DEPARIMENT OF HEALTH A	MEDIC	ARE/MEDICAI			AND TRANSMITTAL	ID: LSCM		
	PART I -	TO BE COMPI	LETED BY T	HE STAT	FE SURVEY AGENCY	Facility ID: 00730		
1. MEDICARE/MEDICAID PROVIDER NO (L1) 245299).	3. NAME AND AL (L3) FRAZEE CA				4. TYPE OF ACTION: <u>7 (</u> L8)		
2.STATE VENDOR OR MEDICAID NO. (L2) 972153000		(L4) 219 WEST M (L5) FRAZEE, M		UE, PO BO	OX 96 (L6) 56544	1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWN (L9) 11/01/2004	ERSHIP	7. PROVIDER/SU 01 Hospital	IPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
 6. DATE OF SURVEY 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	6 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 IIIA 06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF	FISCAL YEAR ENDING DATE: (L35) 09/30		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a): To (b):		Compliance	equirements e Based On:		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN	6. Scope of Services Limit 7. Medical Director		
12. Total Facility Beds	74 (L18)	1. A	cceptable POC			· _		
13.Total Certified Beds	74 (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 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		
 19. DETERMINATION OF ELIGIBILITY _X_ 1. Facility is Eligible to Particip 2. Facility is not Eligible 	pate (L21)		IPLIANCE WITH ITS ACT:	I CIVIL	 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : 			
22. ORIGINAL DATE 23		MENT		TENT		(1.20)		
OF PARTICIPATION 23.	LTC AGREE		4. LTC AGREEN ENDING DAT		26. TERMINATION ACTION: VOLUNTARY _00			
11/01/1985	DEGININING	JDAIL	ENDING DAI	L	01-Merger, Closure 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 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	(()(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 STATE A		REVIEW (INITIAL	/ED BY .s) LB/mm	DATE 12/27/2	016	SIGNATURE OF	SURVEYOR 31256	<u> </u>		DATE 12/21	/2016
REVIEWED BY 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 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 Reg. #		Reg. #	483.75(o)(1)	Completed
LSC	12/21/2016	LSC	12/21/2016	LSC		12/21/2016
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS) LB/mm	DATE 12/27/2016	SIGNATURE OF SURVEYOR 31256		DATE 12/2	1/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVEN	COMPLETED ON	CHECK FOR UNCORREC	I R ANY UNCORRECTED DEFICIEI CTED DEFICIENCIES (CMS-2567)	NCIES. WAS SENT TO T		s 🗆 no

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REVIS	ίT
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING				
245299 _{Y1}	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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4		DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 11/17/2016	ID Prefix Reg. # LSC K0025	Completed	ID Prefix Reg. # LSC	NFPA 101 K0062	Correction Completed 11/17/2016
ID Prefix Reg. # NFPA 101 LSC K0072	Correction Completed 11/17/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC		Correction Completed
REVIEWED BY STATE AGENCY REVIEWED BY CMS RO	REVIEWED BY (INITIALS) TL/mm REVIEWED BY (INITIALS) EY COMPLETED ON		SIGNATURE OF SURVEYOR 365 TITLE R ANY UNCORRECTED DEFICIEN CTED DEFICIENCIES (CMS-2567)	NCIES. WAS	A SUMMARY OF	20/2016 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 _{Y1}	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 Subp. 1	; Completed	Reg. #	MN Rule 4658.04 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 Subp. 3	_ Completed		MN Rule 4658.0465 Subp. 3	Completed	Reg. #	MN Rule 4658.05 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 Subp. 1	Completed		MN Rule 4658.0525 Subp. 1	completed	Reg. #	MN Rule 4658.05 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 Subp. 6 A	Completed		MN Rule 4658.0525 Subp. 6 B	Completed	Reg. #	MN Rule 4658.08 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 Subd. 3	Completed		MN Rule 4658.0900 Subp. 1) Completed	Reg. #	MN Rule 4658.13	45	Completed
LSC		12/21/2016	LSC		12/21/2016	LSC			12/21/2016
			DATE	CIONATUR				DATE	
REVIEW STATE A		NED BY LS) LB/mm	DATE 12/27/20		E OF SURVEYOR 31256			DATE 12/21	/2016
REVIEW CMS RO		WED BY 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 B. Wing Y2 STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96	A. Building B. Wing '12/21/2016 STREET ADDRESS, CITY, STATE, ZIP CODE 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 Y4	DATE Y5	ITEM Y4		DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21805	Correction	ID Prefix 21870		Correction		
Reg. # MN St. Statute 14 Subd. 5	4.651 Completed	Reg. # MN St. Subd.	Statute 144.651 18	Completed		
LSC	12/21/2016	LSC		12/21/2016	_	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS) LB/mm	DATE 12/27/2016	SIGNATURE OF	SURVEYOR 31256	1	DATE 12/21/2016
	REVIEWED BY (INITIALS)	DATE	TITLE			DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/24/2016					NCIES. WAS A SUMMARY SENT TO THE FACILITY?	

DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			CENTERS FOR MED	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 (L1) 245299	ER NO.	3. NAME AND AI (L3) FRAZEE CA				4. TYPE OF ACTION: <u>2 (</u> L8)
2.STATE VENDOR OR MEDICAID N (L2) 972153000	NO.	(L4) 219 WEST M (L5) FRAZEE, M		UE, PO B	OX 96 (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) 11/01/2004		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 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	74 (L17)	X B. Not in Con	npliance with Prog	gram	5. Life Safety Code	9. Beds/Room
			and/or Applied V		* Code: 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	()	COFFICE OR SINGLE S	
19. DETERMINATION OF ELIGIBIL	JTY	20. COM	IPLIANCE WITH	I CIVIL	21. 1. Statement of Finan	ncial Solvency (HCFA-2572)
X 1. Facility is Eligible to P	Participata		HTS ACT:		 Ownership/Contro Both of the Above 	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 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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 FOR MEDICARE & MEDICAID SERVICES			AH "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 FRAZEE, MN	LE AVENUE, PO BOX 96						
ID PREFIX 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						
	 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 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 	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, with the notice (if any) of the State dev hade prior to or upon admission and du doments to it, must be acknowledged in ledicaid benefits, in writing, at the time ones eligible for Medicaid of the items the State plan and for which the resident may ach resident when changes are made to his section. e of admission, and periodically durin harges for those services, including any r diem rate. ts which includes: under paragraph (c) of this section;	ing the stay veloped uring the n writing. e of s and ent may not be charged, o the items g the 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 protection and advocacy network, and file a complaint with the State survey	elephone numbers of all pertinent State client advocacy groups such as ncy, the State licensure office, the State ombudsman program, the d the Medicaid fraud control unit; and a statement that the resident may and certification agency concerning resident abuse, neglect, and 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 applicants for admission oral and writ 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 FRAZEE, MN	PLE AVENUE, PO BOX 96	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIE	NCIES		
F 156	Continued From Page 1			
	This REQUIREMENT is not met as e Based on interview and document revi liability notices, received the required Services (CMS) Form 10123, informin Medicare coverage, 48 hours prior to o Findings include: R52 was provided a Notice of Medicaa would end when she was discharged fr Although R52 received the Notice of N skilled therapy. R52 was given the rig party, a note had been documented wh On 10/24/16 at 10:36 a.m., the assistan required the Notice of Non Coverage 4 they (residents) are to have a 2 day not that R52 would have continued therapy services ended on the 6/23/16. A policy was requested, but not provid	ew, the facility faile Notice of Medicare of them of their right discontinuation of s re Non Coverage of om therapy services Non-Coverage, it want to appeal the not ich indicated R52 v ant director of nursin 48 hours prior to dist tice." The ADON y services up until h	Non-Coverage Centers for Medicare tts to an appeal an expedited review of killed services. A 6/22/16 which indicated her skilled c s on 6/23/16 due to therapy goals being as not provided 48 hours prior to disco- ice, and just below the signature of the would be discharging home on 6/24/16 g (ADON) confirmed R52 had not rec scontinuation of skilled care. The ADO verified she could not find any other do	and Medicaid their overage g met. ntinuation of responsible eived the DN stated, " ocumentation
031099	E	vent ID: I SCM11		If continuation sheet 2

AH

		AND HUMAN SERVICES					APPROVED
		& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	FO	000			
	signature is not req page of the CMS-2	led in ePOC and therefore a uired at the bottom of the first 567 form. Electronic POC will be used as bliance.					
F 201 SS=D	revisit of your facilit validate that substa regulations has bee your verification. 483.12(a)(2) REAS	acceptable POC an on-site y may be conducted to untial compliance with the en attained in accordance with ONS FOR IARGE OF RESIDENT	F 2	201			12/14/16
	the facility, and not resident from the fa discharge is necess	ermit each resident to remain in transfer or discharge the acility unless the transfer or sary for the resident's welfare needs cannot be met in the					
	the resident's healtl	charge is appropriate because h has improved sufficiently so ger needs the services 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, under Medicare or For a resident who	iled, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility. becomes eligible for Medicaid 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 & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	FORI OMB NO	D: 12/15/2016 MAPPROVED D. 0938-0391 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 RAZEE, MN 56544	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 201	charges under Med The facility ceases This REQUIREMEN by: Based on interview facility failed to ensu- inappropriately disc of 1 (R103) resider requirements. Findings include: R103's undated dia diagnoses which ind liver with ascites, he induced insomnia, u chronic obstructive R103's Admission A 10/20/16, identified had clear speech. F revealed R103 was was full weight beau R103's Individual R 10/20/16, identified and was independe (ADL's) including ar Review of R103's n	a resident only allowable icaid; or to operate. T is not met as evidenced and document review, the ure residents are not harged from the facility for 1 hts reviewed for discharge gnoses list identified cluded, alcohol cirrhosis of the epatic encephalopathy, alcohol uncontrolled diabetes and pulmonary disease (COPD). Assessment form dated R103 was alert, oriented and R103's assessment also independent in mobility and ring. esident Care Plan dated R103 was alert and oriented ont with activities of daily living mbulation. urses progress notes from	F 2	201	 F 201 Reason for transfer/discharge of a resident Resident # 103 was discharged from the facility on 10-20-2016. 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. 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. 	
	10/20/16 to 10/21/1 -10/20/16, at 2:00 p facility, was indeper	6 revealed the following: c.m. R103 was admitted to the ndent with ambulation, had the facility and was forgetful at			4. An audit has been developed to monitor the documentation on resident transfers to the hospital for appropriate transfer discharge. The audit will be completed by the DON or designee on all	

