | <ul> <li>Is left shoe off and was and right shoe falling off foot at and right shoe falling off foot at note identified R78 had a povement) in BR (bathroom) st fall physical assessment plained of pain with range of a R78's left leg was noted to right. The ambulance was R78 to the emergency room.</li> <li>harge interagency referral form the nursing home dated, R78 had left trochanteric (surgical repair of the hip) of on 9/23/16.</li> <li>all Risk Assessment form fied R78 had three falls in last acontinent of bladder, used a le to use call light</li> <li>all Risk Assessment form cated R78's risk for falls to te to trends/patterns to falls, a causing the falls, and erventions.</li> <li>k Assessments were found in power and Bladder Functional</li> </ul> |                           | DEFICIENCY  |                                |                         |
| nesota D                 | Evaluation Tool dat  | ed 3/14/16, revealed R78 was<br>and bowel, awoke at night to  |                           |   |                                |                         |

STATE FORM

LSCM11

If continuation sheet 88 of 165

| TATEMENT OF<br>ND PLAN OF C  | DEFICIENCIES<br>ORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION   |                                  | E SURVEY<br>PLETED      |
|--|---|---|-------------------------|--|----------------------------------|-------------------------|
|  |   | 00730   | B. WING                 |  | 10/24/2016                       |                         |
| AME OF PROV  | IDER OR SUPPLIER  | STREET AL   | DRESS, CITY, ST         | TATE, ZIP CODE   |                                  |                         |
| RAZEE CAP  | RE CENTER   |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                  |                         |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 830 Co<br>voi<br>voi<br>use<br>rec<br>toil<br>ma<br>ide<br>Re<br>Eva<br>cor<br>1-2<br>Re<br>Inte<br>nur<br>foll<br>- 4,<br>[pa<br>onl<br>trai<br>[qu<br>Co<br>ass<br>on<br>-5/4<br>D/C<br>wit<br>x [t<br>The<br>lac<br>the<br>Re<br>Re<br>Re<br>cor<br>toil<br>sol<br>trai<br>cor<br>toil<br>ma<br>ide | d/defecate. The<br>e call light, able to<br>juired assist to an<br>et/commode, and<br>jority of time. The<br>ntify a toileting p<br>view of R78's Bo<br>aluation Tool date<br>times weekly.<br>view of R78's Re-<br>erdepartmental C<br>rsing and physical<br>owing:<br>(1/16, Physical T<br>tient] to transfer<br>y. We are workin<br>nsfers and gettin<br>estions] call. Nut<br>nt [continue] with<br>sist] and encoura<br>getting back up b<br>8/16, Physical Th<br>C [discharged] fro<br>h RW [regular was<br>imes] daily Pt. an<br>e form included a<br>ked any respons<br>rapy.<br>view of R78's un<br>ferral For Therap<br>d been demonstri- | to identify the need to<br>tool identified R78 was able to<br>o ask to go to the bathroom,<br>mbulate and transfer to<br>d was able to use the toilet<br>e evaluation tool did not<br>lan for R78.<br>wel and Bladder Function<br>ed 6/23/16, identified R78 was<br>and was incontinent of urine<br>esident Referral<br>Communication forms between<br>al therapy revealed the<br>herapy-"Please encourage Pt.<br>and toilet with stand-by-assist<br>ng towards independent<br>g rid of alarm. Any?<br>rsing responded on 4/6/16-<br>n alarm for now. SBA [stand by<br>uge him to do himself. Working | 2 830                   |  |                                  |                         |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | CONSTRUCTION  |                                | E SURVEY<br>PLETED      |
|--------------------------|---|--|---------------------|---|--------------------------------|-------------------------|
|                          |   | 00730  | B. WING             |   | 10/24/2016                     |                         |
|                          | PROVIDER OR SUPPLIER  |  | DRESS, CITY, S      | TATE. ZIP CODE  | 10/                            | 24/2010                 |
| FRA7FF                   | CARE CENTER   | 219 WES  | T MAPLE AVE         | NUE, PO BOX 96  |                                |                         |
|                          |   |  | MN 56544            |   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ITEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 830                    | Continued From pa   | ge 89  | 2 830               |   |                                |                         |
|                          | and ambulation with<br>from therapy. R78 r<br>issues with safety a<br>recommended R78<br>Review of R78's Nu<br>Assessment dated<br>Alzheimer's, and a<br>assessment identifi<br>impaired cognitive s<br>decisions poor, cue   | ed R78 had moderately<br>skills for daily decision making,<br>ss/supervision required, and<br>sistance with transferring and   |                     |   |                                |                         |
|                          | reports and progress<br>the assistant directed<br>The ADON verified<br>was unsure what in<br>place. The ADON ic<br>fall the post- fall clir<br>nursing, the admini<br>reviewed the facility<br>Assessment. The for<br>nurse when resider<br>reviewed for approp<br>ADON indicated R7<br>to interpret what int<br>following the falls. The<br>believed the falls we<br>appropriate intervent | 7 p.m. a review of R78's fall<br>as notes was conducted with<br>or of nursing (ADON) present.<br>R78's multiple falls, although<br>terventions were currently in<br>dentified following a resident's<br>nical team which included<br>strator and social services,<br>of form titled Fall Risk Post- Fall<br>orm was initiated by the floor<br>nt falls occurred and the team<br>priate interventions. The<br>78's fall reviews were difficult<br>erventions were initiated<br>The ADON indicated she<br>ere fully assessed and<br>ntions were initiated for R78's<br>ned R78 had sustained a hip<br>II on 9/22/16. |                     |   |                                |                         |
|                          | 9/22/16, included va  |  |                     |   |                                |                         |

STATE FORM

|         | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:     |                         | CONSTRUCTION  |                | E SURVEY<br>PLETED |
|---------|--|---|-------------------------|---|----------------|--------------------|
|         |  | 00730   | B. WING                 |   | 10/24/2016     |                    |
| NAME OF | PROVIDER OR SUPPLIER   | STREET AI   | DDRESS, CITY, ST        | TATE, ZIP CODE  | •              |                    |
| RAZEE   | CARE CENTER  |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96  |                |                    |
| (X4) ID | SUMMARY ST   |   | ID                      | PROVIDER'S PLAN OF C  | ORRECTION      | (X5)               |
| PREFIX  |  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | PREFIX<br>TAG           | (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | HE APPROPRIATE | COMPLET<br>DATE    |
| 2 830   | Continued From pa  | age 90  | 2 830                   |   |                |                    |
|         | resident. Resident<br>transferred bed/cha<br>Removed alarms a<br>- 7/24/16, found on<br>closet,minimal one<br>-9/19/16, R78's roo<br>on the floor. R78 for<br>in front of the bathr<br>stated he must of s<br>socks on.<br>-9/22/16, R78 fourn<br>on buttocks and sta<br>finished, stood up a<br>much pain left hip v<br>shortening of left le<br>transport. The note<br>a fractured hip and<br>the following day.<br>On 10/20/16, at 10<br>B stated she felt th<br>the facility must ha<br>large amount of res<br>On 10/20/16, at 10<br>(NA)-I indicated R7<br>the bathroom by hi<br>indicated since R76<br>assistance to go to<br>R78 did not always<br>wheel chair brakes<br>on the wheel chair<br>On 10/21/16, at 1:3<br>a recent decline be<br>hip. NA-B verified F<br>usually related to g<br>coming back from | knees in front of   | F                       |   |                |                    |

| STATEMEN                 | Dita Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                           | CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|--|--|---------------------------|--|--------------------------------|-------------------------|
|                          |  | 00730  | B. WING                   |  | 10/24/2016                     |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, ST          | TATE, ZIP CODE   |                                |                         |
| RAZEE                    | CARE CENTER  |  | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 830                    |  | -  | 2 830                     |  |                                |                         |
|                          | toilet prior to the fall and would turn the call light<br>on for assistance when needed to pull up his<br>pants or to shave. NA-B identified R78 at times<br>used the call light appropriately and other times<br>did not. NA-B indicated a toileting program may<br>have been beneficial for R78 prior to his fall with<br>a fractured hip. |  |                           |  |                                |                         |
|                          | was independent w toileting before the   | 3 p.m. NA-J indicated R78<br>vith dressing, hygiene and<br>fall and hip fracture. NA-J<br>he hip fracture R78 was always<br>pathroom.  |                           |  |                                |                         |
|                          | did not work often v<br>be sitting in the hal  | 89 p.m. NA-A indicated she/he<br>with R78 and stated, "He will<br>I and say 'hey', have to go to<br>staff would assist him.  |                           |  |                                |                         |
|                          | R78's fall resulting<br>assistance of one t<br>ask for help to toile<br>ask or did not ask f<br>toileting program w<br>needed to go to the   | Pp.m. NM-B indicated prior to<br>in a fracture, R78 required<br>o transfer and remind R78 to<br>t because he was reluctant to<br>for help. NM-B indicated R78's<br>as to sound call light when he<br>bathroom or he attempted to |                           |  |                                |                         |
|                          | transfers self when<br>reviewed the 8 falls<br>review of the falls,<br>been a pattern of the<br>off of the toilet. NM  | M-B stated, "He [R78] calls or<br>he needs toilet." NM-B<br>and interventions. After<br>NM-B stated she felt there had<br>he falls was going to or coming<br>-B confirmed R78 was not on<br>and stated," It may have been        |                           |  |                                |                         |
|                          | with the ADON veri<br>hospitalization the  | facility had not initiated a<br>78. The ADON felt R78's falls  |                           |  |                                |                         |

|  |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING:  |  | (X3) DATE SURVEY<br>COMPLETED   |  |
|--|---|--|--|---|--|
|  | 00730   | B. WING  |  | 10/24/2016  |  |
| PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, ST  | TATE, ZIP CODE   |   |  |
| CARE CENTER  |   |  | NUE, PO BOX 96   |   |  |
|  | TEMENT OF DEFICIENCIES  | ID   |  |   | (X5)<br>COMPLET  |
|  |   | TAG  | CROSS-REFERENCED TO 1  | THE APPROPRIATE   | DATE   |
| Continued From pa  | ge 92   | 2 830  |  |   |  |
| had not identified a pattern with R78's falls,<br>however, indicated evaluation for a pattern for<br>falls was not part of the comprehensive   |   |  |  |   |  |
| assessment for R78<br>On 10/24/16, at 2:00<br>(NP)-A indicated sh<br>assess falls routinel<br>pattern or reason fo<br>minimize further fall<br>On 10/24/16, at 4:1<br>R78's physician (MI<br>R78 had a fall which<br>however, was unaw<br>MD-A indicated R78<br>easily redirected. M<br>facility nursing staff<br>going to the bathroot<br>the falls, he would e<br>appropriate interver<br>needs. | he expected the facility staff to<br>ly and attempt to identify a<br>or the falls in an attempt to<br>ls.<br>17 p.m. a phone interview with<br>D)-A verified he was aware<br>h resulted in a fractured hip,<br>vare of the number of falls.<br>8 was demented and was not<br>ID-A verified he would expect<br>to assess the falls and if<br>om is the common reason with<br>expect staff to provide an<br>ntion related to R78's toileting  |  |  |   |  |
| SUGGESTED MET<br>Director of Nursing<br>polices and proced<br>monitoring acciden   | or her designee could develop<br>ures regarding assessing and<br>ts, range of motion and  |  |  |   |  |
|  | CARE CENTER<br>SUMMARY STA<br>(EACH DEFICIENCY<br>REGULATORY OR L<br>Continued From par<br>interventions had b<br>had not identified a<br>however, indicated<br>falls was not part of<br>assessment for R7<br>On 10/24/16, at 2:0<br>(NP)-A indicated sl<br>assess falls routine<br>pattern or reason for<br>minimize further fall<br>On 10/24/16, at 4:7<br>R78's physician (M<br>R78 had a fall which<br>however, was unaw<br>MD-A indicated R72<br>easily redirected. N<br>facility nursing staff<br>going to the bathroot<br>the falls, he would eappropriate interven<br>needs.<br>The requested facill<br>was not provided.<br>SUGGESTED MET<br>Director of Nursing<br>polices and proced<br>monitoring acciden | PROVIDER OR SUPPLIER STREET AL<br>219 WES<br>FRAZEE,<br>SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)<br>Continued From page 92<br>interventions had been in to place. ADON stated<br>had not identified a pattern with R78's falls,<br>however, indicated evaluation for a pattern for<br>falls was not part of the comprehensive<br>assessment for R78.<br>On 10/24/16, at 2:00 p.m. nurse practitioner<br>(NP)-A indicated she expected the facility staff to<br>assess falls routinely and attempt to identify a<br>pattern or reason for the falls in an attempt to<br>minimize further falls.<br>On 10/24/16, at 4:17 p.m. a phone interview with<br>R78's physician (MD)-A verified he was aware<br>R78 had a fall which resulted in a fractured hip,<br>however, was unaware of the number of falls.<br>MD-A indicated R78 was demented and was not<br>easily redirected. MD-A verified he would expect<br>facility nursing staff to assess the falls and if<br>going to the bathroom is the common reason with<br>the falls, he would expect staff to provide an<br>appropriate intervention related to R78's toileting<br>needs.<br>The requested facility policy regarding facility falls<br>was not provided. | DOT30         B. WING           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, ST           SCARE CENTER         219 WEST MAPLE AVE<br>FRAZEE, MN 56544           SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)         ID<br>PREFIX<br>TAG           Continued From page 92         2 830           interventions had been in to place. ADON stated<br>had not identified a pattern with R78's falls,<br>however, indicated evaluation for a pattern for<br>falls was not part of the comprehensive<br>assessment for R78.         2 830           On 10/24/16, at 2:00 p.m. nurse practitioner<br>(NP)-A indicated she expected the facility staff to<br>assess falls routinely and attempt to identify a<br>pattern or reason for the falls in an attempt to<br>minimize further falls.         0n 10/24/16, at 4:17 p.m. a phone interview with<br>R78 had a fall which resulted in a fractured hip,<br>however, was unaware of the number of falls.           MD-A indicated R78 was demented and was not<br>easily redirected. MD-A verified he would expect<br>facility nursing staff to assess the falls and if<br>going to the bathroom is the common reason with<br>the falls, he would expect staff to provide an<br>appropriate intervention related to R78's toileting<br>needs.           The requested facility policy regarding facility falls<br>was not provided.           SUGGESTED METHOD OF CORRECTION: The<br>Director of Nursing or her designee could develop<br>polices and procedures regarding assessing and<br>monitoring accidents, range of motion and | DOT30         B. WING           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE           CARE CENTER         219 WEST MAPLE AVENUE, PO BOX 96<br>FRAZEE, INN 56544           SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)         ID<br>PREFIX<br>TAG         (PROVIDER'S PLAN OF<br>(PROVIDER'S ADDRESS ADDRE | 10/       ROWDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       CARE CENTER       SUMMARY STATEMENT OF DEFICIENCIES<br>FRAZEE, MN 56544       SUMMARY STATEMENT OF DEFICIENCIES<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       DREFIX     ID<br>PREFIX       Continued From page 92     ID<br>Interventions had been in to place. ADON stated<br>had not identified a pattern with R78's fails,<br>however, indicated evaluation for a pattern for<br>fails was not part of the comprehensive<br>assessment for R78.       On 10/24/16, at 2:00 p.m. nurse practitioner<br>(NP)-A indicated evaluation for a pattern for<br>fails was not part of the comprehensive<br>assess fails routinely and attempt to identify a<br>pattern or reason for the fails in an attempt to<br>minimize further fails.       On 10/24/16, at 2:00 p.m. nurse practitioner<br>(NP)-A indicated evaluation for a pattern for<br>fails was unaware of the number of fails.       MD-A indicated revelued the facility staff to<br>assess fails routinely and attempt to identify a<br>pattern or reason for the fails in an attempt to<br>minimize further fails.       On 10/24/16, at 4:17 p.m. a phone interview with<br>R78's physician (MD)-A verified he was aware<br>R78 had a fail which resulted in a fractured hip,<br>however, was unaware of then umber of fails.       MD-A indicated ADO OF CORRECTION: The<br>Director of Nursing or her designee could develop<br>polices and procedures regarding assessing and<br>monitoring accidents, range of motion and       SUGGESTED METHOD OF CORRECTION: The<br>Director of Nursing or her designee could develop<br>polices and procedures regarding assessing and<br>monitoring accidents, range of motion and |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                        | LE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|---|--|------------------------|--|-------------------------------|--------------------------|
|                          |   | 00730  | B. WING                |  |                               |                          |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                        | STATE, ZIP CODE  |                               |                          |
| FRAZEE                   | CARE CENTER   |  | T MAPLE AV<br>MN 56544 | ENUE, PO BOX 96  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLETI<br>DATE |
| 2 830                    | Continued From pa   | ge 93  | 2 830                  |  |                               |                          |
|                          |   | gnee could develop a<br>to ensure residents receive the  |                        |  |                               |                          |
|                          | TIME PERIOD FOR<br>(21) Days  | R CORRECTION: Twenty One   |                        |  |                               |                          |
| 2 885                    | MN Rule 4658.052<br>Nursing Care; Prog  | 5 Subp. 1 Rehabilitation<br>ram required   | 2 885                  |  |                               | 11/17/16                 |
|                          | must have an active<br>nursing care directe<br>resident to achieve<br>practicable physica<br>well-being accordin<br>resident assessme<br>in parts 4658.0400 | n required. A nursing home<br>e program of rehabilitation<br>ed toward assisting each<br>and maintain the highest<br>l, mental, and psychosocial<br>g to the comprehensive<br>nt and plan of care described<br>and 4658.0405. Continuous<br>de to encourage ambulation<br>ivities. |                        |  |                               |                          |
|                          | by:<br>Based on observati<br>review, the facility f<br>services to prevent<br>residents (R38) wh<br>ambulation. R38 wa<br>with ambulation and               | ent is not met as evidenced<br>on, interview and document<br>ailed to provide ambulation<br>loss of function for 1 of 4<br>o required assistance with<br>as not provided assistance<br>d was not re-assessed upon a<br>on. R38's decline in the ability<br>d in actual harm.       |                        | corrected  |                               |                          |
|                          | (MDS) 9/26/16, ide cognitive impairme   | ange Minimum Data Set<br>ntified R38 had moderate<br>nt and had diagnoses which<br>ive joint disease, weakness   |                        |  |                               |                          |

| STATEMEN                 | DIA Department of He<br>NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                           |  |                                | E SURVEY<br>PLETED      |
|--------------------------|--|---|---------------------------|--|--------------------------------|-------------------------|
|                          |  | 00730   | B. WING                   |  | 10/24/2016                     |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, S           | TATE, ZIP CODE   |                                |                         |
| FRAZEE                   | CARE CENTER  |   | T MAPLE AVE<br>, MN 56544 | ENUE, PO BOX 96  |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIV<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 885                    | and back pain. The<br>independent in bec<br>wheelchair indeper<br>the MDS identified<br>turning around and<br>walking and R38 di<br>R38's ADL Care Ar<br>9/26/16, indicated I<br>performance and w<br>plan. The CAA did<br>R38's admission N<br>R38 was not stead<br>human assistance<br>and facing opposite<br>identified R38 had<br>assistance from sta<br>R38's ADL CAA da<br>required assistance<br>and transfer. The C<br>receiving therapies<br>independence in he<br>R38's Behavioral C | MDS identified R38 was<br>mobility, transfers and used a<br>ndently for locomotion. Further,<br>activity did not occur for<br>facing opposite direction while<br>id not walk.<br>rea Assessment (CAA) dated<br>R38 had improved ADL<br>would be addressed on care<br>not address R38's ambulation.<br>MDS dated 5/24/16, identified<br>y, only able to stabilize with<br>for walking and turning around<br>e direction while walking. The<br>ambulated with limited<br>aff.<br>ted 5/24/16, identified R38<br>e from staff to safely ambulate<br>CAA revealed R38 was<br>and her goal was to return to<br>opes of returning home. |                           | DEFICIENCY   |                                |                         |
|                          | the facility hallway,<br>propelling herself to<br>feet. R38 propelled  | 36 p.m. R38 was observed in<br>seated in a wheelchair,<br>o the activity room with both<br>I herself up to a squared table,<br>ewspaper and began to read   |                           |  |                                |                         |
| nnoost- D                |  | 38 p.m. R38 indicated she had<br>o the bathroom and slid hersel   | f                         |  |                                |                         |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED    |                        |
|---|---|---|---|--|----------------------------------|------------------------|
|   |   | 00730   | B. WING                                 |  | 10/24/2016                       |                        |
| IAME OF I   | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, S                         | TATE, ZIP CODE   |                                  |                        |
|   |   | 219 WES   | T MAPLE AVE                             | NUE, PO BOX 96   |                                  |                        |
| RAZEE   | CARE CENTER   | FRAZEE  | , MN 56544                              |  |                                  |                        |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | NTEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLE<br>DATE |
| 2 885   | Continued From pa   | ige 95  | 2 885                                   |  |                                  |                        |
|   | was able to complet<br>liked to be as indep<br>proceeded to proper<br>utilizing both feet to<br>activity. At 3:08 p.m<br>wheelchair in the ac<br>participating in Bing<br>ambulate at any tim<br>On 10/20/16, at 1:5<br>(NA)-F stated R38<br>and was able to pro-<br>destinations. NA-F<br>with all of her person<br>maintain her indepen<br>not think R38 was a<br>assisted R38 to am<br>nursing assistants of<br>residents who were | use the toilet. She stated she<br>the most cares for herself and<br>bendent as possible. R38<br>el herself out of her room,<br>o the activity room to attend an<br>n. R38 was seated in her<br>ctivity room actively<br>go. R38 was not observed to<br>ne during observations.<br>67 p.m. nursing assistant<br>used a wheelchair for mobility<br>opel herself to and from<br>stated R38 was independent<br>onal cares and liked to<br>endence. NA-F stated she did<br>able to walk and had never<br>abulate. NA-F stated the<br>were responsible to ambulate<br>e on an ambulation program<br>not think R38 was on an<br>n in the facility. |   |  |                                  |                        |
|   | not assisted R38 w<br>the past. NA-B stat<br>units were respons<br>programs, after the<br>determined by occu<br>therapies (PT). NA-<br>both PT and OT up<br>months and indicat<br>been placed on the<br>stated she felt R38<br>could R38 ambulat<br>unit often times cou  | 0 p.m. NA-B stated she had<br>ith ambulation at any time in<br>ed the NA on the individual<br>ible for residents walking<br>program had been<br>upational (OT) and physical<br>B stated R38 had received<br>on admission for a few<br>ed she was unsure if R38 had<br>ambulation program. NA-B<br>was unable to fully stand nor<br>e. NA-B stated the NA on the<br>uld not assist residents with<br>ograms due to not enough  |   |  |                                  |                        |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | Ealth<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                            |   |                                 | E SURVEY<br>PLETED      |
|--------------------------|--|---|----------------------------|---|---------------------------------|-------------------------|
|                          |  | 00730   | B. WING                    |   | 10/24/2016                      |                         |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, ST           | TATE, ZIP CODE  |                                 |                         |
| FRAZEE                   | CARE CENTER  |   | ST MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96  |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 885                    | (LPN)-B stated the<br>responsible to amb<br>ambulation program<br>she was unsure if F<br>program at present<br>clinical record, com<br>PT and OT dated 7<br>to be assisted with<br>walker and one-per<br>LPN-B stated she of<br>assisted to ambula<br>On 10/21/16, at 10<br>(RN)-A stated she of<br>ambulation program<br>seen R38 ambulate<br>On 10/21/16, at 11<br>assistant (PTA) stated<br>physical and occup<br>admission to the fa<br>stated R38 was dis<br>in July 2016, with a<br>be placed on an am<br>staff. PTA stated R3<br>one assist and a fro<br>feet consistently, w<br>PTA stated she had<br>residents' ambulati<br>being completed co<br>there was not enou-<br>to complete ambula<br>programs on a rout<br>On 10/21/16, at 11<br>no longer able to w<br>move about the fac<br>walking when she of | NAs on the units were<br>pulate with residents who had<br>ns in the facility. LPN-B stated<br>R38 was on an ambulation<br>t and after review of R38's<br>firmed R38 had a referral from<br>7/8/16, which directed R38 was<br>ambulation twice daily with a<br>rson assistance up to 40 feet.<br>did not think R38 had been<br>te since therapy ended.<br>35 a.m. registered nurse<br>was unaware if R38 was on an<br>n and indicated she had not<br>e with staff in the past.<br>20 a.m. physical therapy<br>ted R38 had received both<br>pational therapy upon<br>cility in May of 2016. PTA<br>continued from both therapies<br>a referral to nursing for R38 to<br>nbulation program with nursing<br>38 was able to ambulate with<br>ont wheeled walker up to 40<br>then PT and OT were stopped.<br>d serious concerns with<br>on and maintenance programs<br>onsistently. PTA stated felt<br>ugh nursing staff in the facility<br>ation and maintenance |                            | DEFICIENC   | "                               |                         |

| STATEMENT OF DEFICIENCIES (X<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 | CONSTRUCTION   |                                  | E SURVEY<br>PLETED     |
|--|---|--|---------------------|--|----------------------------------|------------------------|
|  |   | 00730  | B. WING             |  | 10/24/2016                       |                        |
| IAME OF F  | PROVIDER OR SUPPLIER  |  | DRESS, CITY, S      | TATE. ZIP CODE   |                                  |                        |
|  |   |  |                     | ENUE, PO BOX 96  |                                  |                        |
| RAZEE  | CARE CENTER   | FRAZEE,  | MN 56544            |  |                                  |                        |
| (X4) ID<br>PREFIX<br>TAG                               | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLE<br>DATE |
| 2 885  | Continued From pa   | age 97   | 2 885               |  |                                  |                        |
|  | months ago. R38 s which affected her  | herapy had stopped several<br>tated she had bad knees<br>ability to walk, but felt if she<br>nts" she would be able to walk  |                     |  |                                  |                        |
|  | room, and looked in<br>locations in her roo<br>R38 no longer had<br>stated she would en<br>available so nursing<br>PTA left R38's room<br>wheeled walker and<br>R38. PTA applied a<br>torso and cued R38<br>up to the walker why<br>gait belt. R38 was of<br>from the wheelchai<br>R38's knees remain<br>80 degree angle, w<br>or straighten her kr<br>R38 twice more an<br>stand erect or straig<br>she could not stand<br>stood up for a long<br>remember the last<br>PTA asked R38 wh<br>walked and R38 re<br>confirmed the last t<br>was in July, 2016. F | 36 a.m. PTA entered R38's<br>in her closet and various<br>im for her walker. PTA stated<br>a walker in her room and<br>xpect R38 to have a walker<br>g staff could assist her to walk.<br>in briefly, returned with a front<br>d placed the walker in front of<br>a transfer belt around R38's<br>8 to stand from her wheelchair<br>hile PTA pulled upwards on the<br>only able to lift her buttocks<br>r seat approximately 7 inches.<br>ned bent at approximately an<br>ras unable to stand fully erect<br>hees. PTA attempted to stand<br>d R38 continued to not able to<br>ghten her knees. R38 stated<br>d up all of the way and had not<br>time. R38 stated she could not<br>time she had used a walker.<br>en the last time she had<br>sponded, "with you." PTA<br>time she had worked with R38<br>PTA confirmed R38 had lost<br>and and to ambulate. |                     |  |                                  |                        |
|  | interview, PTA state<br>from therapy, R38 I<br>40-60 feet daily with<br>front wheeled walk<br>referred to an ambu   | 44 a.m. during a follow up<br>ed when R38 was discharged<br>had been ambulating about<br>h minimal assist of one and a<br>er. PTA stated R38 was<br>ulation maintenance program<br>e expected R38 to receive   |                     |  |                                  |                        |

|   | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | • •                               |  |               | E SURVEY<br>PLETED     |  |  |
|---|--|--|-----------------------------------|--|---------------|------------------------|--|--|
|   |  | 00730  | B. WING                           |  | - 10/24/2016  |                        |  |  |
|   | PROVIDER OR SUPPLIER   |  | ET ADDRESS, CITY, STATE, ZIP CODE |  |               |                        |  |  |
|   |  |  |                                   | NUE, PO BOX 96   |               |                        |  |  |
| -KAZEE  | CARE CENTER  | FRAZEE   | , MN 56544                        |  |               |                        |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG               | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE | (X5)<br>COMPLE<br>DATE |  |  |
| 2 885   | Continued From pa  | uge 98   | 2 885                             |  |               |                        |  |  |
| assistance with wal<br>daily. PTA stated sh<br>problem with the fac<br>ambulation/mainten |  | nance program due to staffing<br>d she felt there were not<br>nplete resident<br>nance programs.   |                                   |  |               |                        |  |  |
|   | dated 5/17/16, iden<br>weakness and falls<br>revealed R38 was<br>walking. The summ                       | ospital discharge summary<br>tified R38 had been treated fo<br>at home. The summary<br>having difficulty standing and<br>nary further revealed R38 was<br>or acute rehab due to lower<br>s.                                | r                                 |  |               |                        |  |  |
|   | 8/2/16, revealed R<br>(MD) had seen her<br>revealed R38 had p<br>was ambulating us<br>revealed R38's dau | hysician progress note dated<br>38's primary medical doctor<br>at the clinic. The note also<br>plateau in therapy, however,<br>ing a walker. The note further<br>lighter had concerns that R38<br>ession after therapy was |                                   |  |               |                        |  |  |
|   | 10/6/16, revealed F<br>another practitioner<br>a wheelchair for lor<br>and OT during the                 | aysician progress note dated<br>R38 had established care with<br>r. The note revealed R38 used<br>ng distances, had received PT<br>spring and summer, and at<br>reased care needs R38 was<br>long term patient.            |                                   |  |               |                        |  |  |
|   | indicated she was f<br>and contact guard<br>also indicated R38<br>assist to transfer w                   | plan updated 6/10/16,<br>fully ambulatory with a walker<br>assistance. R38's care plan<br>was receiving therapy and<br>ith one and gait belt, and R38<br>endently in wheelchair. R38's                                     |                                   |  |               |                        |  |  |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | ealth<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                            | CONSTRUCTION   |                                 | E SURVEY<br>PLETED      |
|--------------------------|---|---|----------------------------|--|---------------------------------|-------------------------|
|                          |   | 00730   | B. WING                    |  | 10/24/2016                      |                         |
| NAME OF I                | PROVIDER OR SUPPLIER  |   | DDRESS, CITY, ST           |  |                                 |                         |
| RAZEE                    | CARE CENTER   |   | ST MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 885                    | Continued From pa   | age 99  | 2 885                      |  |                                 |                         |
|                          | care plan did not id<br>6/10/16.  | lentify any updates past  |                            |  |                                 |                         |
|                          | dated 10/17/16, list<br>included R38 was a<br>toileting and ADL's<br>therapy for walking                          | Care Plan Group C form,<br>ted various interventions which<br>assist of one for transfers,<br>, and listed R38 received<br>. The form did not list any<br>for R38's ambulation.   |                            |  |                                 |                         |
|                          | Interdepartmental (<br>revealed therapy has<br>a ambulation progr<br>daily with front walk<br>40 feet. The form a | form titled, Resident Referral<br>Communication dated 7/8/16,<br>ad referred R38 to nursing for<br>ram to include ambulation twice<br>ker and one assistance up to<br>also identified R38 has<br>knee pain and if nursing had<br>all. | 9                          |  |                                 |                         |
|                          | record lacked furth ambulation status of  | edical record revealed the<br>er documentation of R38's<br>or progress and lacked<br>acility forms maintenance ADL  |                            |  |                                 |                         |
|                          |   | notes were reviewed from<br>6, revealed the following:  |                            |  |                                 |                         |
|                          | On 5/17/16, R38 w required one assist   | as full weight bearing and tance with ADL's.  |                            |  |                                 |                         |
|                          | On 6/10/16, the no with therapy.  | te indicated R38 was working  |                            |  |                                 |                         |
|                          |   | uestioned nursing staff on able to return home.   |                            |  |                                 |                         |
|                          | On 8/4/16, R38 rec  | uired one assist with ADL's.  |                            |  |                                 |                         |
|                          | R38's nursing prog  | ress notes lacked any   |                            |  |                                 |                         |

STATE FORM

| Minnesc       | ta Department of He  | alth  |                         |  |                | APPROVE            |
|---------------|--|---|-------------------------|--|----------------|--------------------|
|               | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | E CONSTRUCTION   |                | E SURVEY<br>PLETED |
|               |  |   |                         |  |                |                    |
|               |  | 00730   | B. WING                 |  | 10/2           | 24/2016            |
| NAME OF I     | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S          | TATE, ZIP CODE   |                |                    |
| FRAZEE        | CARE CENTER  |   | T MAPLE AVE<br>MN 56544 | ENUE, PO BOX 96  |                |                    |
| (X4) ID       | SUMMARY STA  | TEMENT OF DEFICIENCIES  | ID                      | PROVIDER'S PLAN OF   | CORRECTION     | (X5)               |
| PRÉFIX<br>TAG |  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG           | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | HE APPROPRIATE | COMPLETE<br>DATE   |
| 2 885         | Continued From pa  | ge 100  | 2 885                   |  |                |                    |
|               | documentation of F<br>in R38's ambulatior  | 38's ambulation and decline n status.   |                         |  |                |                    |
|               | nursing (ADON) co<br>ambulation/mainter<br>been implemented<br>nurse managers we<br>therapy referrals fo<br>programs were star<br>referred. ADON star<br>responsible to initia<br>Maintenance Activit<br>worksheet which we<br>type of assistance we<br>needed and the fre<br>program. ADON co<br>ambulation mainter<br>ambulate with R38<br>to 40 feet twice dail<br>expect R38's ambulation<br>not getting done du<br>stated she felt the M<br>complete all resider<br>On 10/24/16, at 9:2<br>stated she had und | 7 p.m. the assistant director of<br>nfirmed R38's<br>nance program had never<br>in July. ADON stated the<br>ere responsible to ensure<br>r ambulation/maintenance<br>rted once a resident was<br>ted the nurse manager was<br>te a facility form titled,<br>ty of Daily Living (ADL)<br>ould direct the NA on what<br>with ADL the individual resident<br>quency of the maintenance<br>nfirmed R38's referral for<br>nance program directed staff to<br>with a front wheeled walker up<br>y. ADON stated she would<br>lation program to be<br>intain and prevent further<br>tion. ADON stated she felt the<br>i/maintenance program was<br>te to staffing concerns and<br>NA did not have the time to<br>nts programs, including R38. |                         |  |                |                    |
|               | stated she was not ambulate. NM-A st   | aware R38 could not longer<br>ated she was not sure why<br>naintenance program had not  |                         |  |                |                    |
|               | Practice Registered<br>Practitioner (NP)-A   | 8 a.m. R38's Advanced<br>d Nurse/Certified Nurse<br>stated R38 had recently<br>th her in early October. NP-A  |                         |  |                |                    |

| STATEMENT OF DEFICIENCIES (<br>AND PLAN OF CORRECTION |  |  |                           | (X2) MULTIPLE CONSTRUCTION A. BUILDING:   |                                | E SURVEY<br>PLETED      |
|---|--|--|---------------------------|---|--------------------------------|-------------------------|
|   |  | 00730  | B. WING                   |   | 10/24/2016                     |                         |
| NAME OF F   | PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, ST          | TATE, ZIP CODE  | •                              |                         |
| RAZEE   | CARE CENTER  |  | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96  |                                |                         |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENC <sup>1</sup> | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 885   | Continued From pa  | -  | 2 885                     |   |                                |                         |
|   | through with therap<br>ambulation/mainter<br>would have expecte<br>ambulation per the<br>R38's previous prin   | hance programs and she<br>ed R38 to be assisted with<br>therapy referral. NP-A stated<br>nary physician had last seen<br>may have more to comment  |                           |   |                                |                         |
|   |  | t for R38's previous primary<br>hysician did not call back   |                           |   |                                |                         |
|   | 4/1/08 identified res<br>admission for a res<br>ambulation. If a am<br>identified need, a p<br>meet resident need<br>identified residents                      | d, Restorative Program, dated<br>sidents would be assessed on<br>torative program such as<br>ibulation program was an<br>lan would be individualized to<br>ls and goals. The policy further<br>would be supported and their<br>ctioning maintained.  |                           |   |                                |                         |
|   | Director of Nursing<br>polices and proced<br>monitoring residnet<br>appropriate restora<br>Director of Nursing<br>staff on the policies<br>Director of Nursing | THOD OF CORRECTION: The<br>or her designee could develop<br>ures regarding assessing and<br>t physical abilities and provide<br>tive nursing services. The<br>or her designee could educate<br>and procedures. The<br>or her designee could develop<br>n to ensure residents receive<br>e. | )                         |   |                                |                         |
|   | TIME PERIOD FOI<br>(21) Days   | R CORRECTION: Twenty One   |                           |   |                                |                         |

| Minnesc                  | ta Department of He  | alth   |                       |  | FORM              | APPROVED                 |
|--------------------------|--|--|-----------------------|--|-------------------|--------------------------|
| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                       | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>PLETED         |
|                          |  | 00730  | B. WING               |  | 10/24/2016        |                          |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S        | STATE, ZIP CODE  |                   |                          |
| FRAZEE                   | CARE CENTER  |  | 「MAPLE AV<br>MN 56544 | ENUE, PO BOX 96  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| 2 900                    | Continued From pa  | ge 102   | 2 900                 |  |                   |                          |
| 2 900                    | MN Rule 4658.0529<br>Ulcers  | 5 Subp. 3 Rehab - Pressure   | 2 900                 |  |                   | 11/17/16                 |
|                          | comprehensive res<br>of nursing services<br>development of a n<br>provides that:<br>A. a resident wh<br>without pressure so<br>pressure sores unle<br>condition demonstr<br>authenticates, that<br>B. a resident w<br>receives necessary | sores. Based on the<br>ident assessment, the director<br>must coordinate the<br>ursing care plan which<br>o enters the nursing home<br>ores does not develop<br>ess the individual's clinical<br>ates, and a physician<br>they were unavoidable; and<br>ho has pressure sores<br>y treatment and services to<br>revent infection, and prevent<br>veloping. |                       |  |                   |                          |
|                          | by:<br>Based on observati<br>review the facility th<br>timely repositioning<br>repositioning progra<br>be at risk for pressu   | ent is not met as evidenced<br>on, interview and document<br>he facility failed to complete<br>for residents on a turn and<br>am and who were assessed to<br>ure ulcers for 2 of 4 residents<br>and for pressure ulcers.   |                       | corrected  |                   |                          |
| linnerata D              | Review of R18's qu<br>(MDS) dated 7/26/1<br>cognitive impairment<br>communicate with st<br>included, dementia<br>MDS identified R18<br>for activities of daily   | arterly Minimum Data Set<br>6, identified R18 had severe<br>nt, was unable to<br>staff and had diagnoses which<br>, depression and anxiety. The<br>was totally dependent on staff<br>/ living (ADL's) and required 2<br>with bed mobility. The MDS   |                       |  |                   |                          |

|                          | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 |  |                                | E SURVEY<br>PLETED      |
|--------------------------|---|--|---------------------|--|--------------------------------|-------------------------|
|                          |   | 00730  | B. WING             |  | 10/                            | 24/2016                 |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AL  | DDRESS, CITY, S     | TATE, ZIP CODE   |                                |                         |
|                          | CARE CENTER   | 219 WES  | T MAPLE AVE         | NUE, PO BOX 96   |                                |                         |
| nazee                    | CARE CENTER   | FRAZEE   | , MN 56544          |  |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 900                    | Continued From pa   | age 103  | 2 900               |  |                                |                         |
|                          | ulcers and had inte<br>included a pressure  | at risk for developing pressure<br>erventions in place which<br>e reducing device for the chair<br>turning and repositioning   |                     |  |                                |                         |
|                          | identified R18 was<br>ADL's. The MDS ic<br>developing pressur<br>in place which inclu   | nnual MDS dated 4/26/16,<br>totally dependent on staff for<br>lentified R18 was at risk for<br>re ulcers and had interventions<br>uded a pressure reducing<br>r and R18 was on a turning and<br>am.  |                     |  |                                |                         |
|                          | Area Assessment (<br>R18 had cognitive<br>was unable to cohe<br>The CAA revealed<br>spite of her inability<br>R18's Communicat<br>needs must be ant<br>Pressure Ulcer CA<br>potential for skin be<br>incontinence, decre<br>to make her needs<br>R18 could move in<br>required staff assis<br>sitting position. The | ognitive Loss/ Dementia Care<br>(CAA) dated 4/26/16, identified<br>loss related to dementia and<br>erently verbalize her needs.<br>R18's needs were to be met in<br>/ to make her needs known.<br>tion CAA identified R18's<br>icipated by facility staff. R18's<br>A identified R18 had a<br>reakdown related to<br>eased mobility and her inability<br>known. The CAA revealed<br>dependently in bed but<br>stance to reposition when in a<br>e CAA identified R18 required a<br>f turning and had a pressure<br>n wheelchair. |                     |  |                                |                         |
|                          | dated 7/26/16, reve<br>skin breakdown ba<br>(assessment for pr<br>of 14 and a tissue to<br>revealed intervention<br>included, gel cushing   | rehensive Analysis of Skin form<br>ealed R18 was at high risk for<br>used on a Braden scale<br>redicting pressure sores) score<br>tolerance test. The form<br>ons were put in place which<br>on in wheelchair and R18<br>id repositioning with check and   |                     |  |                                |                         |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                        |  |                                   | E SURVEY<br>PLETED                  |
|--------------------------|--|---|----------------------------|--|-----------------------------------|-------------------------------------|
|                          |  | 00730   | B. WING                    | B. WING  |                                   | 24/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, S            | TATE, ZIP CODE   |                                   |                                     |
| RAZEE                    | CARE CENTER  |   | ST MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                   |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLE <sup>-</sup><br>DATE |
| 2 900                    | Continued From pa  | age 104   | 2 900                      |  |                                   |                                     |
|                          | change every 2 hours and as needed (PRN).<br>Review of R18's physician progress note dated<br>10/6/16, revealed R18 had been seen for a<br>routine nursing home visit. The note revealed<br>R18 had severe dementia and Alzheimer's<br>disease and was dependent on facility staff for<br>her needs. |   |                            |  |                                   |                                     |
|                          |  |   |                            |  |                                   |                                     |
|                          | 10/7/16, revealed F<br>was unable to com<br>totally dependent o<br>repositioning needs<br>skin breakdown.  | s and had a potential risk for<br>The care plan listed<br>included to assist R18 to turn<br>by 2 hours and prn, keep skin   |                            |  |                                   |                                     |
|                          |  | 7:03 a.m. to 10:39 a.m.,<br>ations of R18 revealed the  |                            |  |                                   |                                     |
|                          | a gel cushion, fully<br>bed was stripped o   | ras seated in a wheelchair with<br>dressed in her room. R18's<br>f its linens. R18's head was<br>chin to chest position and her   |                            |  |                                   |                                     |
|                          |  | emained seated in the<br>bom. No staff were observed to   | D                          |  |                                   |                                     |
|                          | by R18's roommate<br>the room to assist I<br>housekeeping staff<br>made R18's bed w  | Il light to R18's room was on<br>e, staff was observed to enter<br>R18's roommate. At that time,<br>entered R18's room and<br>hile she remained seated in<br>7:41 a.m. the housekeeping |                            |  |                                   |                                     |

|                          | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                           | CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|---|---|---------------------------|--|--------------------------------|-------------------------|
|                          |   | 00730   | B. WING                   |  | 10/24/2016                     |                         |
| NAME OF F                | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, ST          | TATE, ZIP CODE   |                                |                         |
| RAZEE                    | CARE CENTER   |   | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 900                    | Continued From pa   | age 105   | 2 900                     |  |                                |                         |
|                          | R18 remained with<br>was in a chin to chi<br>staff wheeled R18<br>and placed a clothi<br>At that time R18 cc<br>clothing protector.<br>At 7:56 a.m. R18 re<br>wheelchair in the d<br>(DA)brought R18 h<br>plate on the table in<br>At that time nursing<br>R18, verbally prom<br>handed her a spoo<br>breakfast foods inc | eled R18 to the dining room.<br>her eyes closed and her head<br>est position. Housekeeping<br>to a table in the dining room<br>ng protector around her neck.<br>overed her face with the<br>emained seated in the<br>ining room. A dietary aid<br>her breakfast plate, left the<br>n front of her and walked away<br>g assistant (NA)-G approached<br>pted her to begin eating and<br>n. R18 ate 100% of her<br>dependently. R18 remained |                           |  |                                |                         |
|                          |   | emained seated in her<br>lining room table, and made no   |                           |  |                                |                         |
|                          |   | emained seated in her<br>ining room, having made no<br>he table.  |                           |  |                                |                         |
|                          | wheelchair in the d eyes. Shortly after   | emained seated in her<br>ining room. R18 closed her<br>R18's head dropped forwards<br>osition. No staff offered to<br>positioning.  |                           |  |                                |                         |
|                          | wheelchair in the d<br>her eyes, looked an<br>protector and cove<br>attempt to move av  | emained seated in her<br>ining room. R18 had opened<br>round, took her clothing<br>red her face it. R18 made no<br>way from the table and left her<br>he clothing protector.  |                           |  |                                |                         |
|                          | At 9:37 a.m. NA-D   | entered the dining room, woke   |                           |  |                                |                         |