Facility ID: 00730

If continuation sheet Page 2 of 184

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

If continuation sheet Page 3 of 184

		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	E SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 201	the facility nurse ha room to stop hitting R103's room. R103 escalate and act er arrived at 9:00 a.m. the emergency roor and shoes sent with Review of R103 soc 10/20/16 to 10/21/1 -10/20/16, R103 ha following a 3 month an altered mental s with various relative R103 had orders fo had not been detern declined to complet he requested to pla -10/21/16, at 3:30 p the emergency roor R103 acting erratica staff and residents. Immediate Discharg where R103 had be notified R103's dau facility and the daug guardian several we manager from Whit R103 was a membe contacted Hennepin open case) and Wr admission and disc Review of R103's p	 and heard R103 yelling in his him, though no person was in B's behavior continued to ratically, the ambulance and R103 was transported to m with his clothing, glasses h him. cial services notes from 6 revealed the following: ad been admitted to the facility h hospital stay which was for tatus. R103 had been living es in the last year and a half. or therapy and length of stay mined at that time. R103 had te the admission paperwork as by bingo. o.m. R103 was transported to m following a 911 call due to ally and had been threatening R103 was issued a Notice of ge via fax to the hospital een transported to. SW had ofter had applied for a eeks prior with a case te Earth Reservation where er. The note also revealed SW n County (where R103 had an hite Earth regarding R103's sharge. 	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 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 201	individuals had bee been threatening th caregivers in the fac the health of individ endangered. The m administrator (FM.) Review of R103's fa dated 10/21/16, rev the hospital due to floor and sitting on The summary revea the hospital by amb sent with. Review of the hosp assessment dated been admitted with encephalopathy and disturbances since The note revealed R to the facility. The m regarding R103's th sent with R103 to th further revealed R1 notice from the faci discharge and the h consult the MN Offi Term Care. On 10/24/16, at 3:5 stated he was awar the hospital as well discharged from the stated he had been uncooperative, lying the dining room tab had also threatened	n endangered and R103 had he life of other residents and cility. The notice also revealed luals in the facility would be otice was signed by the facility	F2	201			

Facility ID: 00730

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

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		AND HUMAN SERVICES & MEDICAID SERVICES			FC	DRM A	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3)) DATE	SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E	(X5) COMPLETION DATE
F 201 F 241 SS=D	paperwork and had stated R103's cogn behavior would also inappropriate. NM-0 very well the night b hospital and the mo hospital he had beo staff and residents. operations told ther had made the decis 483.15(a) DIGNITY INDIVIDUALITY The facility must pro- manner and in an e enhances each residents	ge 7 pleted R103's admission worked with him. NM-C ition had fluctuated and his o fluctuate from appropriate to C stated R103 did not sleep before he was sent to the orning R103 was sent to the one very threatening towards NM-C stated the director of in to call 911 and apparently sion to discharge R103. AND RESPECT OF		201			12/14/16
	by: Based on observat review the facility fa 1 residents (R66) w soiled linens. Findings include: R66's quarterly Min 7/13/16 identified R impairment, and wa activities of daily livi more staff to assist further identified R6	NT is not met as evidenced ion, interview, and record iled to maintain dignity for 1 of ho was observed lying in imum Data Set (MDS), dated 66 had severe cognitive is totally dependent of staff for ng (ADLs), and required 2 or with bed mobility. The MDS 66 had diagnoses which orain injury, seizure disorder			 F 241 Resident dignity 1. Resident # R66 has clean linen on her bed. 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. 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 	list rine	