| STATEME                  | Dta Department of He<br>NT OF DEFICIENCIES<br>NOF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | CONSTRUCTION   |                                  | E SURVEY<br>PLETED      |
|--------------------------|--|--|-------------------------|--|----------------------------------|-------------------------|
|                          |  | 00730  | B. WING                 |  | 10/24/2016                       |                         |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AL  | DRESS, CITY, ST         | TATE, ZIP CODE   |                                  |                         |
| RAZEE                    | CARE CENTER  |  | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 900                    | R18 and offered he<br>the clothing protect<br>NA-D to assist her<br>50% of her juice. N<br>glass of water and<br>water. NA-D left R1<br>and left the dining r<br>to offer R18 assista<br>including reposition<br>At 9:42 a.m. medice<br>R18 and assisted h<br>fluids, while R18 re<br>wheelchair. MR ren<br>from R18's neck, R<br>covered her face w<br>At 9:50 a.m. MR as<br>room in her wheelc<br>and handed R18 a<br>call light to R18's w<br>MR was not observ<br>with any cares, incl<br>At 10:01 a.m. NA-E<br>R18's room, did no<br>At 10:09 a.m. NA-E<br>from R18's room, lo<br>walked away.<br>At 10:39 a.m. the A<br>(ADON) was notifie<br>her wheelchair for a<br>minutes. At that tim<br>required assistance<br>checking and chan-<br>time, the ADON con<br>skin breakdown. All | er fluids. R18 awoke, removed<br>or from her face and allowed<br>to drink her juice. R18 drank<br>A-D then handed R18 her<br>R18 independently drank the<br>8 seated in her wheelchair<br>oom. NA-D was not observed<br>ance with personal needs,<br>ing and toileting needs.<br>al records (MR) approached<br>her to drink her remaining<br>mained seated in her<br>noved the clothing protector<br>(18 then took her shirt and<br>ith it, in a cradling position.<br>sisted R18 out of the dining<br>hair, brought her to her room<br>stuffed bear. MR attached the<br>theelchair and left the room.<br>red to offer R18 assistance<br>uding repositioning or toileting. |                         | DEFICIENC  | τ,                               |                         |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | ealth<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                     | CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|--|--|-------------------------|--|--------------------------------|-------------------------|
|                          |  | 00730  | B. WING                 |  | 10/24/2016                     |                         |
| IAME OF                  | PROVIDER OR SUPPLIER   | STREET AL  | DRESS, CITY, ST         | ATE, ZIP CODE  |                                |                         |
| RAZEE                    | CARE CENTER  |  | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 900                    | Continued From pa  | age 107  | 2 900                   |  |                                |                         |
|                          | asked R18 to use t<br>gait belt around R1<br>assisted R18 to sta<br>ambulate to the bai<br>slacks and incontin<br>moderate amount of<br>small amount of sto<br>surface which had<br>pink creases and w<br>peri-rectal area. NA<br>R18 to complete to<br>back in her wheelc<br>On 10/19/16, at 10<br>thought R18 was la<br>a.m. and stated sho<br>others with cares to<br>and toileting needs<br>supposed to be rep<br>checked/changed e<br>NA-E stated R18 w<br>needs and staff wa<br>On 10/20/16, at 2:3<br>needs must be anti<br>dependent on 2 sta<br>repositioning and to<br>required routine ev<br>toileting. NA-B state<br>red at times, but co<br>areas on R18's but<br>On 10/20/16, at 3:2<br>(LPN)-B stated R18<br>staff for all of her n | <ul> <li>39 a.m. NA-E stated she</li> <li>ast repositioned around 6:45</li> <li>a had been too busy helping</li> <li>b assist R18 with repositioning</li> <li>b NA-E stated R18 was</li> <li>b ositioned and</li> <li>b overy 2 hours and as needed.</li> <li>b anticipate R18's needs.</li> <li>as not able to verbalize her</li> <li>b to anticipate R18's needs.</li> <li>b p.m. NA-B stated R18's</li> <li>b cipated as she was totally</li> <li>b for her needs, including</li> <li>b bileting. NA-B stated R18</li> <li>ery 2 hour repositioning and</li> <li>b constrained R18's buttocks would get</li> <li>b public but of the stated R18's would not recall any recent open</li> </ul> |                         |  |                                |                         |

| STATEMENT OF DEFICIENCIES ()<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                            |  | (X3) DATE SURVEY<br>COMPLETED  |                         |
|--|---|---|----------------------------|--|--------------------------------|-------------------------|
|  |   | 00730   | B. WING                    | à  |                                | 24/2016                 |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, ST           | TATE, ZIP CODE   |                                |                         |
| FRAZEE   | CARE CENTER   |   | ST MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG                               | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 900  | immobility.<br>On 10/21/16, at 1:3<br>interview the ADON<br>unable to routinely<br>in a timely manner<br>ADON stated they<br>for sick calls and the<br>facility were unable<br>R66's Admission M<br>dated 1/11/16, iden<br>cognitive impairme<br>staff for activities of<br>required 2 or more<br>The MDS further ic<br>which included trau-<br>disorder and diabe<br>R66 was at risk for<br>required a pressure<br>and bed, and requi-<br>program.<br>R66's quarterly Min<br>7/13/16 identified F<br>impairment, and wa<br>activities of daily liv<br>more staff to assist<br>further identified R | age 108<br>37 p.m. during a follow up<br>N stated she felt staff was<br>reposition and toilet residents<br>, due to staffing shortages. The<br>were not always able to fill in<br>here were times when the<br>to fill holes in the schedule.<br>Minimum Data Set (MDS),<br>htified R66 had severe<br>ant, was totally dependent of<br>f daily living (ADLs) and<br>staff to assist with bed mobility<br>dentified R66 had diagnoses<br>umatic brain injury, seizure<br>tes. The MDS also identified<br>developing pressure ulcers,<br>red a turning and repositioning<br>himum Data Set (MDS), dated<br>R66 had severe cognitive<br>as totally dependent of staff for<br>ring (ADLs), and required 2 or<br>t with bed mobility. The MDS<br>66 had diagnoses which<br>brain injury, seizure disorder | <b>/</b>                   |  |                                |                         |
|  | at risk for developin<br>pressure reducing<br>and required a turn<br>R66's Care Area At<br>1/11/16 identified F   | MDS also identified R66 was<br>ng pressure ulcers, required a<br>device for her chair and bed,<br>ning and repositioning program<br>ssessment (CAA), dated<br>R66 suffered from a traumatic<br>decreased ability to make  |                            |  |                                |                         |

| STATEMEN                 | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                            | CONSTRUCTION   |                              | E SURVEY<br>PLETED      |  |
|--------------------------|---|---|----------------------------|--|------------------------------|-------------------------|--|
|                          |   | 00730   | B. WING                    |  |                              | 10/24/2016              |  |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, S            | TATE, ZIP CODE   |                              |                         |  |
| FRAZEE                   | CARE CENTER   |   | ST MAPLE AVE<br>, MN 56544 | ENUE, PO BOX 96  |                              |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 900                    | perform ADLs with<br>staff. The CAA furth<br>risk for developing<br>inability to move he<br>was uncomfortable<br>her needs and ensi-<br>CAA further identifi<br>mattress and whee<br>regular schedule of<br>prevent pressure.<br>R66's care plan dat<br>at risk for developin<br>fragile skin, not bei<br>immobile and was<br>plan also identified<br>the bed or wear sha<br>feet, and was to be<br>according to her tu<br>care plan further id<br>and was to be check<br>hours.<br>Review of the Aide<br>10/17/16, identified<br>with cares, was to be<br>every 2 hours, and<br>or wear sheepskin<br>Review of a physic<br>identified R66's left<br>developing pressur<br>to be applied to hee<br>to be floated off the<br>Review of physician | but significant assistance from<br>her identified R66 was at high<br>pressure ulcers related to her<br>erself or ask for help when she<br>and staff were to anticipate<br>ure she was repositioned. The<br>ed R66 required a special<br>elchair cushion, and required a<br>f turning and repositioning to<br>ted 2/18/16, identified R66 was<br>ng pressure ulcers related to<br>ng able to turn herself, was<br>bed and chair bound. The care<br>R66 was to suspend heels off<br>eepskin boots to protect her<br>e turned and repositioned<br>rning and positioning plan. The<br>entified R66 was incontinent<br>cked and changed every 2<br>Care Plan, Group B, dated<br>R66 required total assistance<br>be turned and repositioned<br>was to float heels off the bed<br>boots.<br>ian note dated 12/31/15,<br>theel was at risk for<br>re ulcers, Eucerin cream was<br>els twice a day and heels were |                            | DEFICIENCY   |                              |                         |  |
| nesota D                 |   | physician's orders dated,<br>R66 had orders to suspend he   | r                          |  |                              |                         |  |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                                | CONSTRUCTION   |                | E SURVEY<br>PLETED      |  |
|--------------------------|---|---|--------------------------------|--|----------------|-------------------------|--|
|                          |   | 00730   | B. WING                        |  | 10/            | 10/24/2016              |  |
| NAME OF F                | PROVIDER OR SUPPLIER  | STREET AD   | ADDRESS, CITY, STATE, ZIP CODE |  |                |                         |  |
| RAZEE                    | CARE CENTER   |   | T MAPLE AVE<br>MN 56544        | NUE, PO BOX 96   |                |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG            | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE | (X5)<br>COMPLET<br>DATE |  |
| 2 900                    | Continued From pa   | age 110   | 2 900                          |  |                |                         |  |
|                          | heels off of her bed every shift for preventing alteration in skin integrity.                                 |   |                                |  |                |                         |  |
|                          | 1/4/16, identified R  | ive analysis of skin dated<br>66 had pink heels on<br>been free floated for   |                                |  |                |                         |  |
|                          | pressure sores) da<br>at high risk for deve<br>document also ider<br>mattress, heels we<br>R66 continued to n | e (assessment for predicting<br>ted 7/13/16, identified R66 was<br>eloping pressure ulcers. The<br>ntified R66 had a special<br>re to be kept off the bed and<br>eed to be repositioned and<br>n in her wheelchair because<br>of pressure ulcers. |                                |  |                |                         |  |
|                          | resident could be in skin damage) dated   | nce test (length of time<br>n the same position without<br>d 7/13/16, identified R66<br>positiong to prevent pressure   |                                |  |                |                         |  |
|                          | R66's progress not 10/17/16 identified:   | es reviewed from 12/31/15 to  |                                |  |                |                         |  |
|                          | right shin and ankle<br>PROFO boot, staff   | 2 cm X 0.5 cm area on her<br>e from possible rubbing on<br>removed boot and floated her<br>chair had built-in pressure  |                                |  |                |                         |  |
|                          | 2/4/16, R66 had an<br>ankle   | i intact blister on her right   |                                |  |                |                         |  |
|                          |   | ressed concern with R66's right<br>ined areas were from boot and<br>r.  |                                |  |                |                         |  |
|                          | 2/8/16, R66's areas   |   |                                |  |                | 1                       |  |

| STATEMEN                 | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | • •                     | CONSTRUCTION   |                                  | E SURVEY<br>PLETED      |
|--------------------------|--|---|-------------------------|--|----------------------------------|-------------------------|
|                          |  | 00730   | B. WING                 |  |                                  | 24/2016                 |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AL   | DRESS, CITY, ST         | TATE, ZIP CODE   |                                  |                         |
| FRAZEE                   | CARE CENTER  |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 900                    | Continued From pa  | ge 111  | 2 900                   |  |                                  |                         |
|                          | resolving  |   |                         |  |                                  |                         |
|                          | 2/9/16, R66 had superficial, abraded/scraped<br>area on her shin from profo boot and a blister to<br>her inner ankle from being up in her wheelchair<br>with socks off and suspected foot rubbed on foot<br>pedal  |   |                         |  |                                  |                         |
|                          | 2/10/16, blister hea   | ling, heels free floated  |                         |  |                                  |                         |
|                          | 2/13/16, areas to rig<br>resolved.   | ght foot/ankle and right shin   |                         |  |                                  |                         |
|                          | dark, and her door<br>dressed in a hospit<br>her back in bed. Re<br>and her body was o<br>legs were straight,<br>on her mattress. Sk<br>boots. R66's sheep<br>be piled up on R66<br>7:19 a.m. R66 was<br>bed, her eyes were<br>loud mouth breathin<br>the mattress and w<br>boots. At 7:39 a.m.<br>in her bed with her | 00 a.m. R66's bedroom was<br>was fully open. R66 was<br>al gown, and was asleep on<br>56's arms rested on her chest<br>covered with a blanket. R66's<br>and her heels rested directly<br>ne was not wearing sheep skin<br>skin boots were observed to<br>'s dresser across the room. At<br>in the same position in her<br>now open, continued with<br>ng and heels rested directly on<br>as not wearing her sheep skin<br>R66 was in the same position<br>eyes closed. R66's heels<br>ectly on her bed and was not<br>skin boots. |                         |  |                                  |                         |
|                          | entered R66's room<br>were not free floate<br>sheep skin boots.<br>heels were, "kind o<br>her mattress. LPN-<br>to approximately or  | ed practical nurse (LPN)-A<br>n. LPN-A stated R66's heels<br>ad and she was not wearing<br>LPN-A stated she felt R66's<br>f," floated by the bubbles in<br>A then pulled a flat pillow dowr<br>he inch under R66's calves<br>ft R66's heels off the mattress  |                         |  |                                  |                         |

|   | ta Department of He<br>TOF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION   |                 | E SURVEY<br>PLETED |  |
|---|---|---|-------------------------|--|-----------------|--------------------|--|
|   |   | 00730   | B. WING                 |  | 10/             | 0/24/2016          |  |
| NAME OF I   | PROVIDER OR SUPPLIER  | STREET AL   | DRESS, CITY, ST         | ATE, ZIP CODE  |                 |                    |  |
| FRAZEE  | CARE CENTER   |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                 |                    |  |
| (X4) ID   | SUMMARY STA   | TEMENT OF DEFICIENCIES  | ID                      | PROVIDER'S PLAN OF   | CORRECTION      | (X5)               |  |
| PRÉFIX<br>TAG   |   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG           | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | THE APPROPRIATE | COMPLET<br>DATE    |  |
| 2 900   | Continued From pa   | age 112   | 2 900                   |  |                 |                    |  |
|   | immediately left the room.  |   |                         |  |                 |                    |  |
| vo<br>rr<br>a<br>H<br>a<br>V<br>o<br>t<br>s<br>a<br>k<br>F<br>r<br>H<br>k<br>t<br>o<br>o<br>a<br>F<br>F | At 8:03 a.m. the registered nurse (RN) consultant<br>walked in to R66's room and immediately walked<br>out, towards the nurses station. At 8:28 a.m. R66<br>remained in the same position on her back,<br>asleep. R66 remained in that position without<br>heels floated, or sheepskin boots on until 10:05<br>a.m. |   |                         |  |                 |                    |  |
|   | developing pressur<br>think R66 had pres<br>stated R66 sometir<br>and sometimes the<br>bed. LPN-A stated<br>pressure mattress<br>repositioned and ch<br>hours. LPN-A confi<br>been repositioned of<br>that morning. At 10<br>observation (3 hour<br>confirmed both R66<br>and R66 had not w<br>heels and bottom w   | -A stated R66 was at risk for<br>re ulcers. She stated she didn't<br>sure ulcers in the past. LPN-A<br>nes wore her sheepskin boots<br>by floated R66 heels off the<br>R66 had an alternating air<br>and was supposed to be<br>necked and changed every 2<br>rmed the last time R66 had<br>was at approximately 6:00 a.m.<br>1:05 a.m. after continuous<br>rs and 5 minutes) LPN-A<br>6's heels rested on her bed<br>orn sheep skin boots. R66<br>were intact. NA-E entered<br>asisted LPN-A with R66's |                         |  |                 |                    |  |
|   | last time R66 was r<br>was supposed to b<br>checked and chang<br>she would have to<br>see when she repo<br>taking care of R66<br>felt R66 was was a   | E stated she didn't know the<br>repositioned. NA-E stated R66<br>be turned and repositioned,<br>ged every 2 hours. She stated<br>check with partner NA-D to<br>sitioned R66 as they were<br>for the day. NA-E stated she<br>t risk for developing pressure<br>n't think R66 had any skin  |                         |  |                 |                    |  |

| Minnesc                  | ta Department of He  | alth  |                                 |  |               |                          |
|--------------------------|--|---|---------------------------------|--|---------------|--------------------------|
|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE<br>A. BUILDING: _ |  |               | E SURVEY<br>PLETED       |
|                          |  | 00730   | B. WING                         |  | 10/24/2016    |                          |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET ADI  | DRESS, CITY, S                  | TATE, ZIP CODE   |               |                          |
| FRAZEE                   | CARE CENTER  |   | 「MAPLE AVE<br>MN 56544          | ENUE, PO BOX 96  |               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| 2 900                    | Continued From pa  | ge 113  | 2 900                           |  |               |                          |
|                          | <ul> <li>2 900 Continued From page 113</li> <li>didn't wear her sheep skin boots. NA-E confirmed her current care sheet did not direct the use of sheepskin boots. NA-E and LPN-A left R66's room after R66 was in her recliner with her heels floated by a pillow on the footrest of the recliner.</li> <li>On 10/19/16, at 10:40 a.m. NA-D stated she didn't know if R66 was at risk for developing pressure ulcers, or what R66's care plan directed her to do for R66's skin. She stated R66 had a special mattress, and stated she assumed R66 would be at risk. NA-D stated she didn't know if R66 had a history of pressure ulcers and wasn't aware of any sheep skin boots for R66. NA-D stated she did not reposition R66 this morning, and stated she thought the last time R66 had been repositioned was at approximately 630 a.m. by the night staff.</li> </ul> |   |                                 |  |               |                          |
|                          | recliner in front of h<br>heels floated on a p   | 10 p.m. R66 was seated in<br>er TV. R66 did not have her<br>billow and was not wearing her<br>R66's heels rested directly on<br>recliner. |                                 |  |               |                          |
|                          | interview NA-E stat<br>on staff for cares, a   | 3 p.m. during follow-up<br>ed R66 was totally dependent<br>and stated she couldn't really<br>nition was since she didn't talk.            |                                 |  |               |                          |
|                          | interview, NA-D sta<br>staff for her cares,  | 6 p.m. during follow-up<br>ted R66 was dependent on<br>and stated she wasn't sure<br>on was because she didn't talk.                      |                                 |  |               |                          |
| innonata D               | back, legs straight directly on her bed.   | 1 p.m. R66 laid in bed on her<br>out with her heels resting<br>R66 did not have her heels<br>, and was not wearing sheep                  |                                 |  |               |                          |

| STATEMEN                 | Ita Department of He<br>TOF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         |   |                                | E SURVEY<br>PLETED      |
|--------------------------|---|--|-------------------------|---|--------------------------------|-------------------------|
|                          |   | 00730  | B. WING                 |   | - 10/24/2016                   |                         |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S          | TATE, ZIP CODE  |                                |                         |
| FRAZEE                   | CARE CENTER   |  | ۲ MAPLE AVE<br>MN 56544 | ENUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 900                    | Continued From pa   | age 114  | 2 900                   |   |                                |                         |
|                          | interview, LPN-A st<br>dependent on staff<br>R66 was clearer so<br>stated she thought<br>she was clearer.<br>On 10/19/16, at 1:3<br>totally dependent o<br>she wasn't sure of<br>she didn't think R66<br>ulcers, and didn't k<br>ulcers in the past. N<br>rested directly on h<br>wearing sheepskin<br>Aide Care Sheet ar<br>had sheepskin boo<br>sheet, but R66's he | 6 p.m. during follow up<br>ated R66 was totally<br>for cares, and stated she felt<br>ome day's versus others and<br>R66 understood them when<br>84 p.m. NA-B stated R66 was<br>n staff for cares, and stated<br>R66's cognition. She stated<br>5 was at risk for pressure<br>now if R66 had pressure<br>NA-B confirmed R66's heels<br>er bed and she was not<br>boots. NA-B confirmed R66's<br>nd stated she didn't know R66<br>ts as they weren't on her<br>eels were supposed to floated<br>posed to be repositioned every |                         |   |                                |                         |
|                          | (RN)-A stated R66<br>impairment and wa<br>cares. She stated F<br>pressure ulcers bed<br>herself. She stated<br>had ever had any s<br>R66's heels were s<br>her bed, and the N/<br>R66 every 2 hours.<br>On 10/24/16, at 10<br>stated R66 had sev<br>was dependent on<br>was supposed to b   | 53 a.m. Unit Manager (UM-A)<br>vere cognitive impairment and<br>staff for cares. She stated R66<br>e repositioned every 2 hours,   |                         |   |                                |                         |
| innesota D               | her heels were sup<br>bed, or R66 was to  | posed to be floated off of her<br>wear sheepskin boots. R66<br>essure ulcers. She stated she   |                         |   |                                |                         |

| STATEME                  | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |   |                                 | E SURVEY<br>PLETED      |
|--------------------------|--|--|---------------------|---|---------------------------------|-------------------------|
|                          |  | 00730  | B. WING             |   | 10/24/2016                      |                         |
| IAME OF                  | PROVIDER OR SUPPLIER   | STREET AL  | DRESS, CITY, S      | TATE, ZIP CODE  |                                 |                         |
|                          |  |  |                     | NUE, PO BOX 96  |                                 |                         |
| RAZEE                    | CARE CENTER  | FRAZEE   | MN 56544            |   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 900                    | Continued From pa  | ge 115   | 2 900               |   |                                 |                         |
|                          | February from a pro-<br>and that's when the<br>implemented floatin<br>confirmed R66's me<br>directed staff to floa<br>wear sheep skin bo<br>R66 every 2 hours.<br>to follow R66's care<br>apply sheep skin bo<br>reposition R66 ever<br>ulcers. She stated sh<br>needed more educa-<br>floating of heels.<br>On 10/24/16, at 1:4<br>(NP)-A confirmed F<br>pressure ulcers on<br>physician's order to<br>12/31/15. NP-A cor<br>physician's or nursi-<br>boots.<br>On 10/25/16, at 5:0<br>stated R66 had dev<br>shin, and about a q<br>of her ankle on her<br>facility. She stated sh<br>R66 didn't move he<br>cause blisters. She<br>R66's room unless<br>Review of facility po<br>Integrity/Wound Ma<br>determined at risk f<br>receive the proper f<br>included specific ph | had a blister on her heel in<br>ofo boot or splint she wore,<br>ey discontinued the boot and<br>ng R66's heels. UM-A<br>ost recent care plan which<br>at R66's heels off the bed or<br>bots, and turn and reposition<br>She stated she expected staff<br>e plan and float her heels or<br>bots to R66's feet, and<br>ry 2 hours to prevent pressure<br>she felt nursing assistants<br>ation on repositioning and<br>5 p.m. nurse practitioner<br>R66's left heel was at risk for<br>admission, and there was a<br>of loat R66's heels since<br>offirmed there was not a<br>ng order to use the sheepskin<br>r5 p.m. family member (FM)-A<br>arely move her arms now. She<br>veloped a deep ulcer on her<br>uarter size blister on the inside<br>right foot after she got to the<br>they told her it was from her<br>r skin, and the boot was too<br>be questioned them because<br>er legs and feet enough to<br>stated no staff went into<br>they had to.<br>blicy, Pressure Ulcer/Skin<br>anagement identified residents<br>for loss of skin integrity would<br>treatment/services which<br>hysician ordered treatments,<br>guipment, and repositioning |                     |   |                                 |                         |

|               | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                            |  |                | E SURVEY<br>PLETED |
|---------------|---|--|----------------------------|--|----------------|--------------------|
|               |   | 00730  | B. WING                    |  | 10/24/2016     |                    |
| NAME OF F     | PROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, S            | TATE, ZIP CODE   |                |                    |
| RAZEE         | CARE CENTER   |  | ST MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                |                    |
| (X4) ID       | SUMMARY ST  |  |                            | PROVIDER'S PLAN OF C   | CORRECTION     | (X5)               |
| PRÉFIX<br>TAG |   | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | PREFIX<br>TAG              | (EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENC | HE APPROPRIATE | COMPLET<br>DATE    |
| 2 900         | Continued From pa   | age 116  | 2 900                      |  |                |                    |
|               | review the policies<br>and healing of pr<br>Nursing or her des<br>appropriate staff or<br>related to pressure<br>Nursing or her des<br>monitoring system<br>assessed and rece<br>development of pre   | rsing or her designee could<br>and procedures for prevention<br>ressure ulcers. The Director of<br>ignee could educate all<br>n the polices and procedures<br>e ulcers. The Director of<br>ignee could develop a<br>to ensure residents are<br>eive interventions to prevent the<br>essure ulcers.<br>R CORRECTION: Twenty-one | )                          |  |                |                    |
| 2 915         | MN Rule 4658.052  | 25 Subp. 6 A Rehab - ADLs  | 2 915                      |  |                | 11/17/1            |
|               | comprehensive res<br>home must ensure<br>A. a resident is<br>treatments and ser<br>abilities in activities<br>deterioration is a n<br>the resident's cond<br>part, activities of da<br>resident's ability to<br>(1) bathe, dre<br>(2) transfer ar<br>(3) use the toi<br>(4) eat; and<br>(5) use speec | s given the appropriate<br>rvices to maintain or improve<br>s of daily living unless<br>ormal or characteristic part of<br>dition. For purposes of this<br>aily living includes the<br>:<br>ss, and groom;<br>nd ambulate;   |                            |  |                |                    |
|               | This MN Requirem  | nent is not met as evidenced   |                            |  |                |                    |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | ealth<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                          | LE CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|---|--|--------------------------|---|--------------------------------|-------------------------|
|                          |   | 00730  | B. WING                  |   | 10/24/2016                     |                         |
| IAME OF F                | PROVIDER OR SUPPLIER  | STREET AI  | DDRESS, CITY,            | STATE, ZIP CODE   |                                |                         |
| RAZEE                    | CARE CENTER   |  | T MAPLE AV<br>, MN 56544 | ENUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 915                    | Continued From pa   | age 117  | 2 915                    |   |                                |                         |
|                          | review, the facility f<br>assistance with am<br>recommended by p  | ion, interview and document<br>ailed to ensure consistent<br>ibulation was provided as<br>physical therapy (PT) for 3 of 4<br>9, R46 ) who required<br>ibulation.  |                          | corrected   |                                |                         |
|                          | Findings include:   |  |                          |   |                                |                         |
|                          | Review of R44's quarterly Minimum Data Set<br>(MDS) dated 7/31/16, identified R44 was<br>cognitively intact and had diagnoses which<br>included generalized osteoarthritis, depressive<br>disorder and anxiety. The MDS identified R44<br>required limited assistance to ambulate in the<br>corridors and was independent in transfers, bed<br>mobility and walking in her room. The MDS<br>further identified R44 used a walker and a<br>wheelchair for mobility. The MDS revealed R44<br>was steady at all times during transitions, while<br>walking and when turning around and facing the<br>opposite direction. |  |                          |   |                                |                         |
|                          | Functional/Rehabil<br>Assessment dated<br>required assistance<br>unable to ambulate<br>related to an unste  | ctivity of daily living (ADL)<br>itation Potential Care Area<br>1/29/16, identified R44<br>e with some ADL's and was<br>any distance independently<br>ady gait. The CAA identified<br>h one nursing assistant (NA) a<br>elt. |                          |   |                                |                         |
|                          | identified R44 had rising from a seate  | alls CAA dated 1/29/16,<br>difficulty with balance upon<br>d position, when turning with<br>abulating long distances.  |                          |   |                                |                         |
|                          | Review of R44's cu  | irrent care plan updated   |                          |   |                                |                         |

| STATEMEN          | Dia Department of He<br>NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | CONSTRUCTION                               |                | E SURVEY<br>PLETED |  |
|-------------------|---|--|-------------------------|--|----------------|--------------------|--|
|                   |   | 00730  | B. WING                 |  | 10/            | 10/24/2016         |  |
| NAME OF           | PROVIDER OR SUPPLIER  |  | DRESS, CITY, ST         | TATE, ZIP CODE                             |                |                    |  |
| FRAZEE            | CARE CENTER   |  | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96                             |                |                    |  |
| (X4) ID<br>PREFIX | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL   | ID<br>PREFIX            | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT | TION SHOULD BE | (X5)<br>COMPLET    |  |
| TAG               | REGULATORY OR L   | SC IDENTIFYING INFORMATION)  | TAG                     | CROSS-REFERENCED TO<br>DEFICIENC           |                | DATE               |  |
| 2 915             | Continued From pa   | ge 118   | 2 915                   |  |                |                    |  |
|                   | mobility in a wheelc<br>with ambulation with  | 44 was independent with<br>hair and required assistance<br>h use of a walker. R44's care<br>o offer to walk with R44 to all  |                         |  |                |                    |  |
|                   | 10/17/16, listed vari<br>included R44 was a<br>directed staff to ass  | e Plan Group C form, dated<br>ous interventions which<br>assist one for ADL's and<br>sist R44 with ambulation twice<br>th a rear wheeled walker and  |                         |  |                |                    |  |
|                   | standard wheelchai<br>dining room and wh<br>table. R44 verbalize<br>obtained her food a<br>a.m. R44 had eater   | 6 a.m. R44 was seated in a<br>r, propelling herself into the<br>neeled herself up to a circular<br>ed her breakfast order,<br>nd ate independently. At 8:34<br>n 100% of her meal and at that<br>elf out of the dining room. |                         |  |                |                    |  |
|                   | Worksheet from Ap<br>identified R44's was<br>twice a day (BID) lo<br>with a walker and tr<br>also indicated R44 | form titled Maintenance ADL<br>ril 2016, to October 2016,<br>s on an ambulation program<br>ng distances in the hallways<br>ansfer belt. The worksheet<br>was to be assisted to<br>feet (ft.) R44's worksheets<br>ng:         |                         |  |                |                    |  |
|                   | R44 had received h  | pril 2016, worksheet identified<br>er ambulation program 16 out<br>n hours and 25 out of 31 days   |                         |  |                |                    |  |
|                   | identified R44 had r  | ay 21016, worksheet<br>received her ambulation<br>1 days in the am and 20 days   |                         |  |                |                    |  |

| STATEMEN                 | Dia Department of He<br>NT OF DEFICIENCIES<br>OF CORRECTION                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                        | CONSTRUCTION  |                                | E SURVEY<br>PLETED      |
|--------------------------|--|--|------------------------|---|--------------------------------|-------------------------|
|                          |  | 00730  | B. WING                |   | 10/24/2016                     |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, ST        | TATE, ZIP CODE  |                                |                         |
| RAZEE                    | CARE CENTER  |  | 「MAPLE AVE<br>MN 56544 | NUE, PO BOX 96  |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 915                    | Continued From pa  | age 119  | 2 915                  |   |                                |                         |
|                          | R44 had received h   | une 2016, worksheet identified<br>her ambulation program 8 out<br>m and 24 out of 30 days in the   |                        |   |                                |                         |
|                          | R44 had received h   | uly 2016, worksheet identified<br>her ambulation program 7 out<br>m and 12 out of 30 days in the   |                        |   |                                |                         |
|                          | identified R44 had   | ugust 2016, worksheet<br>received her ambulation<br>1 days in the am and pm.   |                        |   |                                |                         |
|                          | identified R44 had   | eptember 2016, worksheet<br>received her ambulation<br>ut of 30 in the am and 8 days   |                        |   |                                |                         |
|                          | identified R44 had   | October 2016, worksheet<br>received her ambulation<br>t of 17 in the the am and 0<br>e pm.   |                        |   |                                |                         |
|                          | assessment dated<br>discharged from the<br>placed on the nursi<br>program) and was | pational Therapy (OT)<br>3/12/15, revealed R44 was<br>erapy services and had been<br>ing gait list (ambulation<br>to ambulate with a front<br>h stand by assistance. |                        |   |                                |                         |
|                          |  | ambulation/maintenance<br>om OT was requested, the<br>to provide.  |                        |   |                                |                         |
|                          |  | re conference summary notes<br>/16 revealed the following:   |                        |   |                                |                         |
|                          | -8/16/16, did not ac program.  | dress R44's ambulation   |                        |   |                                |                         |

STATE FORM

|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                              |  |                                | E SURVEY<br>PLETED      |
|--------------------------|---|--|------------------------------|--|--------------------------------|-------------------------|
|                          |   | 00730  | B. WING                      |  | 10/                            | 24/2016                 |
| NAME OF I                | PROVIDER OR SUPPLIER  |  | DDRESS, CITY, S <sup>-</sup> |  |                                |                         |
| RAZEE                    | CARE CENTER   |  | ST MAPLE AVE<br>, MN 56544   | ENUE, PO BOX 96  |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIV<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 915                    | Continued From pa   | age 120  | 2 915                        |  |                                |                         |
|                          | ambulation in am a  | ived assistance with<br>and hs(hour of sleep) with<br>stance of one staff.   |                              |  |                                |                         |
|                          |   | R44 received frequent<br>and by assistance of one staff.   |                              |  |                                |                         |
|                          |   | ursing progress notes from<br>, revealed the following:  |                              |  |                                |                         |
|                          | -5/14/16, revealed staff.   | R44 ambulated in the hall with   |                              |  |                                |                         |
|                          | -10/15/16, revealed with staff.   | d R44 ambulated in the hall  |                              |  |                                |                         |
|                          |   | ntatio of R44's ambulation<br>Ilation status was found in<br>Iress.  |                              |  |                                |                         |
|                          | (NA)-F stated R44<br>cares on her own.<br>assistance to ambu<br>on an ambulation p<br>am and in the pm. | 59 p.m. nursing assistant<br>was able to complete most<br>NA-F stated R44 required<br>ulate in the hallways and was<br>program for twice a day in the<br>NA-F stated there were days<br>assisted to ambulate due to<br>g staff on the floor. |                              |  |                                |                         |
|                          | required limited as<br>and ambulation. Na<br>ambulation program<br>residents ambulation                 | 34 p.m. NA-B stated R44<br>sistance with ADL's of dressing<br>A-B stated R44 was on an<br>m for twice a day. NA-B stated<br>on/maintenance programs<br>one as they should due to not<br>his included R44.                                    |                              |  |                                |                         |
|                          |   | 24 p.m. licensed practical nurse<br>4 was on a ambulation  | e                            |  |                                |                         |

STATE FORM

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                       | CONSTRUCTION   |               | E SURVEY<br>PLETED      |
|--------------------------|---|---|---------------------------|--|---------------|-------------------------|
|                          |   | 00730   | B. WING                   |  | 10/24/2016    |                         |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AL   | DDRESS, CITY, S           | TATE, ZIP CODE   |               |                         |
| RAZEE                    | CARE CENTER   |   | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |               |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 2 915                    | Continued From pa   | age 121   | 2 915                     |  |               |                         |
|                          | stated R44 liked to was not assisted w  | program for twice a day in the am and pm. LPN-B stated R44 liked to walk and felt the times R44 was not assisted with ambulation was due to not enough staff on the floor.  |                           |  |               |                         |
|                          | on a walking progra<br>walk twice a day. F<br>to 3 times a day an<br>was walked once a<br>told her they were to<br>not receive her am<br>that had been happ<br>several months. R<br>around the entire b<br>perimeter around th<br>time would get a bi<br>like she should. R4<br>was not as steady<br>R44 stated she fea<br>to walk if she did no<br>program of twice a<br>therapy assess her<br>R44 stated she felt | :08 a.m. R44 stated she was<br>am which she was supposed to<br>R44 stated she used to walk up<br>of stated she was lucky if she<br>a day. R44 stated the staff had<br>too busy on the days she did<br>bulation program. R44 stated<br>bening routinely for the last<br>44 stated she was able to walk<br>lock (200 feet square<br>he nursing station,) but at the<br>t winded due to not walking<br>44 stated she felt as though she<br>on her legs as she used to be.<br>and she would lose her ability<br>ot continue with her ambulation<br>day. R44 agreed to having<br>ability to walk at that time.<br>bad the nursing staff was<br>and did not want to add to their<br>t to be walked. |                           |  |               |                         |
|                          | (RN)-A confirmed F<br>program twice daily<br>walker and gait bel<br>R44 was routinely   | :18 a.m. registered nurse<br>R44 was on an ambulation<br>y to 200 feet with assist of one,<br>t. RN-A did not comment if<br>receiving her ambulation<br>d R44 would be best person to<br>n.   |                           |  |               |                         |
|                          | therapy assistant (<br>been referred to nu<br>program last year a   | :38 a.m. certified occupational<br>COTA) confirmed R44 had<br>Irsing for an ambulation<br>and was to be ambulated twice<br>th one assist, gait belt and   |                           |  |               |                         |

| STATEMEN      | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:     |                         | CONSTRUCTION   |                | E SURVEY<br>PLETED |
|---------------|---|---|-------------------------|--|----------------|--------------------|
|               |   | 00730   | B. WING                 |  | 10/24/2016     |                    |
| NAME OF       | PROVIDER OR SUPPLIER  | STREET AI   | DRESS, CITY, S          | TATE, ZIP CODE   |                |                    |
| FRAZEE        | CARE CENTER   |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                |                    |
| (X4) ID       |   | TEMENT OF DEFICIENCIES                                    | ID                      | PROVIDER'S PLAN OF   |                | (X5)               |
| PREFIX<br>TAG |   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | PREFIX<br>TAG           | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | HE APPROPRIATE | COMPLET<br>DATE    |
| 2 915         | Continued From pa   | age 122   | 2 915                   |  |                |                    |
|               | walker. OTA stated  | she felt R44 would be able to                             |                         |  |                |                    |
|               |   | to ambulate when the                                      |                         |  |                |                    |
|               |   | stently implemented. COTA                                 |                         |  |                |                    |
|               | stated she felt there   | e were huge problems with the                             |                         |  |                |                    |
|               |   | program due to not enough                                 |                         |  |                |                    |
|               |   | A stated the NA's were                                    |                         |  |                |                    |
|               | responsible for con   |   |                         |  |                |                    |
|               |   | nance programs and were too                               |                         |  |                |                    |
|               |   | y complete each residents                                 |                         |  |                |                    |
|               |   | ted NA's had verbalized they                              |                         |  |                |                    |
|               |   | ble to complete residents<br>vere unable to due to not    |                         |  |                |                    |
|               | enough staff.   |   |                         |  |                |                    |
|               |   |   |                         |  |                |                    |
|               |   | :46 a.m. physical therapy                                 |                         |  |                |                    |
|               |   | sisted R44 to ambulate in the                             |                         |  |                |                    |
|               |   | belt, walker and contact guard                            |                         |  |                |                    |
|               |   | she was getting, "short on air,"                          |                         |  |                |                    |
|               |   | been happening lately when                                |                         |  |                |                    |
|               |   | imbulated to her wheelchair                               |                         |  |                |                    |
|               |   | contact guard assist from PTA.                            |                         |  |                |                    |
|               |   | ated she never used to get                                |                         |  |                |                    |
|               |   | he walked and she was not                                 |                         |  |                |                    |
|               |   | ar as she used to. R44 then                               |                         |  |                |                    |
|               |   | ve her gait belt and thanked                              |                         |  |                |                    |
|               | PTA for the walk.   |   |                         |  |                |                    |
|               | On 10/21/16, at 10:   | :50 a.m. PTA stated she felt                              |                         |  |                |                    |
|               |   | pulate the distance the same                              |                         |  |                |                    |
|               |   | ast seen her. PTA stated as far                           |                         |  |                |                    |
|               |   | R44's shortness of breath was                             |                         |  |                |                    |
|               |   | e to not consistently receiving                           |                         |  |                |                    |
|               | her ambulation pro  | gram. PTA stated she had                                  |                         |  |                |                    |
|               |   | vere not consistently receiving                           |                         |  |                |                    |
|               |   | aintenance programs due to                                |                         |  |                |                    |
|               |   | TA stated she had placed                                  |                         |  |                |                    |
|               |   | enance programs and has had                               |                         |  |                |                    |
|               |   | to therapy for treatment due                              |                         |  |                |                    |
|               | to a decline. PIA si  | tated she felt this was due to                            |                         |  |                |                    |

| STATEMEN                 | DIA Department of He<br>NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                           | CONSTRUCTION  |                                | E SURVEY<br>PLETED      |
|--------------------------|---|---|---------------------------|---|--------------------------------|-------------------------|
|                          |   | 00730   | B. WING                   |   | 10/24/2016                     |                         |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, ST          | TATE, ZIP CODE  |                                |                         |
| FRAZEE                   | CARE CENTER   |   | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96  |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 915                    |   | -   | 2 915                     |   |                                |                         |
|                          | residents programs<br>were responsible fa<br>ambulation/mainte<br>there were not eno<br>stated she had void<br>residents ambulation<br>nursing and admin<br>medicare meeting<br>ago. PTA stated th<br>was the staff were<br>On 10/21/16, at 11<br>nursing (ADON) co<br>consistently receive<br>ADON stated she e<br>complete ambulation<br>resident. ADON state<br>ambulation/mainte<br>done due to staffin<br>the NA's did not has<br>residents programs<br>she did not feel R4<br>ambulate and woul<br>wanted to be ambu<br>R29<br>R29 had not been | nance programs, however,<br>ugh NA'S on the floor. PTA<br>ced her concerns about<br>on/maintenance programs to<br>istration during the weekly<br>as recently as a month or so<br>he response she had received<br>going to "talk" to the NA's.<br>:13 a.m. assistant director of<br>onfirmed R44 was not<br>ing her ambulation program.<br>expected staff to routinely<br>on/maintenance programs for<br>ated she felt the facility's<br>nance program was not getting<br>g concerns and stated she felt<br>twe the time to complete all<br>s, including R44. ADON stated<br>4 had lost any ability to<br>Id ask R44 how often she |                           |   |                                |                         |
|                          | nursing assistant g<br>nursing assistance<br>for residents).<br>R29's Order Summ<br>identified R29 had  | noup sheet (a reference<br>used regarding specific care<br>nary form dated 9/16/16,<br>diagnoses which included   |                           |   |                                |                         |
| nnosota D                | R29's admission N<br>7/14/16, identified  | malaise, and psychosis.<br>Ainimum Data Set (MDS) dated<br>R29 had severe cognitive<br>equired extensive assistance   | k                         |   |                                |                         |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | · · /                         |  |                                  | E SURVEY<br>PLETED     |  |
|--------------------------|---|---|-------------------------------|--|----------------------------------|------------------------|--|
|                          |   | 00730   | B. WING                       |  | 10/24/2016                       |                        |  |
| IAME OF F                | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, STATE, ZIP CODE |  |                                  |                        |  |
| RAZEE                    | CARE CENTER   |   | T MAPLE AVE<br>, MN 56544     | NUE, PO BOX 96   |                                  |                        |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLE<br>DATE |  |
| 2 915                    | Continued From pa   | ige 124   | 2 915                         |  |                                  |                        |  |
|                          | the unit, dressing a  | nsfer, locomotion on and off o<br>and hygiene. The MDS<br>on did not occur for R29 during<br>riod.  |                               |  |                                  |                        |  |
|                          | R29 had dementia,<br>memory problems,<br>appeared related to  | AA dated 7/14/16, identified<br>both short term and long term<br>and had poor balance which<br>decreased weight bearing<br>I prior to admission.                                |                               |  |                                  |                        |  |
|                          | revealed R29 had a<br>walker with assist<br>ambulation, toileting<br>R29's care plan dire                     | plan revised 10/14/16,<br>an unsteady gait, used a<br>of one and assist with<br>g, and mobility as needed.<br>ected assist of one with front<br>d wheelchair for ambulation.    |                               |  |                                  |                        |  |
|                          | her wheelchair, at a<br>propelled herself w<br>room towards her r<br>On 10/19/2016, at<br>her wheelchair with | 9:02 a.m. R29 self propelled<br>her feet in the hall. R29<br>ns to her room and then  |                               |  |                                  |                        |  |
|                          | nurse (LPN)-C amb<br>desk with a front w<br>around R29's waist  | 9:57 a.m. R29 propelled her   |                               |  |                                  |                        |  |
|                          | Interdepartmental (<br>to nursing from phy<br>receive the followin<br>ambulate twice dail                     | ed Resident Referral,<br>Communication dated 8/4/16,<br>/sical therapy directed R29<br>g: "Recommend Pt (patient)<br>y with fww (front wheeled<br>nd CGA (contact guard assist) |                               |  |                                  |                        |  |