Event ID:LSCM11

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	her bed, on her bac gown. Licensed pra nursing assistant (N room for morning ca R66's white sheet a R66's body and set NA-E was positione LPN-A was positione bed. R66' bottom bed sh several dried brown dried, yellow stain of which extended to t where LPN-A was p R66. The stains we hand on the bed LF with her torso and s multiple browns stre on R66's sheet. LPI streaks and large ye urine, covered the r R66's white cotton I perform R66's morr On 10/19/16, at 1:0 facility practice was changed on resider linens became soile received a bath on was today. NA-E in how long R66's beco indicated she thoug repositioned R66 in On 10/19/16, at 1:0	 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 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. 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. 6 p.m. NA-D stated facility 	F 2	241	 linens with each incontinent episode 4. An audit has been developed to monitor resident bed linens. The audit be completed by the DON, or desig monitor the cleanliness of resident linens on all three shifts. The audit completed 2-3 per week on all three X 4 weeks, the weekly for 4 weeks, monthly X 2 months. Audit findings reported to the QA committee x 3 m with follow-up to committee recommendations. 5. Deficient practice will be correct December 14, 2016 	o udit will nee to bed will be e shifts then s will be nonths	
		ent bed sheets on their bath hey had an "accident."					

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

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

Facility ID: 00730

		AND HUMAN SERVICES			FORM	12/15/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 242	"months" since she and indicated she u lack of nursing staff On 10/20/16, at 1:5 understood R61 wa a week in the eveni received her baths On 10/21/16, at 11:1 had met with R61 o had not been routin week as care plann On 10/21/16, at 1:3 interview, ADON sta to routinely complet on residents prefere staffing shortages. On 10/24/16, at 9:3 stated she was una getting done 3 time care plan should be A facility policy titleo 1, 2008, revealed a included the right to with reasonable acc needs and preferen residents right to ch	 floor. R61 stated it had been had received 3 baths a week, inderstood it was due to the f. 2 a.m. NA-F stated she as supposed to receive 2 baths ngs and was not sure if R61 routinely. 02 a.m. ADON indicated she on 10/20/16 and confirmed R61 iely receiving her 3 baths a ned. 7 p.m. during a follow up ated she felt staff were unable te the number of baths based ence, such as R61, due to 1 a.m. nurse manager (NM)-A tware R61's baths were not s a week. She stated R61's e followed. d Resident Rights, dated April list of resident rights which o receive services in the facility commodation of individual nees. The policy also revealed noose activities, schedules, nsistent with interests, 	F 242			
F 244 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 FORM APPROVED MB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY 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 FRAZEE, MN 56544				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION		
F 244	CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 2	244	a bath plan ated. ated. and to be ent 5, and will be by the ances and e plans hoice ively vill be nput. tion I 17, dure on the their Staff 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 AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				MB NO. 0938-0391 (X3) DATE SURVEY 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 FRAZEE, MN 56544						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 244	conferences. She s told her they will loc anything about it. Si weren't getting the of they were short stat director (AD) was a meeting and she wo to the ones she sho not doing any good. R27 stated she was who had brought up long call light wait ti had not given any e concern continued. telling resident court the residents contin again, and again. Review of the reside from 7/27/16, 8/31/ -7/27, residents were needs to have their than 2 hours -8/31, residents were long to answer their further identified R2 morning at 8:00 a.m answered until 10:0 indicated R27 state long because she w morning activities. T residents had the sa	ight waits during her care tated the facility had always ik into it, but they hadn't done he stated she felt residents care they needed because ifed. She stated the activities t every resident council build tell residents she talked build talk to, but evidently it was	F 2	244	 response times. 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 5. Deficient practice will be correct December 14, 2016 	led I, R2, at thing he I, or X 4 Audit ttee			
	long because she w morning activities.	vanted to get up to go to The minutes identified other							

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 244	 9/28, residents had weren't being answ up to an hour to get time during the day Review of the resid forms from 7/27/16, identified: -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. 	a concern that their call lights ered and residents could wait their lights answered at any ent council concern follow-up , 8/31/16, and 9/28/16 arsing (DON) identified the neerns and indicated audits been done. DON also room for improvement and all ed to assist in answering DON further indicated the ted in the nursing and and discussed at the with administrator and DON identified she would call lights and address any as needed. tant indicated she witnessed imes on 8/31/16, and fing plans with regional ses and interim administrator. communicated call light d resident concerns to nursing ed documentation of actions for or improve the staffing call lights responses. tant indicated indicated she all light response time ng plan with regional director,	F2	244			

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

Facility ID: 00730

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 12/15/2016 APPROVED . 0938-0391			
STATEMENT	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION (X3) DAT	E SURVEY 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 FRAZEE, MN 56544						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 244 F 248 SS=D	meeting. The AD confirmed r minutes and follow September. AD stat residents received a call lights were not l was going to be dor Review of facility po Council dated 4/1/0 group exists, the fac and act upon their of recommendations of and operational dec care and quality of l 483.15(f)(1) ACTIV/ INTERESTS/NEED The facility must pro- of activities designed the comprehensive the physical, menta of each resident. This REQUIREMEN by: Based on observat review the facility factors	ext scheduled resident council resident council meetings up forms in July, August, and ted she didn't always feel like a straight answer for why their being answered, and what ne to fix the problem. blicy Resident Council/Family 8, identified when a resident cility must listen to their views concerns and of residents concerning policy cisions that affected resident life. ITIES MEET		244	F 248 Activities meet interests/needs of each resident 1. Resident R66 was reassessed for	12/14/16			
	assessment for 1 of	f 3 residents (R66) who was to provide all leisure activities.			activities of interest on November 15, 2016; R66 s care plan was updated to 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 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	Continued From pa	.ge 18	F 2	248			
	Assessment dated staff indicated they activities to let her of and indicated R66 v assessment further included cards and large group program group activities suc programing would b enjoyed watching th Review of R66's ac dated 7/26/16, iden involvement was fa passive, R66 was u a meaningful way. watched TV on a da watched movies. Th sometimes watch th would rather watch visits by staff each	be needed, and R66 also ne birds and TV. tivities quarterly progress note					
	10/11/16, identified was fair, participation R66 was unable to meaningful way. The also watches movies player. The note fun 4, 1:1 visits by active would sometimes re- indicated family visits wheeled her around weather was nice.	quarterly progress note dated R66's activity involvement on level remained passive and structure her time in a ne note indicated R66 loved TV es on her personal DVD rther identified R66 would have vity staff each week and they ead her a book. The note also ited once per week and d or took her outside if the The progress note identified was appropriate, had met her					

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		AND HUMAN SERVICES				FORM	: 12/15/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 248	goal for the last 3 m were effective. and recommended for F Review of the facilit residents from 4/16 activities per week in such as music, B and manicures. Review of R66's Re Chart forms from 4, R66 consistently wa However, the attend consistent 1:1 visits include attendance acclivities. The mo follows: -4/16, 6 out of 16 op staff for the month, No other document activities or activitie -5/16, 7 out of 18 op staff for the month, activities room, 1 m glasses. -6/16, 9 out of 16 op staff for the month, unable. -7/16, 5 of out 18 op staff for the month, watching, 2 cleanin and 3 unable	nonths, activity interventions no changes were R66's activity program. Ty activity calendar for to 10/16 identified 4-5 which R66 had special interest singo, movies, outside walks esident Activity Attendance /1/16 to 10/17/16 revealed atched TV and family visited. dance charts did not include s, and did not consistently at either large or small group nthly documentation as pportunities of 1:1 visits from and 3 unable and 1 refused. ation of large or small group	F2	248			

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		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 248	the month, 1 bird w 1 cleaning glasses, -9/16, 7 out of 18 op the month, 1 outsid unable -10/1-10/24/16, 7 or visits, 1 sitting in far glasses, 1 outside On 10/19/16, during to 10:03 a.m. R66's and her bedroom de observed on her ba hospital gown. R66 position with no me and 3 minutes. R66 calendar posted on the foot of her bed, sign was posted on recliner and identifie -R66 was to be cha -No more Kardashia -Family Feud on ch -Wheel of fortune -Jeopardy 5:00 p.m -Judge Judy 9:00 a -get movie going ea On 10/19/16, at 10: were in R66's room her recliner. LPN-A going to watch on T those Kardashian g R66 a hard time ab	atching, 1 wheeling, 1 outside, and 1 unable pportunities for 1:1 visits for e, 1 cleaning glasses, and 1 ut of 13 opportunities for 1:1 mily lounge, 2 cleaning g observation from 7:00 a.m. s room was dark and quiet, oor was open. R66 was tock in bed, dressed in a 5 remained in the same vaningful activity for 3 hours 5 had a monthly activities her closet door across from and a hand written 8.5 X 11 the wall across from R66's ed: unged during check ups ans'! annel 11:00 a.m.	F2	248			