| STATEMEN   | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |  |                                 | E SURVEY<br>PLETED      |  |  |
|--|--|---|---------------------|--|---------------------------------|-------------------------|--|--|
|  |  | 00730   | B. WING             |  | 10/24/2016                      |                         |  |  |
| NAME OF  | PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, S     | TATE, ZIP CODE   |                                 |                         |  |  |
| FRAZEE CARE CENTER       219 WEST MAPLE AVENUE, PO BOX 96         FRAZEE, MN 56544 |  |   |                     |  |                                 |                         |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |  |
| 2 915  | Continued From pa  | age 125   | 2 915               |  |                                 |                         |  |  |
|  | therapy. Pt may rec  | ambulated up to 150' in<br>quire verbal cues to maintain<br>d take larger steps."   |                     |  |                                 |                         |  |  |
|  | through 10/23/16, t<br>received therapy fo<br>not note that reside<br>nursing staff to aml<br>day, nor was there   | es were reviewed 6/30/16,<br>he notes identified R29 had<br>or strengthening; however did<br>ent had received the referral for<br>bulate resident two times a<br>documentation that R29 had<br>n services with floor staff.   | -                   |  |                                 |                         |  |  |
|  |  | ambulation program sheet in nt maintenance book.  |                     |  |                                 |                         |  |  |
|  | assistant (PTA) sta<br>with residents amb<br>programs being con<br>stated felt there wa<br>the facility to compl<br>maintenance progr<br>stated residents su<br>receive their ambul<br>On 10/24/2016, at<br>R29 was not on a w<br>indicated R29 woul | 20 a.m. physical therapy<br>ted she had serious concerns<br>ulation and maintenance<br>mpleted consistently. PTA<br>is not enough nursing staff in<br>lete ambulation and<br>ams on a routine basis. PTA<br>ch as R29 did not routinely<br>lation programs.<br>10:14 a.m. NA-I indicated<br>valking program. NA-I<br>d self transfer and staff would<br>r room to the bathroom. |                     |  |                                 |                         |  |  |
|  |  | 10:16 a.m. (NA)-E indicated<br>luled on a list for an<br>n.   |                     |  |                                 |                         |  |  |
|  | assistant (PTA)-G i<br>reached their goal i<br>from therapy servic<br>ambulation or lowe   | t 10:32 a.m. physical therapy<br>ndicated residnets who had<br>in therapy were discontinued<br>ces and then continue with a<br>r extremity exercise program<br>the nursing assistants in orde   | r                   |  |                                 |                         |  |  |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                     |  | (X3) DATE SURVEY<br>COMPLETED<br>10/24/2016 |                         |
|--------------------------|--|--|-------------------------|--|---|-------------------------|
|                          |  | 00730  | B. WING                 |  |   |                         |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AL  | DDRESS, CITY, ST        | TATE, ZIP CODE   |   |                         |
| FRAZEE                   | CARE CENTER  |  | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ON SHOULD BE<br>HE APPROPRIATE              | (X5)<br>COMPLET<br>DATE |
| 2 915                    | to maintain the pro-<br>therapy. PTA-G ver<br>therapy in August of<br>currently walking tw<br>PTA-G indicated ar<br>would not be enoug<br>walking program.<br>On 10/24/16, at 10<br>(CM)-B indicated R<br>program for one sta<br>hallway with use of<br>was unaware how of<br>verified R29's Resi<br>Interdepartmental O<br>to nursing from phy<br>following: "Recomm<br>twice daily with fww<br>belt, and CGA (card<br>has ambulated up to<br>require verbal cues<br>and take larger ste<br>have a form which<br>program in the NA<br>verified the NA group<br>current care plan a<br>R29 was to receive<br>two times a day witt<br>CM-B indicated witt<br>observations of R2<br>was unaware if R29<br>ambulation program<br>feet.<br>On 10/24/16, at 111<br>R29's ambulation a | gress which was made in<br>rified R29 was discharged from<br>of 2016, and should be<br>vo times a day up to 150 feet.<br>mbulation into the bathroom<br>gh steps to be considered a<br>:52 a.m. the clinical manager<br>(29 had an ambulation<br>aff to walk the full length of the<br>a gait belt and a walker. CM-B<br>often R29 ambulated. CM-B |                         |  |   |                         |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                            | CONSTRUCTION   |                                 | E SURVEY<br>PLETED      |
|--------------------------|--|---|----------------------------|--|---------------------------------|-------------------------|
|                          |  | 00730   | B. WING                    |  | 10/24/2016                      |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, ST           | TATE, ZIP CODE   |                                 |                         |
| FRAZEE                   | CARE CENTER  |   | ST MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 915                    | Continued From pa  | age 127   | 2 915                      |  |                                 |                         |
|                          | ambulation as whe from physical thera  | n she had been discharged<br>py services.   |                            |  |                                 |                         |
|                          | R46<br>R46 was not receiv<br>directed by physica   | ring ambulation services as<br>Il therapy.  |                            |  |                                 |                         |
|                          | On 10/24/2016, at 11:00 p.m. R46 was laying on<br>top of her bed on her right side, covered with two<br>small blankets, the call light was secured to the<br>grab bar attached to the side of the bed, and a<br>wheel chair was approximately 3 feet from the<br>bed in which R46 lay. |   |                            |  |                                 |                         |
|                          |  | rders dated 9/20/16, identified<br>I muscle weakness, syncope   |                            |  |                                 |                         |
|                          | 8/11/16, identified F<br>required extensive<br>locomotion on and<br>toilet use, limited a<br>personal hygiene.   | nimum Data Set (MDS) dated<br>R46 had intact cognition, and<br>assistance for transfer,<br>off of the unit, dressing and<br>ssistance for bed mobility and<br>The MDS identified ambulation<br>46 during the assessment |                            |  |                                 |                         |
|                          | 11/9/15, included: (<br>Functional status: /<br>limited assistance (   | ssessment (CAAS) dated<br>Cognitive Patterns- intact.<br>Activities of daily living status-<br>of one staff for transfers,<br>of staff to ambulate in room,<br>dor did not occur.                                       |                            |  |                                 |                         |
|                          | Interdepartmental (<br>to nursing from phy<br>receive the followin<br>(patient) with RW (  | ed Resident Referral,<br>Communication dated 11/6/15,<br>vsical therapy directed R46<br>ng: "Please ambulate Pt<br>regular walker), transfer belt,<br>K (times) daily. Pt. amb.   |                            |  |                                 |                         |

|                          | Dia Department of He<br>NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|--|--|-------------------------|--|--------------------------------|-------------------------|
|                          |  | 00730  | B. WING                 |  | 10/24/2016                     |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AI  | DDRESS, CITY, S         | TATE, ZIP CODE   |                                |                         |
| RAZEE                    | CARE CENTER  |  | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC <sup>1</sup> | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 915                    | Continued From pa  | age 128  | 2 915                   |  |                                |                         |
|                          | (ambulate) up to 20  | 00' any ? (questions) call."   |                         |  |                                |                         |
|                          | R46 had an unstea  | plan revised 8/22/16, revieled<br>dy gait and weakness, SBA<br>one for transfer and with   |                         |  |                                |                         |
|                          | through 10/1/16, d   | es were reviewed 4/3/16,<br>id not note that R46 had<br>n services with floor staff.   |                         |  |                                |                         |
|                          |  | ambulation program sheet in nt maintenance book.   |                         |  |                                |                         |
|                          | R29 was not schec<br>ambulation program  | 10:16 a.m. (NA)-E indicated<br>luled on a list for an<br>n. NA-E stated R29 could pivo<br>couple steps but not walk any  |                         |  |                                |                         |
|                          | assistant (PTA)-G i<br>reached their goal<br>from therapy servic<br>ambulation or lowe<br>to be completed by<br>to maintain the pro<br>therapy. PTA-G ver<br>from therapy and s<br>times a day up to 2<br>tolerated. PTA-G in<br>to be walking with I<br>program should co | t 10:32 a.m. physical therapy<br>ndicated residnets who had<br>in therapy were discontinued<br>es and then continued with a<br>r extremity exercise program<br>r the nursing assistants in order<br>gress which was made in<br>rified R46 had been discharged<br>should be currently walking two<br>00 feet or as far as R46<br>idicated she would expect staff<br>R46 in the hall and the<br>ntinue unless the resident had |                         |  |                                |                         |
|                          | if a decline were to<br>be re-screened. PT   | zation or pain. PTA-G indicated<br>occur the resident should ther<br>A-G indicated ambulation into<br>d not be enough steps to be<br>ng program.   |                         |  |                                |                         |
|                          | On 10/24/16, at 10 epartment of Health   | :52 a.m. the clinical manager  |                         |  |                                |                         |

| STATEMEN                 | Dita Department of He<br>NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                           | CONSTRUCTION   |                                  | E SURVEY<br>PLETED      |
|--------------------------|---|--|---------------------------|--|----------------------------------|-------------------------|
|                          |   | 00730  | B. WING                   |  | 10/24/2016                       |                         |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AI  | DDRESS, CITY, ST          | TATE, ZIP CODE   |                                  |                         |
| RAZEE                    | CARE CENTER   |  | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 915                    | (CM)-B indicated si<br>ambulate. CM-B in<br>therapy was receive<br>or other exercise p<br>form for the nursing<br>maintenance book.<br>Referral, Interdepa<br>11/6/15, to nursing<br>the following: "Plea<br>RW (regular walker<br>(assist) 2 X (times)<br>to 200' any ? (ques<br>did not have a form<br>program in the NA<br>review of R46's cha<br>ambulation program<br>months of Decemb<br>July 2016, but no fu<br>documentation was<br>R46's ambulation p<br>being performed.<br>On 10/24/16, at 11:<br>nursing staff did no<br>had not asked her<br>walking with the us | age 129<br>he had never seen R46<br>ndicated when a referral from<br>ed for an ambulation program<br>rogram it would be written on a<br>g assistants(NA) in the NA<br>CM-B verified R46's Resident<br>rtmental Communication dated<br>from physical therapy directed<br>se ambulate Pt (patient) with<br>r), transfer belt, and 1 A<br>daily. Pt. amb. (ambulate) up<br>tions) call." CM-B verified R46<br>o which directed the ambulation<br>maintenance book. With<br>art, CM-B verified the<br>n had been in place for the<br>per 2015, April, May, June and<br>urther ambulation program<br>s found. The CM-B verified<br>program was not currently<br>c11 a.m. R46 verified the<br>t walk with her in the hall and<br>to walk with them. While<br>e of a walker, gait belt and<br>," I can feel I have not walked |                           |  |                                  |                         |
|                          | in a while, I can fee<br>approximately 8 fee<br>stop a while to rest<br>minutes, R46 conti  | I it in my arms." R46 walked<br>et, stopped and requested to<br>her arms. After resting a few<br>nued to walk with PTA-G back<br>as breathing heavily when she   |                           |  |                                  |                         |
|                          | R46's ambulation a<br>stand from bed and<br>the hall. R46 was a<br>from her room towa   | 11 a.m. (PTA)-G assessed<br>bility. PTA-G assisted R46 to<br>ambulate out of her room into<br>ble to ambulate 1/2 of the hall<br>ard the nurses desk and then<br>PTA-G indicated R46 had not   |                           |  |                                  |                         |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED  |                         |
|--------------------------|--|--|---|--|--------------------------------|-------------------------|
|                          |  | 00730  | B. WING                                 |  | 10/24/2016                     |                         |
| NAME OF                  | PROVIDER OR SUPPLIER   |  | DDRESS, CITY, ST                        | TATE, ZIP CODE   |                                |                         |
| RAZEE                    | CARE CENTER  |  | T MAPLE AVE<br>MN 56544                 | NUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 915                    | declined and had re<br>level with ambulatic<br>discharged from ph<br>On 10/24/16, at 11:<br>with R46 identified<br>walk more; howeve<br>were very busy and<br>assistance and tool<br>On 10/24/16, at 2:0<br>(PA)-A indicated sh<br>follow resident care<br>recommended walk<br>prevent resident care<br>recommended walk<br>prevent resident gua<br>not providing recom<br>is not uncommon h<br>A facility policy titled<br>4/1/08, identified re<br>admission and as r<br>program including a<br>identified residents<br>highest level of fund<br>SUGGESTED MET<br>The director of nurs<br>could review or rev<br>for staff regarding r | emained at the functioning<br>on as when she had been<br>hysical therapy services.<br>24 a.m. a follow up interview<br>she was aware she should<br>ir, believed the facility staff<br>I she required a lot of<br>k a lot of the staffs time.<br>0 p.m. physician assistant<br>e would expect facility staff to<br>e plans and to initiate<br>sing or exercise programs to<br>nctional decline and a decline<br>ality of life. PA-A stated, " Sadly<br>mended restorative exercises<br>ere."<br>d, Restorative Program, dated<br>sidents would be assessed on<br>needed for a restorative<br>ambulation. The policy further<br>would be supported and their<br>ctioning maintained.<br>THOD OF CORRECTION:<br>sing (DON) and/or designee<br>ise policies, provide education<br>esident ambulation services.<br>ment and Assurance (QAA)<br>o random audits to ensure<br>R CORRECTION: |   |  |                                |                         |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                        | E CONSTRUCTION (X  | 3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|--|------------------------|--|-----------------------------|
|                          |   | 00730  | B. WING                |  | 10/24/2016                  |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                        | STATE, ZIP CODE  |                             |
| FRAZEE                   | CARE CENTER   |  | T MAPLE AV<br>MN 56544 | ENUE, PO BOX 96  |                             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                             |
| 2 920                    | Continued From pa   | ge 131   | 2 920                  |  |                             |
| 2 920                    | MN Rule 4658.052  | 5 Subp. 6 B Rehab - ADLs   | 2 920                  |  | 11/17/16                    |
|                          | comprehensive res<br>home must ensure<br>B. a resident who<br>activities of daily liv   | is unable to carry out<br>ing receives the necessary<br>n good nutrition, grooming,  |                        |  |                             |
|                          | by:<br>Based on observati<br>review the facility fa<br>were completed in<br>residents (R18) rev   | ent is not met as evidenced<br>ion, interview and document<br>ailed to ensure personal cares<br>a timely manner for 1 or<br>iewed for urinary incontinence<br>n a routine check and change   |                        | corrected  |                             |
|                          | Findings include:   |  |                        |  |                             |
|                          | (MDS) dated 7/26/1<br>cognitive impairment<br>communicate with so<br>included, dementia<br>MDS identified R18<br>for activities of daily<br>staff for assistance<br>hygiene and toiletin<br>was frequently inco<br>The MDS identified | arterly Minimum Data Set<br>16, identified R18 had severe<br>nt, was unable to<br>staff and had diagnoses which<br>, depression and anxiety. The<br>8 was totally dependent on staff<br>y living (ADL's) and required 2<br>with bed mobility, personal<br>Ig. The MDS identified R18<br>Intinent of bowel and bladder.<br>R18 was not on a toileting<br>or bladder incontinence. |                        |  |                             |
|                          | identified R18 was<br>ADL's. The MDS id<br>incontinent of bowe  | nual MDS dated 4/26/16,<br>totally dependent on staff for<br>entified R18 was frequently<br>el and bladder. The MDS<br>not on a toileting program for  |                        |  |                             |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                            | CONSTRUCTION  |                                 | E SURVEY<br>PLETED      |
|--------------------------|---|---|----------------------------|---|---------------------------------|-------------------------|
|                          |   | 00730   | B. WING                    |   | 10/24/2016                      |                         |
| NAME OF F                | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, S            | TATE, ZIP CODE  |                                 |                         |
| RAZEE                    | CARE CENTER   |   | ST MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96  |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 920                    | Continued From pa   | age 132   | 2 920                      |   |                                 |                         |
|                          | bowel or bladder in   | ncontinence.  |                            |   |                                 |                         |
|                          | Area Assessment (<br>R18 had cognitive<br>was unable to cohe<br>The CAA revealed<br>spite of her inability<br>Communication CA<br>be anticipated by fa<br>Incontinence CAA<br>incontinent of bowe | ognitive Loss/ Dementia Care<br>(CAA) dated 4/26/16, identified<br>loss related to dementia and<br>erently verbalize her needs.<br>R18's needs were to be met in<br>y to make requests. R18's<br>AA identified R18's needs must<br>acility staff. Urinary<br>identified R18 was frequently<br>el and bladder and needed<br>mobility and was toileted or<br>d. | 1                          |   |                                 |                         |
|                          | Evaluation tool revi<br>had functional urina<br>totally dependent o<br>tool revealed R18 r<br>every 2 hours durin   | I and Bladder Functional<br>iewed 7/26/16, revealed R18<br>ary incontinence and was<br>on staff for toileting needs. The<br>required assistance to toilet<br>ng the day and to change and<br>d 3rd rounds during the night.   |                            |   |                                 |                         |
|                          | 10/6/16, revealed F   | nysician progress note dated<br>R18 had severe dementia and<br>se and to be dependent on<br>needs.  |                            |   |                                 |                         |
|                          | 10/7/16, revealed F<br>was unable to com<br>totally dependent o<br>repositioning needs<br>incontinent of bowe<br>incontinent brief. T   | s and was frequently<br>el and bladder and wore an<br>l'he care plan directed staff<br>R18 every 2 hours for  |                            |   |                                 |                         |
|                          | On 10/19/16, from   | 7:03 a.m. to 10:39 a.m.,  |                            |   |                                 |                         |

|                          |   | alth<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                           |  | (X3) DATE SURVEY<br>COMPLETED    |                         |
|--------------------------|---|---|---------------------------|--|----------------------------------|-------------------------|
|                          |   | 00730   | B. WING                   |  | 10/24/2016                       |                         |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AI   | DDRESS, CITY, ST          | TATE, ZIP CODE   |                                  |                         |
| RAZEE                    | CARE CENTER   |   | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 920                    | continuous observa<br>following:<br>On 10/19/16, at 7:0<br>gel cushioned whee<br>room. R18's bed wa<br>were balled into a b<br>was hung forward in<br>her eyes were close<br>-at 7:38 a.m. the ca<br>by R18's roommate<br>the room to assist F<br>housekeeping staff<br>made R18's bed wh<br>the wheelchair. At 7<br>staff member whee<br>R18 had remained<br>head was in a chin<br>Housekeeping staff<br>dining room and pla<br>around her neck, at<br>face with the clothir<br>-at 7:56 a.m. R18 re<br>wheelchair in the di<br>(DA)brought R18 ho<br>plate on the table in<br>At that time nursing<br>approached R18, p<br>and verbally promp<br>opened her eyes ar | ations of R18 revealed the<br>3 a.m. R18 was seated in a<br>elchair, fully dressed in her<br>as stripped of its linens which<br>bundle on her bed. R18's head<br>in a chin to chest position and<br>ed.<br>Ill light to R18's room was on<br>e, staff were observed to enter<br>R18's roommate. At that time,<br>entered R18's room and<br>hile she remained seated in<br>7:41 a.m. the housekeeping<br>led R18 to the dining room.<br>with her eyes closed and her<br>to chest position.<br>wheeled R18 to a table in the<br>aced a clothing protector<br>t that time R18 covered her<br>ng protector.<br>emained seated in the<br>ning room. A dietary aid<br>er breakfast plate, left the<br>n front of her and walked away<br>g assistant (NA)-G<br>laced a hand on her shoulder<br>ted her to wake up. R18<br>nd NA-G verbally prompted<br>and handed her a spoon. |                           | DEFICIENC  | <b>T</b> )                       |                         |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                        | CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|---|--|----------------------------|--|--------------------------------|-------------------------|
|                          |   | 00730  | B. WING                    |  | 10/24/2016                     |                         |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, ST           | TATE, ZIP CODE   |                                |                         |
| RAZEE                    | CARE CENTER   |  | ST MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 920                    | -at 8:46 a.m. R18 r<br>wheelchair at the d<br>attempt to leave fro<br>completed her mea<br>juice and water in f<br>attempt to reach fo<br>spoon, and would r<br>the lipped edge of<br>her spoon.<br>-at 9:01 a.m. R18 r<br>wheelchair in the d<br>attempts to leave th<br>R18 and asked how<br>respond, NA-H wal<br>repeatedly run her<br>of the plate, while s | age 134<br>remained seated in her<br>lining room table, had made no<br>om the table. R18 had<br>al, had a glass of milk orange<br>front of her though made no<br>or them. R18 held onto her<br>repeatedly run the spoon over<br>her plate, periodically licking<br>remained seated in her<br>ining room, having made no<br>he table. NA-H approached<br>w her day was, R18 did not<br>lked away. R18 continued to<br>spoon around the lipped edge<br>she periodically licked her<br>ade no attempts to drink her | 2 920                      |  |                                |                         |
|                          | wheelchair in the d<br>spoon on the table<br>Shortly after R18's<br>chin to chest positi<br>assist R18 with rep<br>-at 9:30 a.m. R18 r<br>wheelchair in the d<br>her eyes, looked an<br>protector and cove  | remained seated in her<br>ining room. R18 had set the<br>, and had closed her eyes.<br>head dropped forward in a<br>on. No staff had offered to<br>positioning.<br>remained seated in her<br>ining room. R18 had opened<br>round, took her clothing<br>red her face it. R18 made no<br>way from the table and held he  | r                          |  |                                |                         |
|                          | -at 9:37 a.m. NA-D<br>awoke R18 and off<br>awake, removed th<br>face and allowed N  | he clothing protector.<br>entered the dining room,<br>ered R18 her fluids. R18<br>he clothing protector from her<br>IA-D to assist her to drink her<br>0% of her juice. NA-D then  |                            |  |                                |                         |

|                          | NT OF DEFICIENCIES   | Alth<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                           | CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|--|--|---------------------------|--|--------------------------------|-------------------------|
|                          |  | 00730  | B. WING                   |  | 10/                            | 24/2016                 |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AI  | DDRESS, CITY, ST          | TATE, ZIP CODE   |                                |                         |
| FRAZEE                   | CARE CENTER  |  | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 920                    | handed R18 her gla<br>independently dran<br>seated in her whee<br>room. NA-D was no<br>assistance with car<br>needs.<br>-at 9:42 a.m. NA-H<br>her to drink her rem<br>remained seated in<br>removed the clothir<br>R18 then took her s<br>it, in a cradling posi<br>-at 9:50 a.m. NA-H<br>room while seated it<br>to her room and ha<br>NA-H attached the<br>and left R18's room<br>offer R18 with any c<br>or toileting.<br>-at 10:01 a.m. NA-E<br>R18's room, did not<br>-at 10:09 a.m. NA-<br>hallway from R18's<br>R18's room and im<br>the hallway.<br>-at 10:39 a.m. assis<br>(ADON) was notifie<br>her wheelchair for a<br>minutes. At that tim<br>required assistance<br>checking and chang<br>confirmed R18 was<br>ADON went to R18 | ass of water and R18<br>k the water. NA-D left R18<br>lchair and exited the dining<br>of observed to offer R18<br>es, repositioning or toileting<br>approached R18 and assisted<br>naining fluids, while R18<br>her wheelchair. NA-H<br>ng protector from R18's neck,<br>shirt and covered her face with |                           | DEFICIENC  | Υ)                             |                         |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                       | CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|---|--|---------------------------|--|--------------------------------|-------------------------|
|                          |   | 00730  | B. WING                   |  | 10/24/2016                     |                         |
| NAME OF F                | PROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, S           | TATE, ZIP CODE   |                                |                         |
| RAZEE                    | CARE CENTER   |  | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC <sup>1</sup> | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 920                    | Continued From pa   | age 136  | 2 920                     |  |                                |                         |
|                          | asked R18 to use t<br>gait belt across R11<br>assisted R18 to sta<br>ambulate to the bai<br>slacks and incontin<br>amount of urine in<br>amount of bowel. A<br>buttocks surface w<br>had deep blush pin<br>surrounding her pe<br>blanchable. NA-E a | E entered R18's room and<br>he bathroom. NA-E donned a<br>8's torso, NA-E and ADON<br>and from the wheelchair,<br>throom and removed R18's<br>ent brief. R18 had a moderate<br>her brief as well as a small<br>ADON confirmed R18's entire<br>hich had contact with the brief<br>k creases and was moist<br>ri-rectal area, though was<br>and ADON assisted R18 to<br>needs and assisted R18 to sit<br>hair. |                           |  |                                |                         |
|                          | of 3 hours and 36 r   | in a seated position for a total<br>ninutes, during that time no<br>d to offer R18 assistance with   |                           |  |                                |                         |
|                          | thought R18 was la<br>a.m. and had state<br>helping others with<br>repositioning and to<br>R18 was supposed<br>checked and chang<br>needed. NA-E state  | 39 a.m. NA-E stated she<br>ast repositioned around 6:45<br>d she had been too busy<br>cares to assist R18 with<br>bileting needs. NA-E stated<br>to be repositioned and<br>ged every 2 hours and as<br>ed R18 was not able to<br>staff needed to anticipate  |                           |  |                                |                         |
|                          | needs must be anti<br>dependent on 2 sta<br>repositioning and to<br>required routine ev<br>toileting. NA-B state  | 66 p.m. NA-B stated R18<br>icipated and was totally<br>iff for her needs, including<br>bileting. NA-B stated R18<br>ery 2 hour repositioning and<br>ed R18's buttocks would get<br>buld not recall any recent open<br>tocks.   |                           |  |                                |                         |

|                   | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                            | CONSTRUCTION                               |                | E SURVEY<br>PLETED |
|-------------------|---|---|----------------------------|--|----------------|--------------------|
|                   |   | 00730   | B. WING                    |  | 10/24/2016     |                    |
| NAME OF I         | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, ST           | TATE, ZIP CODE                             | •              |                    |
| RAZEE             | CARE CENTER   |   | ST MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96                             |                |                    |
| (X4) ID<br>PREFIX |   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL  | ID<br>PREFIX               | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT |                | (X5)<br>COMPLET    |
| TAG               |   | SC IDENTIFYING INFORMATION)   | TAG                        | CROSS-REFERENCED TO T<br>DEFICIENC         | HE APPROPRIATE | DATE               |
| 2 920             | Continued From pa   | ge 137  | 2 920                      |  |                |                    |
|                   | (LPN)-B stated R18<br>staff of for all of her<br>was not able to ver  |   | e                          |  |                |                    |
|                   | interview ADON sta<br>to routinely repositi<br>timely manner, suc<br>shortages. ADON s<br>able to fill in for sick                          | 7 p.m. during a follow up<br>ated she felt staff were unable<br>oning and toilet residents in a<br>h as R18, due to staffing<br>stated they were not always<br>c calls and there were times<br>are unable to fill holes in the                        |                            |  |                |                    |
|                   | Management dated<br>facility's policy to er<br>or bladder incontine<br>treatment and servi<br>functioning. The po<br>an individual toiletir | d Bowel and Bladder<br>I 4/1/08, revealed it was the<br>asure each resident with bowe<br>ence would receive appropriate<br>ices to maintain normal<br>licy directed staff to develop<br>ag schedule for all incontinent<br>d on resident carte plans. |                            |  |                |                    |
|                   | director of nursing of follow care plans in   | HOD OF CORRECTION: The could re-educate all staff to regards to specific resident , and could develop a system r for compliance.  |                            |  |                |                    |
|                   | TIME PERIOD FOR<br>(21) days.   | R CORRECTION: Twenty-one  |                            |  |                |                    |
| 21375             | MN Rule 4658.080<br>Program   | 0 Subp. 1 Infection Control;  | 21375                      |  |                | 11/17/16           |

If continuation sheet 138 of 165

| STATEMEN                 | ta Department of He<br>TOF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | LE CONSTRUCTION   | (X3) DATE<br>COMPI   |                         |
|--------------------------|--|---|---------------------|---|--|-------------------------|
|                          |  | 00730   | B. WING             |   | 10/2   | 4/2016                  |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AL   | DRESS, CITY,        | STATE, ZIP CODE   |  |                         |
| FRAZEE                   | CARE CENTER  |   | T MAPLE A           | ENUE, PO BOX 96   |  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)   | JLD BE   | (X5)<br>COMPLET<br>DATE |
| 21375                    | Subpart 1. Infection<br>home must establis<br>control program de<br>sanitary environme<br>This MN Requirem   | on control program. A nursing<br>sh and maintain an infection<br>signed to provide a safe and   | 21375               |   |  |                         |
|                          | facility failed to esta<br>program which incl<br>surveillance of resid<br>surveillance and invidentified. This had<br>residents who resid<br>the facility failed to<br>soiled clothing and   | r and document review, the<br>ablish an infection control<br>uded comprehensive<br>dent symptoms, analysis of the<br>vestigation of patterns<br>the potential to affect all 52<br>ded in the facility. In addition,<br>ensure proper handling of<br>linens during personal cares<br>(R18) observed for personal   |                     | <ul> <li>MN 144A.04 Tuberculosis Preve<br/>Control</li> <li>1. Tuberculosis screening has b<br/>completed for R42 and R92. Tul<br/>Skin Testing has been completed<br/>Tuberculin skin testing has comp<br/>E1. Facility has completed an ar<br/>facility TB risk assessment.</li> <li>2. All residents are at risk due to<br/>practice.</li> </ul>   | een<br>berculin<br>d for R42.<br>bleted for<br>hnual                 |                         |
|                          | reviewed from 4/11<br>identified tracked o<br>which antibiotics we<br>surveillance process<br>of the following: loc<br>facility, if the infecti<br>community associa<br>onset of symptoms<br>present, cultures per<br>treatment provided<br>resolved. Furtherm | ion Control Logs were<br>/16, through 9/22/16. The logs<br>nly residents with infections for<br>ere prescribed. The facility's<br>eses also lacked identification<br>ration of the resident within the<br>on was healthcare or<br>tted, site of infection, date<br>erformed/ organism identified,<br>and the date the infection<br>ore, the logs lacked analysis<br>n of patterns identified. |                     | <ol> <li>Mandatory staff education of f<br/>Tuberculosis Control Program wi<br/>provided November 30, 2016. In<br/>control nurse will be educated or<br/>completion of facility annual TB r<br/>assessment.</li> <li>All current employee and resin<br/>health/medical records have bee<br/>for 2 step TSTs. Newly hired em<br/>and newly admitted resident records<br/>be audited weekly x 3 months.</li> <li>Deficient practice will be correct<br/>December 14, 2016.</li> </ol> | II be<br>ifection<br>isk<br>dent<br>n audited<br>ployee<br>ords will |                         |
|                          | manager (UM)-B w   | n 10/24/16, at 2:00 p.m. unit<br>ho was responsible for the<br>ontrol program, confirmed the  |                     |   |  |                         |

| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                              | CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|--|--|------------------------------|--|--------------------------------|-------------------------|
|                          |  | 00730  | B. WING                      |  | 10/                            | 24/2016                 |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, S <sup>-</sup> | TATE, ZIP CODE   |                                |                         |
| RAZEE                    | CARE CENTER  |  | ST MAPLE AVE<br>, MN 56544   | NUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21375                    | monthly infection lo<br>thoroughly for each<br>stated in her lack o<br>incomplete. UM-B<br>tracked infections of<br>antibiotics, and cor<br>currently in place to<br>viral illnesses's suc<br>gastroenteritis or in<br>she was assigned<br>control program, sl<br>or direction on wha<br>the program. UM-I<br>has not had any ou<br>Review of the facilit<br>Prevention and Co<br>indicated the facility<br>maintained an infe | bgs were not completed<br>in resident identified. UM-B<br>if time the logs were<br>also stated the facility only<br>which were treated with<br>ifirmed there was no system<br>to track and trend any other<br>thas the common cold,<br>ifluenza. UM-B stated when<br>responsibility of the infection<br>the did not receive any training<br>it should have been included in<br>B confirmed the facility luckily                          | 21375                        |  |                                |                         |
|                          | development and t<br>Review of R18's qu<br>(MDS) dated 7/26/<br>cognitive impairme<br>communicate with<br>included, dementia<br>MDS identified R18<br>for activities of daily<br>staff for assistance<br>hygiene and toiletir<br>was frequently inco<br>The MDS identified   | nment to help prevent the<br>ransmission of infection.<br>uarterly Minimum Data Set<br>16, identified R18 had severe<br>nt, was unable to<br>staff and had diagnoses which<br>depression and anxiety. The<br>was totally dependent on staf<br>y living (ADL's) and required 2<br>with bed mobility, personal<br>ng. The MDS identified R18<br>ontinent of bowel and bladder.<br>d R18 was not on a toileting<br>or bladder incontinence. |                              |  |                                |                         |
|                          |  | nnual MDS dated 4/26/16, totally dependent on staff for  |                              |  |                                |                         |

| STATEMEN  | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         |  |                | E SURVEY<br>PLETED |
|---|--|--|-------------------------|--|----------------|--------------------|
|   |  | 00730  | B. WING                 |  | 10/24/2016     |                    |
| NAME OF   | PROVIDER OR SUPPLIER   | STREET AL  | DDRESS, CITY, S         | TATE, ZIP CODE   |                |                    |
| FRAZEE  | CARE CENTER  |  | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                |                    |
| (X4) ID   | SUMMARY STA  |  | ID                      | PROVIDER'S PLAN OF   | COBBECTION     | (X5)               |
| PREFIX<br>TAG   | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG           | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | TION SHOULD BE | COMPLET<br>DATE    |
| 21375   | Continued From pa  | ige 140  | 21375                   |  |                |                    |
|   | incontinent of bowe  | entified R18 was frequently<br>and bladder. The MDS<br>not on a toileting program for<br>continence.   |                         |  |                |                    |
| Ar<br>R <sup>-</sup><br>wa<br>Th<br>sp<br>Co<br>be<br>Ind<br>ind<br>as<br>ch<br>Re<br>10<br>wa<br>toi<br>re<br>ind<br>ind<br>ch | Area Assessment (<br>R18 had cognitive I<br>was unable to cohe<br>The CAA revealed<br>spite of her inability<br>Communication CA<br>be anticipated by fa<br>Incontinence CAA i<br>incontinent of bowe                                    | dentified R18 was frequently<br>and bladder and needed<br>mobility and was toileted or   |                         |  |                |                    |
|   | 10/7/16, revealed F<br>was unable to com-<br>totally dependent o<br>repositioning needs<br>incontinent of bowe<br>incontinent brief. T   | and was frequently<br>and bladder and wore an<br>he care plan directed staff<br>R18 every 2 hours for  |                         |  |                |                    |
|   | wheelchair in her ro<br>head. R18's right he<br>and had fecal matter<br>up to her first knuch<br>her thumb. R18's ri<br>leg also had smear<br>entire hand. R18 be<br>covered right hand<br>that time the director<br>down the hall and v | 0 p.m. R18 was seated in a<br>bom, her shirt was over her<br>and rested on her right thigh<br>er on her right hand, covering<br>kles on all of her fingers and<br>ght upper (thigh height) pant<br>red fecal matter the size of her<br>egan to move her fecal<br>towards the front of her. At<br>or of nursing was walking<br>vas notified of R18's condition.<br>g assistant (NA)-H entered |                         |  |                |                    |

|                          | ota Department of He<br>NT OF DEFICIENCIES<br>N OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION   |                                  | E SURVEY<br>PLETED      |
|--------------------------|--|---|-------------------------|--|----------------------------------|-------------------------|
|                          |  | 00730   | B. WING                 |  | 10/24/2016                       |                         |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, ST         | TATE, ZIP CODE   |                                  |                         |
| FRAZEE                   | E CARE CENTER  |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21375                    | R18's room and asl<br>the bathroom, R18<br>reached up with hei<br>hair. NA-H took a p<br>and cleansed R18's<br>reached down with<br>soiled area on her s<br>obtaining clean clot<br>would re-wipe R18's<br>reach down and ha<br>times. At that time I<br>dependent on 2 sta<br>frequently incontine<br>3:44 p.m. NA-H req<br>cares. R18 continue<br>re-soiling her right h<br>pant leg and NA-H<br>the wipes.<br>-At 3:53 p.m. NA-H<br>requested assistant<br>were times when sh<br>another staff memb<br>requiring 2 staff ass<br>stated she had bee<br>when the DON pull<br>3:56 p.m. NA-H left<br>out assistance with<br>R18's pant leg. R18<br>immediately after N<br>-At 3:59 p.m. NA-F<br>in a grape sized am<br>the floor near R18's<br>as she approached<br>hands with a washo<br>NA-F backed away<br>gait belt across R18 | ked R18 if she wanted to use<br>lifted her head out of her shirt,<br>r right hand and touched her<br>ackaged pre-moistened wipe<br>s right hand. R18 repeatedly<br>her hand and touched the<br>slacks while NA-H was<br>thes from her closet. NA-H<br>s hand, and R18 would again<br>ndle the soiled slacks several<br>NA-H stated R18 was totally<br>ff for all of her cares and was<br>ent of bowel and bladder. At<br>juested assistance with R18's<br>ed to repeat the process of<br>nand with the bowel on her<br>would re-wipe her hand with<br>used her walkie talkie and<br>ce, NA-H then stated there<br>he had to wait a long time for<br>per to help with residents<br>sistance, including R18. NA-H<br>n assigned to another wing<br>ed her into R18's room. At<br>t R18's room to physically seek<br>out covering the bowel on<br>B re-soiled her right hand | 21375                   | DEFICIENC  | Υ)                               |                         |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE<br>A. BUILDING: _ | CONSTRUCTION  |                                | E SURVEY<br>PLETED      |
|--|--|---------------------------------|---|--------------------------------|-------------------------|
|  | 00730  | B. WING                         |   | 10/24/2016                     |                         |
| NAME OF PROVIDER OR SUPPLIER   | STREET AL  | DRESS, CITY, ST                 | ATE, ZIP CODE   |                                |                         |
| FRAZEE CARE CENTER   |  | T MAPLE AVE<br>MN 56544         | NUE, PO BOX 96  |                                |                         |
| PREFIX (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| <ul> <li>the bathroom. NA-incontinent brief whand bladder and blaincontinent brief in soiled slacks on the shirt and placed it of slacks. NA-F and N cleansing, applied clothing for R18. N cushion and stated the floor with a wip shirt and slacks and floor with her glove entered the soiled R18 with a baby do room.</li> <li>On 10/17/16, at 4:1 usual practice to pl floor. NA-F stated the place the soiled clother bag to the soiled her she was unaware of assisted with toileting et a report from the resident cares were not that day. NA-F getting report from consistent basis du On 10/21/16, at 1:3 nursing stated it was soiled clothing on t usual practice was bags, then to bring hopper rooms to be added to bag.</li> </ul> | elchair, assisted R18 to walk to<br>F removed R18's slacks and<br>hich were saturated with bowel<br>adder. NA-F discarded R18's<br>the garbage and placed R18's<br>e floor. NA-H removed R18's<br>on the floor next to R18's soiled<br>VA-H assisted R18 with<br>a clean brief and donned clean<br>VA-H checked R18's seat<br>I she felt it was clean, washed<br>e. NA-F picked up R18's soiled<br>d soiled washcloths from the<br>d hands, left the room and<br>hopper room. NA-H provided<br>oll, her call light and left R18's<br>I7 p.m. NA-F stated it was not<br>aced soiled clothing on the<br>the usual practice would be<br>othing in a bag and bring the<br>opper room. NA-F also stated<br>of the last time R18 had been<br>ng. NA-F stated she used to<br>he previous shift NA of when<br>e last completed, though did<br>stated she had not been<br>the previous shift NA on a<br>ue to short staffing.<br>B7 p.m. the assistant director of<br>as not usual practice to place<br>he floor. ADON stated the<br>to place soiled clothing in<br>the closed bags into the<br>e rinsed and placed in laundry<br>tated she expected staff to |                                 |   | 1                              |                         |

| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                            | CONSTRUCTION  |                                | E SURVEY<br>PLETED       |
|--------------------------|--|--|----------------------------|---|--------------------------------|--------------------------|
|                          |  | 00730  | B. WING                    |   | 10/24/2016                     |                          |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, ST           | TATE, ZIP CODE  |                                |                          |
| FRAZEE                   | CARE CENTER  |  | ST MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96  |                                |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETI<br>DATE |
| 21375                    | Review of a facility<br>dated 4/1/08, revea<br>when handling, pro<br>linens, staff were to<br>prevent the spread<br>directed staff to imm  | ge 143<br>policy titled., Linens-Handling,<br>led it was the facility's policy<br>cessing and transporting<br>o use specific procedures to<br>of infection. The policy<br>nediately remove soiled linens<br>room and taken to a utility  |                            |   |                                |                          |
|                          | The director of nurs<br>develop and impler<br>related to a compre-<br>program, to include<br>investigating all illne<br>or designee could r<br>proper infection cor<br>cares and linen har<br>assessment and as<br>perform random au | THOD FOR CORRECTION:<br>sing (DON) or designee could<br>nent policies and procedures<br>thensive infection control<br>tracking, trending and<br>esses in the facility. The DON<br>eview and educate staff on<br>ntrol practices for resident<br>adling. The quality<br>ssurance committee could<br>dits to ensure compliance.<br>R CORRECTION: Twenty (21) |                            |   |                                |                          |
| 21426                    | MN St. Statute 144<br>Prevention And Con<br>(a) A nursing home<br>maintain a compreh<br>infection control pro<br>current tuberculosis<br>issued by the Unite<br>Control and Preven<br>Tuberculosis Elimin<br>Morbidity and Morta     | A.04 Subd. 3 Tuberculosis<br>htrol<br>e provider must establish and<br>hensive tuberculosis<br>ogram according to the most<br>s infection control guidelines<br>d States Centers for Disease<br>tion (CDC), Division of<br>hation, as published in CDC's<br>ality Weekly Report (MMWR).<br>include a tuberculosis  | 21426                      |   |                                | 11/17/16                 |