		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
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		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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 248	On 10/19/16, at 12: seated in her reclinit type program was of turned away from the window. On 10/20/16, at 9:4 dressed in a hospita and her eyes were On 10/18/16, at 12: (FM-A) stated no fat felt no facility staff with had to. She stated as week and a nurse use even when she was now. On 10/21/16, at 10: nurse (LPN-A) state on staff for ADLs. State on 10/24/16, at 10: stated R66 spent ho get 1:1 visits. She state open curtains, and the TV shows she hist stated she didn't kn of her room, and sta sit at the nurses de and missed 1:1 visits or it was hard to provide R66 required so mu- get up. She stated as	age 21 10 p.m. R66 was dressed and er, in front of the TV. A political on TV and R66 eyes were he TV and out her bedroom 2 a.m. R66 was in her bed al gown. R66's TV was off, focused on the ceiling. 17 p.m. family member acility staff visits R66 and she went into her room unless they she visited R66 about twice a used to come and visit R66 sn't working, but she was gone 24 a.m. licensed practical ed R66 was totally dependent the stated the usual routine up, she spent her day watching 08 a.m. activities aide (AA-A) er day watching TV and would stated during 1:1 visits they sit with her talk to her about iked, or put a movie on. She low how often R66 came out ated sometimes they had her sk. She stated R66 slept a lot, ts because she was in bed ated activity staff tried to n an attempt basis. She stated de activities for R66 because uch care, and was difficult to she felt R66 was probably up amily visited, and staff had	F2	248			

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		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 248	tried to get her out i difficult. On 10/24/16, at 10: (CM-A) stated staff recliner and she wa because they were bed or her Broda ch the time. She confir and stated she und time with her in her On 10/24/16, at 12: stated activity staff room which told sta and stated R6 also her room. AD indica had wanted to bring Adventure activity, i during the week, bu attend because she stated R66 used to staff struggled with her wheelchair to a she would like R66 it was such a hassle her wheelchair, and or recliner. AD confi stated her care plar stated her care plar portable DVD playe activity records and TV. She confirmed R66's care plan had current information.	to story time but it was too 53 a.m. clinical manager would get her up in her atched the Kardashians' on a lot, otherwise R66 was in nair in her room the majority of rmed R66's current care plan erstood activities staff spent room. 27 p.m. activities director (AD) had posted a sign in R66's aff what TV shows R66 liked had a portable DVD player in ated in the past activities staff g R66 to the Afternoon which was scheduled daily at struggled to get R66 to e was not in her chair. She get her nails done but activity finding staff to get her up in ttend the activity. She stated to attend music programs but e to find staff to get her up in d R66 was usually in her bed firmed R66's care plan and n could be updated. She n was TV focused and the er also. AD confirmed R66's I stated R66 mostly watched the sign posted in room and d not been updated with	F	248			
	stated her care plar portable DVD playe activity records and TV. She confirmed R66's care plan had current information. Review of facility po- identified the facility	n was TV focused and the er also. AD confirmed R66's I stated R66 mostly watched the sign posted in room and d not been updated with					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/15/2016 APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						(X3) DATE SURVEY 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 FRAZEE, MN 56544							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 248	Continued From pa interests, physical, well-being of each r comprehensive ass	mental, and psychosocial esident based on	F2	248						
F 279 SS=D	483.20(d), 483.20(k COMPREHENSIVE		F2	279			12/14/16			
		he results of the assessment and revise the resident's n of care.								
	plan for each reside objectives and time medical, nursing, and	velop a comprehensive care ent that includes measurable tables to meet a resident's nd mental and psychosocial tified in the comprehensive								
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	describe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided s exercise of rights under he right to refuse treatment).								
	by: Based on observat review the facility fa which included a the motion (ROM) prog	NT is not met as evidenced ion, interview and document iled to develop a plan of care erapy recommended range of ram for 1 of 4 residents (R66) decline in her upper			 F 279 Development of a comprehending care plan 1. Resident R 66 was evaluated by therapy with recommendations for land upper extremity splinting. R66s plan was updated. 2. All residents with a functional d 	oy ROM s care				
						200				

Facility ID: 00730

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CENTERS F	FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			0	FORM	12/15/2016 APPROVED 0938-0391
STATEMENT OF I AND PLAN OF CC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				E SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
R6 7/1 inc an se de aci ide of exi or R6 ha de Th on dic nu R6 1/1 all las col R6 ap an cal spl da cal	13/16, identified F cluded traumatic k d diabetes. The N vere cognitive imp pendent on staff f tivities of daily livi entified R66 had f motion on both si tremities, and did restorative nursin 66's annual MDS of d severe cognitive pendent on staff f e MDS identified both sides, uppe f not receive thera rsing services. 66's Care Area As 11/16, identified R ADLs related to t st year, and had d mmunication and 66's care plan date hasic (non verbal d was unable to r re plan also ident lints for 2 hours o y, and was to wea re plan failed to ic d did not identify rsing program for cline.	imum Data Set (MDS) dated (66 had diagnoses which orain injury, seizure disorder ADS identified R66 had pairment, and was totally for assistance with all ng (ADLs). R66's MDS unctional limitations in range des, upper and lower not receive therapy services ag services. dated 1/11/16, identified R66 e impairment, and was totally for assistance with all ADLs. R66 had functional limitations r and lower extremities, and apy services or restorative sessment (CAA) dated (66 was dependent on staff for raumatic brain injury over the ifficulty with mobility,	F 2	279	 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. 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. 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. 5. Deficient practice will be correct December 14, 2016 	Follow and/or cted in with ave tion 17, rative focus M oid a hitor cation Il be or and e, 2 ded to ths	