| (EACH DEFICIENCY<br>REGULATORY OR LS<br>ontinued From pa<br>fection control pla<br>upaid employees,<br>sidents, and volu<br>ealth shall provide<br>garding implemer  | 219 WEST<br>FRAZEE,<br>TEMENT OF DEFICIENCIES<br>(MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)<br>ge 144<br>In that covers all paid and<br>contractors, students,<br>inteers. The Department of<br>technical assistance<br>technical assistance<br>thation of the guidelines.                           | T MAPLE AV<br>MN 56544   | 10 STATE, ZIP CODE /ENUE, PO BOX 96 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | /24/2016  |
|--|--|--|--|---|
| RE CENTER<br>SUMMARY STA<br>(EACH DEFICIENCY<br>REGULATORY OR LS<br>ontinued From pa<br>fection control pla<br>upaid employees,<br>sidents, and volu<br>ealth shall provide<br>garding implemen  | 219 WEST<br>FRAZEE,<br>TEMENT OF DEFICIENCIES<br>(MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)<br>ge 144<br>In that covers all paid and<br>contractors, students,<br>inteers. The Department of<br>technical assistance<br>technical assistance<br>thation of the guidelines.                           | T MAPLE AV<br>MN 56544   | /ENUE, PO BOX 96<br>PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE  | COMPLET   |
| SUMMARY STA<br>(EACH DEFICIENCY<br>REGULATORY OR LS<br>ontinued From pa<br>fection control pla<br>upaid employees,<br>sidents, and volu<br>ealth shall provide<br>garding implemer   | FRAZEE,<br>TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)<br>ge 144<br>In that covers all paid and<br>contractors, students,<br>inteers. The Department of<br>technical assistance<br>technical assistance<br>tation of the guidelines.   | MN 56544   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE  | COMPLET   |
| (EACH DEFICIENCY<br>REGULATORY OR LS<br>ontinued From pa<br>fection control pla<br>upaid employees,<br>sidents, and volu<br>ealth shall provide<br>garding implemer  | ge 144<br>an that covers all paid and<br>contractors, students,<br>nteers. The Department of<br>technical assistance<br>ntation of the guidelines.   | PREFIX<br>TAG<br>21426   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE   | COMPLET   |
| ection control pla<br>paid employees,<br>sidents, and volu<br>ealth shall provide<br>garding implemer<br>) Written complia   | In that covers all paid and<br>contractors, students,<br>nteers. The Department of<br>technical assistance<br>ntation of the guidelines.   |  |  |   |
|  |  |  |  |   |
| ased on interview<br>led to ensure a T<br>reening had beer<br>sidents (R42,R94<br>provide a second<br>r 1 of 5 residents<br>led to provide the<br>quired timeframe<br>nployees (E1) rev<br>ogram. In additio   | Tuberculosis Skin Test (TST)<br>(R42). In addition, the facility<br>e second TST within the<br>for 1 of 5 newly hired<br>riewed for Tuberculosis (TB)<br>on, the facility failed to produce  |  | corrected  |   |
| the R42's immun<br>seline symptom s<br>mpleted upon ad<br>Idition, the immur<br>cond TST was no  | nization record revealed the TB<br>screening form had not been<br>mission to the facility. In<br>nization record revealed R42's<br>of given.   |  |  |   |
| si prilequino e na 12 ti sindico prilequino e na 12 ti sindico prine interna 12 ti sin | dents (R42,R94<br>rovide a second<br>1 of 5 residents<br>ed to provide the<br>uired timeframe<br>oloyees (E1) rev<br>gram. In addition<br>required written<br>dings include:<br>2 was admitted to<br>ne R42's immun<br>eline symptom so<br>to the immun<br>ond TST was no<br>4 was admitted to<br>894's immunizato | dents (R42,R94) upon admission, and failed<br>rovide a second Tuberculosis Skin Test (TST)<br>1 of 5 residents (R42). In addition, the facility<br>ed to provide the second TST within the<br>uired timeframe for 1 of 5 newly hired<br>bloyees (E1) reviewed for Tuberculosis (TB)<br>gram. In addition, the facility failed to produce<br>required written TB risk assessment.<br>dings include:<br>2 was admitted to the facility in 2016. Review<br>he R42's immunization record revealed the TB<br>eline symptom screening form had not been<br>hpleted upon admission to the facility. In<br>ition, the immunization record revealed R42's<br>ond TST was not given. | dents (R42,R94) upon admission, and failed<br>rovide a second Tuberculosis Skin Test (TST)<br>1 of 5 residents (R42). In addition, the facility<br>ed to provide the second TST within the<br>uired timeframe for 1 of 5 newly hired<br>bloyees (E1) reviewed for Tuberculosis (TB)<br>gram. In addition, the facility failed to produce<br>required written TB risk assessment.<br>dings include:<br>2 was admitted to the facility in 2016. Review<br>he R42's immunization record revealed the TB<br>eline symptom screening form had not been<br>hpleted upon admission to the facility. In<br>ition, the immunization record revealed R42's<br>ond TST was not given.<br>4 was admitted to the facility in 2016. Review<br>R94's immunization record revealed the TB<br>eline symptom screening form had not been | dents (R42,R94) upon admission, and failed<br>rovide a second Tuberculosis Skin Test (TST)<br>1 of 5 residents (R42). In addition, the facility<br>ed to provide the second TST within the<br>uired timeframe for 1 of 5 newly hired<br>oloyees (E1) reviewed for Tuberculosis (TB)<br>gram. In addition, the facility failed to produce<br>required written TB risk assessment.<br>dings include:<br>2 was admitted to the facility in 2016. Review<br>he R42's immunization record revealed the TB<br>eline symptom screening form had not been<br>pleted upon admission to the facility. In<br>ition, the immunization record revealed R42's<br>ond TST was not given.<br>4 was admitted to the facility in 2016. Review<br>R94's immunization record revealed the TB<br>eline symptom screening form had not been |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 | CONSTRUCTION   |                                  | E SURVEY<br>PLETED     |
|--------------------------|---|--|---------------------|--|----------------------------------|------------------------|
|                          |   | 00730  | B. WING             |  | 10/24/2016                       |                        |
|                          | PROVIDER OR SUPPLIER  |  | DDRESS, CITY, S     | TATE. ZIP CODE   | 10/                              | 24/2010                |
|                          | CARE CENTER   |  |                     | NUE, PO BOX 96   |                                  |                        |
| NAZEE                    | CARE CENTER   | FRAZEE   | , MN 56544          |  |                                  |                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLE<br>DATE |
| 21426                    | Continued From pa   | age 145  | 21426               |  |                                  |                        |
|                          | completed upon ac   | Imission to the facility.  |                     |  |                                  |                        |
|                          | was given on 6/3/10<br>a result documenter<br>TST was not given<br>7/28/16 with a result<br>During interview on<br>manager (UM)-B w<br>facility's TB program<br>admission and new<br>required to have th<br>screening and two-<br>reported the facility | ed employee. The first TST<br>6, and was read on 6/6/16 with<br>ed as negative. The second<br>until 7/25/16, and was read on<br>it documented as negative.<br>10/24/16, at 2:00 p.m. unit<br>who was responsible for the<br>m confirmed all residents upon<br>vly hired employees were<br>e TB baseline symptom<br>step TST completed. UM-B<br>'s TB risk was low, however,<br>duce the required TB written<br>view. |                     |  |                                  |                        |
|                          | undated, revealed<br>two-step skin testin<br>residents upon adn<br>employees. The po<br>assessment would  | ty policy titled TB Control Plan,<br>TB symptom screening and<br>ing would be completed for all<br>nission and newly hired<br>plicy also indicated a TB risk<br>be completed, at least<br>ine the risk of exposure to TB   |                     |  |                                  |                        |
|                          | The infection contro<br>designee could rev<br>procedures to ensu<br>included. Appropri<br>regarding requirem  | THOD OF CORRECTION:<br>ol coordinator/nurse or<br>iew the TB policies and<br>ure required information is<br>ate staff could be educated<br>ents. Audits could be could be<br>results reviewed at the quality<br>is.  |                     |  |                                  |                        |
|                          | TIME PERIOD FOI<br>(21) days.   | R CORRECTION: Twenty-one   |                     |  |                                  |                        |

| STATEMEN                 | ta Department of He  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                        | E CONSTRUCTION   | (X3) DATE<br>COMF | SURVEY<br>PLETED         |
|--------------------------|--|--|------------------------|--|-------------------|--------------------------|
|                          |  | 00730  | B. WING                |  | 10/2              | 24/2016                  |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S         | STATE, ZIP CODE  |                   |                          |
| FRAZEE                   | CARE CENTER  |  | ۲ MAPLE AV<br>MN 56544 | ENUE, PO BOX 96  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| 21435                    | Continued From pa  | ge 146   | 21435                  |  |                   |                          |
| 21435                    | MN Rule 4658.0900<br>Recreation Program  | ) Subp. 1 Activity and<br>n; General   | 21435                  |  |                   | 11/17/16                 |
|                          | recreation program<br>based on each indiv<br>strengths, and need<br>meet the physical, r<br>well-being of each r<br>comprehensive res<br>comprehensive plat<br>4658.0400 and 468<br>provided opportunit        | an organized activity and<br>. The program must be<br>vidual resident's interests,<br>ds, and must be designed to<br>mental, and psychological<br>resident, as determined by the<br>ident assessment and<br>n of care required in parts<br>58.0405. Residents must be<br>ies to participate in the<br>opment of the activity and             |                        |  |                   |                          |
|                          | by:<br>Based on observati<br>review the facility fa<br>activities identified i<br>assessment for 1 o<br>dependent on staff   | ent is not met as evidenced<br>on, interview and record<br>illed to provide meaningful<br>n the comprehensive<br>f 3 residents (R66) who was<br>to provide all leisure activities.   |                        | corrected  |                   |                          |
|                          | 1/11/16 identified R<br>included traumatic I<br>and diabetes. The N<br>severe cognitive im<br>dependent of staff f<br>(ADLs), and require<br>transfers and locom<br>identified R66 enjoy<br>around animals suc | inimum Data Set (MDS), dated<br>66 had diagnoses which<br>brain injury, seizure disorder<br>MDS identified R66 had<br>pairment, and was totally<br>for activities of daily living<br>ed 2 staff to assist with<br>notion off the unit. The MDS<br>yed listening to music, being<br>th as pets, keeping up with the<br>with groups of people, |                        |  |                   |                          |

| STATEME       | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED<br><b>10/24/2016</b> |                 |
|---------------|---|---|-------------------------|--|--|-----------------|
|               |   | 00730   | B. WING                 |  |  |                 |
| NAME OF       | PROVIDER OR SUPPLIER  | STREET AL   | DDRESS, CITY, ST        | TATE, ZIP CODE   |  |                 |
| FRAZEE        | CARE CENTER   |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |  |                 |
| (X4) ID       | SUMMARY STA   | ATEMENT OF DEFICIENCIES   | ID                      | PROVIDER'S PLAN OF   | CORRECTION   | (X5)            |
| PRÉFIX<br>TAG |   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG           | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | THE APPROPRIATE                                    | COMPLET<br>DATE |
| 21435         | Continued From pa   | age 147   | 21435                   |  |  |                 |
|               | participating in favorite activities and spending time outdoors.  |   |                         |  |  |                 |
|               | 1/11/16 identified R<br>brain injury, was un<br>needs known and v<br>her ADL. The CAA<br>people with her eye  | essessment (CAA), dated<br>166 suffered from a traumatic<br>hable to speak and make<br>was dependent on staff for all<br>further identified R66 followed<br>as and blinked to answer yes<br>d appeared to watch TV when   |                         |  |  |                 |
|               | a big fan of duck D<br>the Kardashians. R<br>liked to browse thro<br>enjoyed a good boo<br>directed activity sta<br>room to inform all s<br>Dynasty and Keepin<br>activity staff were to<br>and activity staff were<br>(people, Us Weekly<br>during 1:1 visits and<br>enjoy story time. Re<br>R66 required a mee<br>her up and into her | ted 2/18/16 identified R66 was<br>ynasty and Keeping up with<br>166's care plan indicated she<br>bugh gossip magazines and<br>ok at times. R66's care plan<br>iff had posted a sign in her<br>staff that she enjoys Duck<br>ing up with the Kardashians,<br>o complete 4 1:1 visits a week,<br>buld provide gossip magazines<br>y, Star) and would read to her<br>d would see if she was up to<br>66's care plan further directed<br>chanical lift and 2 staff to get<br>wheelchair, and R66 would be<br>er destinations as desired and |                         |  |  |                 |
|               | Assessment dated<br>staff indicated they<br>activities to let her of<br>and indicated R66<br>assessment further<br>included cards and<br>large group program<br>group activities suc  | Therapeutic Programs<br>1/4/16, identified activities<br>would try to bring her to<br>observe and be around people<br>was in bed a lot. The<br>r identified R66's past interests<br>games and plan included<br>ms and entertainment, small<br>th as manicures, 1:1<br>be needed, and R66 also   |                         |  |  |                 |

| STATEMEN                 | DIA Department of He<br>NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                              | CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|--|---|------------------------------|--|--------------------------------|-------------------------|
|                          |  | 00730   | B. WING                      |  | 10/24/2016                     |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   |   | DDRESS, CITY, S <sup>-</sup> |  |                                |                         |
| FRAZEE                   | CARE CENTER  |   | 6T MAPLE AVE<br>, MN 56544   | NUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIV<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21435                    | Continued From pa  | age 148   | 21435                        |  |                                |                         |
|                          | enjoyed watching t   | he birds and TV.  |                              |  |                                |                         |
|                          | dated 7/26/16, ider<br>involvement was fa<br>passive, R66 was u<br>a meaningful way.<br>watched TV on a d<br>watched movies. T<br>sometimes watch t<br>would rather watch<br>visits by staff each  | ctivities quarterly progress note<br>ntified R66's activity<br>air and participation was<br>unable to structure her time in<br>The note identified R66<br>aily basis, and sometimes<br>'he note indicated R66 would<br>he birds, but staff felt R66<br>TV and R66 would have 4, 1:1<br>week. The note also indicated<br>per week and took her   | L                            |  |                                |                         |
|                          | 10/11/16, identified<br>was fair, participati<br>R66 was unable to<br>meaningful way. Th<br>also watches movie<br>player. The note fu<br>4, 1:1 visits by active<br>would sometimes r<br>indicated family vis<br>wheeled her aroun<br>weather was nice.<br>R66's activity plan<br>goal for the last 3 r<br>were effective. and | a quarterly progress note dated<br>R66's activity involvement<br>on level remained passive and<br>structure her time in a<br>he note indicated R66 loved TV<br>es on her personal DVD<br>rther identified R66 would have<br>vity staff each week and they<br>read her a book. The note also<br>ited once per week and<br>d or took her outside if the<br>The progress note identified<br>was appropriate, had met her<br>nonths, activity interventions<br>I no changes were<br>R66's activity program. | /                            |  |                                |                         |
|                          | residents from 4/16 activities per week  | ty activity calendar for<br>5 to 10/16 identified 4-5<br>which R66 had special interes<br>Bingo, movies, outside walks  | t                            |  |                                |                         |
| nnoacte D                |  | esident Activity Attendance<br>/1/16 to 10/17/16 revealed   |                              |  |                                |                         |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                              | CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|--|---|------------------------------|--|--------------------------------|-------------------------|
|                          |  | 00730   | B. WING                      |  | 10/24/2016                     |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, S <sup>-</sup> | TATE, ZIP CODE   |                                |                         |
| RAZEE                    | CARE CENTER  |   | ST MAPLE AVE<br>, MN 56544   | NUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)            | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21435                    | Continued From page 149<br>R66 consistently watched TV and family visited.<br>However, the attendance charts did not include<br>consistent 1:1 visits, and did not consistently<br>include attendance at either large or small group<br>acclivities. The monthly documentation as<br>follows:<br>-4/16, 6 out of 16 opportunities of 1:1 visits from<br>staff for the month, and 3 unable and 1 refused.<br>No other documentation of large or small group<br>activities or activities out of room |   | 21435                        |  |                                |                         |
|                          |  |   |                              |  |                                |                         |
|                          |  |   |                              |  |                                |                         |
|                          | staff for the month,   | pportunities for 1:1 visits from<br>1 in family lounge, 1 in<br>nail reading, and 2 cleaning    |                              |  |                                |                         |
|                          |  | pportunities of 1:1 visits from<br>1 mail reading,1 glider, and 4                               |                              |  |                                |                         |
|                          | staff for the month,   | opportunities for 1:1 visits from<br>1 special event, 1 bird<br>ng glasses, 2 outside, 1 glider |                              |  |                                |                         |
|                          |  | opportunities for 1:1 visits for<br>vatching, 1 wheeling, 1 outside,<br>, and 1 unable          | ,                            |  |                                |                         |
|                          |  | pportunities for 1:1 visits for<br>le, 1 cleaning glasses, and 1                                |                              |  |                                |                         |
|                          |  | out of 13 opportunities for 1:1<br>mily lounge, 2 cleaning                                      |                              |  |                                |                         |
|                          |  | g observation from 7:00 a.m.<br>s room was dark and quiet,                                      |                              |  |                                |                         |

STATE FORM

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         |   |                                | E SURVEY<br>PLETED      |
|--------------------------|--|--|-------------------------|---|--------------------------------|-------------------------|
|                          |  | 00730  | B. WING                 |   | 10/24/2016                     |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AL  | DDRESS, CITY, S         | TATE, ZIP CODE  |                                |                         |
| RAZEE                    | CARE CENTER  |  | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96  |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| TAG<br>21435             | Continued From pa<br>and her bedroom d<br>observed on her ba<br>hospital gown. R60<br>position with no me<br>and 3 minutes. R60<br>calendar posted or<br>the foot of her bed,<br>sign was posted or<br>recliner and identifi<br>-R66 was to be cha<br>-No more Kardashi<br>-Family Feud on ch<br>-Wheel of fortune<br>-Jeopardy 5:00 p.m<br>-Judge Judy 9:00 a<br>-get movie going ea<br>On 10/19/16, at 10<br>were in R66's room<br>her recliner. LPN-A<br>going to watch on<br>those Kardashian g<br>R66 a hard time ab<br>you never now wha<br>On 10/19/16, at 12<br>seated in her recline<br>type program was o<br>turned away from t<br>window.<br>On 10/20/16, at 9:4<br>dressed in a hospit | age 150<br>door was open. R66 was<br>ack in bed, dressed in a<br>6 remained in the same<br>eaningful activity for 3 hours<br>6 had a monthly activities<br>a her closet door across from<br>, and a hand written 8.5 X 11<br>a the wall across from R66's<br>ied:<br>anged during check ups<br>ians'!<br>hannel 11:00 a.m. | 21435                   |   |                                | DATE                    |
|                          | (FM-A) stated no fa<br>felt no facility staff  | :17 p.m. family member<br>acility staff visits R66 and she<br>went into her room unless they<br>she visited R66 about twice a  |                         |   |                                |                         |

| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                           | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED    |                         |
|--------------------------|---|--|---------------------------|--|----------------------------------|-------------------------|
|                          |   | 00730  | B. WING                   |  | 10/24/2016                       |                         |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AI  | DDRESS, CITY, ST          | TATE, ZIP CODE   |                                  |                         |
| FRAZEE                   | CARE CENTER   |  | T MAPLE AVE<br>, MN 56544 | ENUE, PO BOX 96  |                                  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21435                    | Continued From pa   | age 151  | 21435                     |  |                                  |                         |
|                          |   | week and a nurse used to come and visit R66<br>even when she wasn't working, but she was gone<br>now.  |                           |  |                                  |                         |
|                          | nurse (LPN-A) stat<br>on staff for ADLs. S  | :24 a.m. licensed practical<br>ed R66 was totally dependent<br>She stated the usual routine<br>up, she spent her day watching  |                           |  |                                  |                         |
|                          | stated R66 spent h<br>get 1:1 visits. She s<br>open curtains, and<br>the TV shows she l<br>stated she didn't kr<br>of her room, and st<br>sit at the nurses de<br>and missed 1:1 visi<br>and asleep. She st<br>provide 1:1 visits of<br>it was hard to provi<br>R66 required so m<br>get up. She stated<br>in her chair when fa | :08 a.m. activities aide (AA-A)<br>er day watching TV and would<br>stated during 1:1 visits they<br>sit with her talk to her about<br>liked, or put a movie on. She<br>now how often R66 came out<br>tated sometimes they had her<br>esk. She stated R66 slept a lot,<br>its because she was in bed<br>ated activity staff tried to<br>n an attempt basis. She stated<br>de activities for R66 because<br>uch care, and was difficult to<br>she felt R66 was probably up<br>amily visited, and staff had<br>to story time but it was too |                           |  |                                  |                         |
|                          | (CM-A) stated staff<br>recliner and she wa<br>because they were<br>bed or her Broda c<br>the time. She confi  | 53 a.m. clinical manager<br>would get her up in her<br>atched the Kardashians'<br>on a lot, otherwise R66 was in<br>hair in her room the majority of<br>rmed R66's current care plan<br>lerstood activities staff spent<br>room.   |                           |  |                                  |                         |
|                          | stated activity staff   | :27 p.m. activities director (AD)<br>had posted a sign in R66's<br>aff what TV shows R66 liked   |                           |  |                                  |                         |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE<br>A. BUILDING: _ | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED<br> |                         |
|--------------------------|---|--|---------------------------------|---|-----------------------------------|-------------------------|
|                          |   | 00730  | B. WING                         |   |                                   |                         |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AI  | DDRESS, CITY, ST                | TATE, ZIP CODE  |                                   |                         |
| FRAZEE                   | CARE CENTER   |  | T MAPLE AVE<br>, MN 56544       | NUE, PO BOX 96  |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENC) | ON SHOULD BE<br>HE APPROPRIATE    | (X5)<br>COMPLET<br>DATE |
| 21435                    | and stated R6 also<br>her room. AD indica<br>had wanted to bring<br>Adventure activity,<br>during the week, bu<br>attend because she<br>stated R66 used to<br>staff struggled with<br>her wheelchair to a<br>she would like R66<br>it was such a hassle<br>her wheelchair, and<br>or recliner. AD confi<br>stated her care plan<br>stated her care plan<br>stated her care plan<br>stated her care plan<br>portable DVD playe<br>activity records and<br>TV. She confirmed<br>R66's care plan had<br>current information.<br>Review of facility po<br>identified the facility<br>program for activitie<br>interests, physical,<br>well-being of each n<br>comprehensive ass<br>SUGGESTED MET<br>The Activity Directo<br>review, and/or revis<br>ensure resident's h<br>program that meets<br>The Activity Directo<br>all appropriate staff<br>procedures. | had a portable DVD player in<br>ated in the past activities staff<br>p R66 to the Afternoon<br>which was scheduled daily<br>at struggled to get R66 to<br>be was not in her chair. She<br>get her nails done but activity<br>finding staff to get her up in<br>ttend the activity. She stated<br>to attend music programs but<br>e to find staff to get her up in<br>d R66 was usually in her bed<br>irmed R66's care plan and<br>n could be updated. She<br>n was TV focused and the<br>er also. AD confirmed R66's<br>d stated R66 mostly watched<br>the sign posted in room and<br>d not been updated with<br>olicy, Activities, dated 4/1/08<br>y must provide an ongoing<br>es designed to meet the<br>mental, and psychosocial<br>resident based on<br>sessment.<br>THOD OF CORRECTION:<br>r or designee could develop,<br>the policies and procedures to<br>ave an indivdualized activity<br>to their needs.<br>r or designee could educate<br>on the policies and<br>r or designee could develop | 21435                           | DEFICIENCY  |                                   |                         |

| Minneso       | ta Department of He   | alth  |                       |   | FORM              | APPROVED         |
|---------------|---|---|-----------------------|---|-------------------|------------------|
| STATEMEN      | OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                       | E CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED  |
|               |   | 00730   | B. WING               |   | 10/2              | 4/2016           |
| NAME OF F     | PROVIDER OR SUPPLIER  | STREET ADI  | DRESS, CITY,          | STATE, ZIP CODE   |                   |                  |
| FRAZEE        | CARE CENTER   |   | 「MAPLE AV<br>MN 56544 | ENUE, PO BOX 96   |                   |                  |
| (X4) ID       |   | TEMENT OF DEFICIENCIES  | ID                    | PROVIDER'S PLAN OF CORRECTIO  |                   | (X5)             |
| PREFIX<br>TAG |   | MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG         | (EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) |                   | COMPLETE<br>DATE |
| 21435         | Continued From pa   | ge 153  | 21435                 |   |                   |                  |
|               | TIME PERIOD FOF<br>(21) days.   | R CORRECTION: Twenty-one  |                       |   |                   |                  |
| 21620         | MN Rule 4658.1345   | 5 Labeling of Drugs   | 21620                 |   |                   | 11/17/16         |
|               | Drugs used in the n in accordance with  | ursing home must be labeled<br>part 6800.6300.  |                       |   |                   |                  |
|               | by:<br>Based on observati<br>review, the facility fa<br>labeled with open o<br>opened for 2 of 5 re<br>addition, the facility<br>for consistent and ti<br>discontinued narcot | tics to prevent loss or potential medication rooms reviewed for   |                       | corrected   |                   |                  |
|               | observed to have th   | 0 p.m. medication cart B was<br>ne following bottles of eye<br>without a date identified so<br>uld be determined:                   |                       |   |                   |                  |
|               | dispensed on 6/4/10   | eate PF Solution 0.5%,<br>6.<br>Solution 0.005%, dispensed  |                       |   |                   |                  |
|               | indicated R31 was<br>Solution 0.5% Solut  | cian orders dated 9/27/16,<br>prescribed Timolol Maleate PF<br>tion, 1 drop in left eye one time<br>, with an ordered start date of |                       |   |                   |                  |