Facility ID: 00730

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY 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 FRAZEE, MN 56544		
PREFIX (EACH DEFIC	ENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
 with care's and off every 2 hou on all night. The R66 had contrator or restorative in decline. R66's Admissional and the restoration of the restora	n As and and and and and and and and and and	R66 required total assistance to wear hand splints on and uring the day and leave them de Care Plan did not identify res or that she required a ROM ng program to prevent further ssessment form dated R66 was non verbal, was thad elbow contractures. ssessment form indicated had not been assessed. esident Referral Communication form dated directions for nursing to ssive range of motion (PROM) mities, active range of motion d, and included instruction to d close fingers and to have s hand with her left hand daily h. d Resident Referral from /16, identified R66's hand edule as for R66 to wear splints 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> 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 PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 279	Continued From pa	ige 26	F 2	79				
	-1/21/16, R66 was o remote.	changing TV channels with						
	techniques and lack	es lacked further arding communication skills or ked any documentation of tion, exercises, or decline in						
	Review of R66's ph 2/9/16 to 10/16/16 i	ysician progress notes from identified:						
	injury in 12/14, had care facility, but fan closer to their home communicate verba did not communicat push her call light b	R66 suffered a traumatic brain been in a former long term nily had requested a transfer e. R66's could not ally. Nursing had reported R66 te verbally but was able to putton and could change the with her TV remote.						
	which involved the physician would ma	R66 still had some movement left upper extremity, and the ake sure therapy had a en from a contracture and point for R66.						
	-10/6/16, identified with left hand.	R66 could squeeze his fingers						
	On 10/19/16, obser a.m. were conducte	rvations from 7:00 a.m. to 9:47 ed:						
	back in bed, with he arms were bent at t	was observed lying on her er eyes closed. Both R66's the elbow, her right hand was her chest, and her left hand						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	and hand slightly till devices were not of hands, and the splir in her room. -7:49 a.m. licensed entered R66's room (artificial opening at confirmed R66 was stated R66 had not recent past becaus uncomfortable for F and did not apply R -8:03 a.m. the nurs room and immediat station. R66 remain her hands and arms splints observed. -8:20 a.m. R66 rem same position with and her hands reste position. No hand s hands and splints w room. -9:47 a.m. R66 rem bed, no hand splints present in R66's roo On 10/19/16, at 10: had not worn hand wear the splints "at aware when R66 la indicated she thoug	d position with fingers bent ted away from her body. Splint oserved on either of R66's int devices were not observed practical nurse (LPN)-A in to provide her trachea t windpipe) site care. She not wearing hand splints and been wearing them in the e she thought the splints were R66. LPN-A exited R66's room 66's hand splints. Be consultant walked in R66's rely walked down to the nurses hed on her back in bed, with s in the same positron, no hained lying in bed in the R66's arms bent at her elbows ed on her chest in the same plints were observed on R66's vere not observed in R66's mained in the same position in s were observed on R66 or	F	279			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	Continued From pa	ge 28	F 2	279			
	(NA)-E confirmed F hand splints, and st the last time R66 ha provided a copy of t confirmed the care wear hand splints. S aware R66 was to w LPN-A exited R66's hand splints. On 10/19/16, at 10: not aware of how R	33 am nursing assistant 866 did not routinely wear ated she could not remember ad worn her splints. NA-E the a NA care sheet and sheet directed for R66 to She stated she had not been wear hand splints. NA-A and room and did not apply her 40 a.m. NA-D stated she was 66's care plan directed her to stated she was not aware if					
	wear them. On 10/19/16, at 12: her recliner in her re on her chest, right h	ts or if R66 was supposed to 10 p.m. R66 was seated in oom with both hands resting hand in fist, left hand curled in id not have hand splints on					
	interview, NA-B star receive range of mo	30 a.m., during follow up ted R66 presently did not otion services or presently was orative nursing program.					
	interview, NA-D sta her hands and was stiffness had gotten not aware if R66 wa received range of m reviewed the therap assistant reference and stated she felt	9:36 a.m., during follow up ted R66 did not routinely use not aware if R66's hand worse. She stated she was as on a restorative program or notion services. NA-D by referral in the nursing book at the nursing station R66's therapy screening was 6 did not need range of					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DAT	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279	motion services and since the screen was stated she was sure motion when they d On 10/20/16, at 9:4 nursing stated she had been disconting she questioned if the indicated she felt R contracted than whe On 10/20/16, at 10: (OT)-A stated R66 I time of admission, a aware if R66 had co confirmed R66's the 2/18/16, and indicat 2/18/16, was compl the style of splint fo stated a comprehen contractures had not the facility did not h consult. She stated baseline for her cor not include measure stated the ROM and recommended for F contracture and dis OT-A stated the fac providing ROM serve applying R66's splir had a book of recor programs at the nur- was unable to move independently. She fingers were tighter	 d did not need to wear splints as old (February 2016) She a R66 got enough range of ressed her. 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. 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 	F	279			