| STATEMEN                 | Dita Department of He<br>NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                           | CONSTRUCTION   |                                 | E SURVEY<br>PLETED      |  |
|--------------------------|--|--|---------------------------|--|---------------------------------|-------------------------|--|
|                          |  | 00730  | B. WING                   |  | 10/                             | 10/24/2016              |  |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, ST          | TATE, ZIP CODE   |                                 |                         |  |
| FRAZEE                   | CARE CENTER  |  | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                 |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 21620                    | Continued From pa  | age 154  | 21620                     |  |                                 |                         |  |
|                          | indicated R43 was<br>Solution 0.005%, 1  | cian orders dated 10/6/16,<br>prescribed Latanoprost<br>drop in both eyes at bedtime<br>an ordered4 start date of  |                           |  |                                 |                         |  |
|                          | (RN)-D confirmed to<br>were not dated who<br>stated they should<br>she did not work or<br>but stated any nurs<br>they are opened. If<br>pharmacist comes | ervation, registered nurse<br>the eye drop medication bottles<br>en they were opened, and<br>have been. RN-D reported<br>in the B medication cart often,<br>se can date the drops when<br>RN-D also reported a<br>to the facility monthly to review<br>ts for expired medications. |                           |  |                                 |                         |  |
|                          | of nursing (ADON)<br>date the eye drops<br>have been done.   | 36 p.m. the assistant director<br>stated the expectation was to<br>when opened, and it should<br>The ADON then stated she was<br>macist did not flag the undated<br>nedications.   |                           |  |                                 |                         |  |
|                          | Medicine dated 3/1 the dating of medic   | or Labeling and Storing<br>4 and 4/15, did not address<br>cation bottles or indicate when<br>o medications once they were  |                           |  |                                 |                         |  |
|                          | Expiration Guidelin expired 28 days af   | Specialty Pharmacy Eye Drop<br>les indicated Timolol would be<br>ter opened, and Latanoprost<br>weeks after opened.  |                           |  |                                 |                         |  |
|                          | conducted of the fa<br>rooms. At 1:17 p.m<br>(LPN)-C unlocked<br>the west medicatio  | I7 p.m. observations were<br>acility's medication storage<br>a licensed practical nurse<br>a double locked cupboard in<br>n room. In the cupboard were<br>vith narcotics which were  |                           |  |                                 |                         |  |

|                          | NT OF DEFICIENCIES  | alth<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                           | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED<br>10/24/2016 |                         |
|--------------------------|---|---|---------------------------|--|---|-------------------------|
|                          |   | 00730   | B. WING                   |  |   |                         |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, ST          | TATE, ZIP CODE   |   |                         |
| FRAZEE                   | CARE CENTER   |   | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE                               | (X5)<br>COMPLET<br>DATE |
| 21620                    | discontinued and w<br>bottles of morphine<br>shelf, some with ph<br>2015 and Septemb<br>filled with various n<br>morphine, hydromo<br>On the outside of th<br>the destruction of c<br>also on the counter<br>were 12 bound nard<br>On 10/24/16, at 1:2<br>nursing (ADON) un<br>cupboard in the eas<br>cupboard were two<br>narcotics which we<br>destruction. One bo<br>adjacent to the nard<br>The Inventory And I<br>Substances Form:<br>affixed to the west of<br>The document iden<br>drug name, strengt<br>medication was pla<br>signature of the nur<br>entries from 8/31/10<br>document.<br>During interview on<br>stated all discontinu<br>stored in the double<br>reported when a na<br>nurses were to doc<br>ledger, and on the s<br>what the medication<br>placed in the cupbo | aiting for destruction. Multiple<br>were observed on the upper<br>armacy label dates of January<br>er 2015. The lower self was<br>arcotics such as oxycodone,<br>irphone and fentanyl patches.<br>he cupboard door was taped<br>ontrolled substances form,<br>below the narcotic cupboard<br>cotic ledgers.<br>5 p.m. the assistant director of<br>locked a double locked<br>at medication room. In the<br>smaller shelves filled with<br>re discontinued and waiting for<br>bund narcotic ledger was noted | F<br>J                    | DEFICIENC  |   |                         |

|                          | ta Department of He  |   |                         |  |                                |                         |
|--------------------------|--|---|-------------------------|--|--------------------------------|-------------------------|
|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         |  |                                | E SURVEY<br>PLETED      |
|                          |  | 00730   | B. WING                 |  | 10/24/2016                     |                         |
| NAME OF F                | PROVIDER OR SUPPLIER   |   | DRESS, CITY, S          |  |                                |                         |
| FRAZEE                   | CARE CENTER  |   | T MAPLE AVE<br>MN 56544 | INUE, PO BOX 96  |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>( MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21620                    | Continued From pa  | ge 156  | 21620                   |  |                                |                         |
|                          | nurse managers ha<br>narcotic cupboards<br>want to be respons<br>discontinued narco<br>She stated the curr   | stated 3 different nurses and<br>ad keys to the discontinued<br>. LPN-C indicated she did not<br>ible for the large volume of<br>tic medications in the facility.<br>ent facility practice of storing<br>scontinued narcotics for long<br>ared" her.  |                         |  |                                |                         |
|                          | ADON confirmed b<br>contained many dis<br>double locked cupts<br>several months. The<br>started destroying to<br>medications. The A<br>Of The Inventory At<br>Substances Form w<br>discontinued narco<br>The ADON confirm<br>on the form were do<br>bound ledger, and w<br>the time of destruct<br>was a large quantity<br>the facility. The ADO<br>had access to the k<br>discontinued narco<br>the medications we<br>they were placed in<br>ADON confirmed th<br>process for storage<br>discontinued narco | DON confirmed the Certificate<br>nd Destruction Of Controlled<br>was not a complete list of all<br>tics waiting for destruction.<br>ed all of the medications not<br>ocumented in the narcotic<br>would be cross referenced at<br>tion. The ADON stated there<br>y of discontinued narcotics in<br>ON also stated multiple nurses<br>keys which opened the<br>tic cupboard, and confirmed<br>are not counted again after<br>the locked cupboard. The<br>facility lacked a consistent<br>and destruction of<br>tics. |                         |  |                                |                         |
|                          | 3/1/14, indicated ur<br>and the control reco<br>director's office, and<br>time for destruction<br>Pharmacy Board.  | bled Medication policy dated<br>nused controlled medications<br>ord be taken to the nursing<br>d should be locked up until<br>in accordance with State  |                         |  |                                |                         |
|                          | epartment of Health<br>VI  |   | 6899 I C                | SCM11  | If continuation                |                         |

| Minneso                  | ta Department of He   | alth  |                         |  | FORM        | APPROVED                 |
|--------------------------|---|---|-------------------------|--|-------------|--------------------------|
| STATEMEN                 | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | E CONSTRUCTION   |             | SURVEY<br>PLETED         |
|                          |   | 00730   | B. WING                 |  | 10/         | 24/2016                  |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S          | TATE, ZIP CODE   |             |                          |
| FRAZEE                   | CARE CENTER   |   | T MAPLE AVE<br>MN 56544 | ENUE, PO BOX 96  |             |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | I SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| 21620                    | Continued From pa   | ge 157  | 21620                   |  |             |                          |
|                          | The director of nurs<br>implement policies<br>labeling medication<br>necessary such as<br>assessment and as           | HOD FOR CORRECTION:<br>sing (DON) could develop and<br>and procedures related to<br>s when opened when<br>eye drops. The quality<br>ssurance committee could<br>dits to ensure compliance.                            |                         |  |             |                          |
|                          | TIME PERIOD FOF<br>days.  | R CORRECTION: Twenty (21)   |                         |  |             |                          |
| 21805                    | MN St. Statute 144<br>Residents of HC Fa  | .651 Subd. 5 Patients &<br>ac.Bill of Rights  | 21805                   |  |             | 11/14/16                 |
|                          | residents have the courtesy and respe   | us treatment. Patients and<br>right to be treated with<br>ct for their individuality by<br>rsons providing service in a   |                         |  |             |                          |
|                          | by:<br>Based on observati<br>review the facility fa   | ent is not met as evidenced<br>on, interview, and record<br>iled to maintain dignity for 1 of<br>tho was observed lying in  |                         | corrected  |             |                          |
|                          | Findings include:   |   |                         |  |             |                          |
|                          | 7/13/16 identified R<br>impairment, and wa<br>activities of daily liv<br>more staff to assist<br>further identified R | imum Data Set (MDS), dated<br>66 had severe cognitive<br>as totally dependent of staff for<br>ing (ADLs), and required 2 or<br>with bed mobility. The MDS<br>66 had diagnoses which<br>brain injury, seizure disorder |                         |  |             |                          |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                       | CONSTRUCTION  |                                | E SURVEY<br>PLETED      |
|--------------------------|---|--|---------------------------|---|--------------------------------|-------------------------|
|                          |   | 00730  | B. WING                   |   | 10/24/2016                     |                         |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AI  | DDRESS, CITY, S           | TATE, ZIP CODE  |                                |                         |
| FRAZEE                   | CARE CENTER   |  | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96  |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21805                    | Continued From pa   | age 158  | 21805                     |   |                                |                         |
|                          | and diabetes.   |  |                           |   |                                |                         |
|                          | her bed, on her bad<br>gown. Licensed pra<br>nursing assistant (I<br>room for morning of<br>R66's white sheet a<br>R66's body and se<br>NA-E was position   | :05 a.m. R66 was observed in<br>ck and dressed in a hospital<br>actical nurse (LPN)-A and<br>NA)-E were present in her<br>cares. LPN-A pulled away<br>and white cotton blanket from<br>t both off to R66's right side.<br>ed on R66's right side and<br>ned on R66's left side of her  |                           |   |                                |                         |
|                          | several dried brown<br>dried, yellow stain<br>which extended to<br>where LPN-A was<br>R66. The stains we<br>hand on the bed L<br>with her torso and<br>multiple browns str<br>on R66's sheet. LP<br>streaks and large y<br>urine, covered the | heet was observed to have<br>n streaks, and a large round,<br>on her white cotton bed sheet<br>the left edge of her bed sheet<br>positioned to perform cares on<br>ere next to R66's left arm and<br>.PN-A leaned over R66's bed<br>scrub top resting on the<br>reaks and yellow stained areas<br>2N-A confirmed multiple brown<br>vellow stain were feces and<br>multiple stained areas with<br>blanket and continued to<br>ming cares. |                           |   |                                |                         |
|                          | facility practice was<br>changed on reside<br>linens became soil<br>received a bath on<br>was today. NA-E in<br>how long R66's be   | 03 p.m. NA-E stated the usual<br>s for resident's sheets to be<br>nt bath days, and whenever<br>ed. She stated R66 had<br>Monday, and her next bath<br>ndicated she was not aware<br>d linens had been soiled, and<br>ght night shift had last<br>n bed.   |                           |   |                                |                         |
| anoacta D                |   | 06 p.m. NA-D stated facility dent bed sheets on their bath   |                           |   |                                |                         |

| AND PLAN OF CORRECTION   |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING |  | (X3) DATE SURVEY<br>COMPLETED<br>10/24/2016 |                         |
|--------------------------|---|---|---|--|---|-------------------------|
|                          |   | 00730   |   |  |   |                         |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AI   | DDRESS, CITY, ST                                | TATE, ZIP CODE   |   |                         |
| FRAZEE                   | CARE CENTER   |   | T MAPLE AVE<br>, MN 56544                       | NUE, PO BOX 96   |   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                             | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE            | (X5)<br>COMPLET<br>DATE |
| 21805                    | Continued From pa   | ge 159  | 21805   |  |   |                         |
|                          | day, or whenever th   | ney had an "accident."  |   |  |   |                         |
|                          | facility practice was<br>changed whenever<br>on bath days. She  | 6 p.m. LPN-A stated the usual<br>s for resident's sheets to be<br>the linens became soiled, and<br>stated R66's soiled sheets<br>changed right away when they   |   |  |   |                         |
|                          | (CM)-A stated resic<br>checked for cleanlin<br>resident care. She<br>be changed whene<br>and routinely on the<br>should have been v<br>R66's sheets becar | 53 a.m. clinical manager<br>dent bed sheets should be<br>ness when staff provide<br>stated resident sheets should<br>ver staff notice they are soiled<br>eir bath days. She stated it<br>very obvious to staff when<br>me soiled, and she would<br>nge the sheets right away. | ,   |  |   |                         |
|                          | 3/1/14, identified so<br>immediately remov<br>and taken to the lau<br>identified dirty laund<br>person's body and<br>handling dirty laund                 | blicy, Linens-Handling dated<br>biled linen was to be<br>ed from the resident's room<br>undry room. The policy further<br>dry should not be close to a<br>hands were to be washed after<br>fry and prior to handling clean<br>the spread of infection.                        | r   |  |   |                         |
|                          | The administrator of<br>and revised policies<br>staff on the residen<br>promoted for each<br>and social services  | THOD OF CORRECTION:<br>or social services could review<br>s on dignity and in-service all<br>ts rights so they can be<br>resident. The administrator<br>could monitor cares to ensure<br>esidents in the facility.  | ,   |  |   |                         |
|                          | TIME PERIOD FOR<br>days.  | R CORRECTION: Seven (7)   |   |  |   |                         |

|                          |   | alth<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                        |   | (X3) DATE SURVEY<br>COMPLETED |                         |
|--------------------------|---|--|------------------------|---|-------------------------------|-------------------------|
|                          |   | 00730  | B. WING                |   | 10/24/20                      | 10/24/2016              |
| NAME OF F                | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY,           | STATE, ZIP CODE   |                               |                         |
| FRAZEE                   | CARE CENTER   |  | T MAPLE AV<br>MN 56544 | ENUE, PO BOX 96   |                               |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE CO                       | (X5)<br>DMPLETI<br>DATE |
| 21870                    | Continued From pa   | ge 160   | 21870                  |   |                               |                         |
| 21870                    | MN St. Statute 144<br>Residents of HC Fa  | .651 Subd. 18 Patients & ac.Bill of Rights   | 21870                  |   | 11/                           | 17/16                   |
|                          | residents shall have  | nsive service. Patients and<br>the right to a prompt and<br>se to their questions and  |                        |   |                               |                         |
|                          | by:<br>Based on interview<br>facility failed to ens<br>related to sufficient<br>response times we   | ent is not met as evidenced<br>and document review the<br>ure resident council concerns<br>staffing and long call light<br>re acted upon for 5 of 5<br>R2, R5, R45) who voiced<br>ident council.   |                        | corrected   |                               |                         |
|                          | Findings include:   |  |                        |   |                               |                         |
|                          | 8/17/16, identified F<br>required extensive   | num Data Set (MDS), dated<br>R27 had intact cognition and<br>assistance from staff for<br>Iressing, transferring and toilet  |                        |   |                               |                         |
|                          | routinely attended r<br>she had reported a<br>she had waited free<br>when she put her line<br>stated she was beg<br>something wrong a<br>answer light for tha<br>residents had also<br>responses from sta | 1 p.m. R27 stated she<br>esident council meetings and<br>t the resident council meetings<br>quently for at least 2 hours<br>ght on and needed help. R27<br>inning to feel like she did<br>nd that was why staff didn't<br>t long. She stated other<br>complained of long call light<br>ff and short staff in the<br>elt the facility had not<br>oncerns. |                        |   |                               |                         |

| Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1)         PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00730 |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING:   |                         | (X3) DATE SURVEY<br>COMPLETED  |                                  |                         |
|--|---|---|-------------------------|--|----------------------------------|-------------------------|
|  |   | 00730   | B. WING                 |  | 10/24/2016                       |                         |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET AI   | DDRESS, CITY, ST        | TATE, ZIP CODE   |                                  |                         |
| FRAZEE   | CARE CENTER   |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                  |                         |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21870  | R27 stated she had<br>staff, and long call I<br>conferences. She s<br>told her they will loo<br>anything about it. Si<br>weren't getting the o<br>they were short staff<br>director (AD) was a<br>meeting and she wo<br>to the ones she sho<br>not doing any good.<br>R27 stated she was<br>who had brought up<br>long call light wait ti<br>had not given any e<br>concern continued.<br>telling resident cour<br>the residents contin<br>again, and again.<br>Review of the reside<br>from 7/27/16, 8/31/<br>-7/27, residents wer<br>needs to have their<br>than 2 hours<br>-8/31, residents wer<br>long to answer their<br>further identified R2<br>morning at 8:00 a.m<br>answered until 10:0<br>indicated R27 state<br>long because she w<br>morning activities. T | I also brought up the lack of<br>ight waits during her care<br>tated the facility had always<br>ik into it, but they hadn't done<br>he stated she felt residents<br>care they needed because<br>ffed. She stated the activities<br>t every resident council<br>buld tell residents she talked<br>buld talk to, but evidently it was |                         |  |                                  |                         |

|                          |   |   | CONSTRUCTION            | (X3) DATE SURVEY<br>COMPLETED  |                                 |                         |
|--------------------------|---|---|-------------------------|--|---------------------------------|-------------------------|
|                          | 00730   |   | B. WING                 |  | 10/24/2016                      |                         |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, ST         | TATE, ZIP CODE   |                                 |                         |
| FRAZEE                   | CARE CENTER   |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21870                    | Continued From pa   | ge 162  | 21870                   |  |                                 |                         |
|                          | weren't being answ  | a concern that their call lights<br>ered and residents could wait<br>t their lights answered at any   |                         |  |                                 |                         |
|                          |   | ent council concern follow-up<br>, 8/31/16, and 9/28/16   |                         |  |                                 |                         |
|                          | resident council con<br>and monitoring had<br>indicated they had<br>staff had been aske<br>resident call lights.<br>concerns were pos<br>communication boa<br>morning meetings<br>department heads. | ard and discussed at the<br>with administrator and<br>DON identified she would<br>call lights and address any   |                         |  |                                 |                         |
|                          | call light response to<br>communicated staff<br>director, facility num<br>She indicated she<br>response times and<br>staff. The form lack<br>to be taken to correct                                 | tant indicated she witnessed<br>times on 8/31/16, and<br>fing plans with regional<br>ses and interim administrator.<br>communicated call light<br>d resident concerns to nursing<br>ted documentation of actions<br>ect or improve the staffing<br>call lights responses. |                         |  |                                 |                         |
|                          | reviewed resident c<br>concerns and staffi<br>scheduler, nursing<br>administrator. She<br>education on the im<br>response. The form   | tant indicated indicated she<br>call light response time<br>ng plan with regional director,<br>staff, and interim<br>indicated she provided<br>aportance of timely call light<br>a lacked further documentation<br>en or monitoring to correct or                         |                         |  |                                 |                         |

| Minnesota Department of Health           STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING:   |                         | (X3) DATE SURVEY<br>COMPLETED  |                                  |                          |
|--|---|---|-------------------------|--|----------------------------------|--------------------------|
|  |   | 00730   | B. WING                 |  |                                  | 24/2016                  |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET AL   | DRESS, CITY, S          | TATE, ZIP CODE   |                                  |                          |
| FRAZEE   | CARE CENTER   |   | T MAPLE AVE<br>MN 56544 | NUE, PO BOX 96   |                                  |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETI<br>DATE |
| 21870  |   | ge 163<br>g concerns and long call lights   | 21870                   |  |                                  |                          |
|  | (AD) stated she coo<br>council meetings at<br>She stated the usua<br>minutes from the la<br>review any follow u<br>concerns, reviewed<br>and inform resident<br>facility. She stated<br>over all of the servi | 8 p.m. the activities director<br>ordinated the facility's resident<br>nd typed the meeting minutes.<br>al practice was to review the<br>st resident council meeting,<br>p or response to previous<br>I old business, new business,<br>ts of upcoming events in the<br>at every meeting she went<br>ce areas individually and<br>speak up if they had any<br>departments. |                         |  |                                  |                          |
|  | meetings and R27,<br>voiced concerns re<br>short-staffed and lo<br>She stated almost of<br>complained about r<br>waits, and not eno<br>the assistant director<br>registered nurse co                          | every month residents<br>nursing and long call light<br>ugh staff. She stated she knew<br>or of nursing and the<br>insultant were aware of<br>regarding long call light waits   |                         |  |                                  |                          |
|  | resident council als<br>meetings to all dep<br>concerns were alwa<br>quality assurance n<br>sometimes she fille<br>Concern Follow-up<br>nursing, or put the<br>stated nursing com                             | ight up resident concerns from<br>o verbally during morning<br>artment heads, and resident<br>ays brought up at monthly<br>neetings. She stated<br>id out a Resident Council<br>form, and delivered it to<br>form in their mailboxes. She<br>pleted and returned the form<br>ext scheduled resident council   |                         |  |                                  |                          |

Minnesota Department of Health STATE FORM

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING:   |                           | (X3) DATE SURVEY<br>COMPLETED  |                                |                         |
|---|--|---|---------------------------|--|--------------------------------|-------------------------|
|   |  | 00730   |                           | B. WING  |                                | 24/2016                 |
| NAME OF   | PROVIDER OR SUPPLIER   | STREET AI   | DDRESS, CITY, ST          | TATE, ZIP CODE   |                                |                         |
| RAZEE   | CARE CENTER  |   | T MAPLE AVE<br>, MN 56544 | NUE, PO BOX 96   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21870   | Continued From pa  | age 164   | 21870                     |  |                                |                         |
|   | minutes and follow<br>September. AD star<br>residents received<br>call lights were not<br>was going to be do<br>Review of facility po<br>Council dated 4/1/0<br>group exists, the fa<br>and act upon their<br>recommendations of<br>and operational dee<br>care and quality of<br>SUGGESTED MET<br>The director of nurs<br>that residents conc<br>upon timely. The di<br>could review policy<br>monitor systems, i<br>evaluate the proces<br>upon resident coun<br>related to staffing c | of residents concerning policy<br>cisions that affected resident<br>life.<br>THOD OF CORRECTION:<br>sing or designee could assure<br>erns are listened to and acted<br>rector of nursing or designee<br>y and procedures, train staff,<br>nterview residents and<br>ss to assure the facility acts<br>icil grievances, specifically |                           |  |                                |                         |