Facility ID: 00730

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

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

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

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

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

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

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

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TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	0938-039 SURVEY 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 PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 280	Continued From pa	-	F 2	280		thic	
	transfers and locomotion off the unit. The MDS identified R66 enjoyed listening to music, being around animals such as pets, keeping up with the news, doing things with groups of people, participating in favorite activities and spending time outdoors. R66's Care Area Assessment (CAA), dated 1/11/16 identified R66 suffered from a traumatic brain injury, was unable to speak and make needs known and was dependent on staff for all				 have the potential to be affected in area. Care plans reviewed and up as needed. 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 	dated to staff er 16 on the	
	needs known and w her ADL. The CAA people with her eye or no questions and it was on. R66's care plan dat a big fan of duck D the Kardashians. R				care planning for residents depend staff for activities and need for a restorative nursing ambulation prog A licensed nurse to monitor restora nursing program progress through monthly review of residents receivi restorative care, ADL score, and de in ADL score, and from Casper rep	ent on gram. ttive a ng ecline	
	directed activity sta room to inform all s Dynasty and Keepi activity staff were to and activity staff were (people, Us Weekly during 1:1 visits an enjoy story time. Re R66 required a mere her up and into her	bk at times. R66's care plan ff had posted a sign in her staff that she enjoys Duck ing up with the Kardashians, o complete 4 1:1 visits a week, buld provide gossip magazines y, Star) and would read to her d would see if she was up to 66's care plan further directed chanical lift and 2 staff to get wheelchair, and R66 would be er destinations as desired and			 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. 5. Deficient practice will be correct. 	are f M and e 2 ided to 1ths	
	Assessment dated staff indicated they activities to let her	Therapeutic Programs 1/4/16, identified activities would try to bring her to observe and be around people, was in bed a lot. The			December 14, 2016		

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

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

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

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

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

Facility ID: 00730

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	R29's admission M 7/14/16, identified F impairment, and rec for bed mobility, tra the unit, dressing a identified ambulatio the assessment per R29's admission C/ R29 had dementia, memory problems, appeared related to status related to fall R29's current care f revealed R29 had a walker with assist of ambulation, toileting R29's care plan dire wheeled walker and On 10/19/2016, at her wheelchair, at a propelled herself wi room towards her re On 10/19/2016, at her wheelchair with asked staff direction continued to self pro On 10/19/2016, at nurse (LPN)-C amb desk with a front wh around R29's waist On 10/24/2016, at wheelchair in the ha The facility form title	 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. 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. plan revised 10/14/16, an unsteady gait, used a of one and assist with g, and mobility as needed. ected assist of one with front d wheelchair for ambulation. 8:46 a.m. R29 was seated in a table in the dining room. R29 th her feet, from the dining oom. 9:02 a.m. R29 self propelled her feet in the hall. R29 ns to her room and then opel down the hall. 10:30 a.m. licensed practical pulated R29 past the nurses neeled walker and a gait belt . 9:57 a.m. R29 propelled her 	F 2	280			

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		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	to nursing from phy receive the following ambulate twice daily walker), gait belt, ar x (times) 1. Pt has a therapy. Pt may req upright posture and R29's progress note through 10/23/16, th received therapy for not note that reside nursing staff to amb day, nor was there of received ambulation R29 did not have a the nursing assistan On 10/21/16, at 11:: assistant (PTA) stat with residents ambu programs being cor stated felt there was the facility to comple maintenance progras stated residents suc receive their ambula On 10/24/2016, at R29 was not on a w indicated R29 would walk with her in her On 10/24/2016, at 1 R29 was not schedi ambulation program	 vsical therapy directed R29 vg: "Recommend Pt (patient) 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. 10:14 a.m. NA-I indicated valking program. NA-I d self transfer and staff would room to the bathroom. 10:16 a.m. (NA)-E indicated luled on a list for an 	F2	280			

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

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DEPART	FORM	APPROVED						
	CARENCIES	& MEDICAID SERVICES		тір	LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
-	OF DEFICIENCIES 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 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 SC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOUL 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 I muscle weakness, syncope						
	and collapse.	muscle weakness, syncope						
	•							
		nimum Data Set (MDS) dated R46 had intact cognition, and						
		assistance for transfer,						
		off of the unit, dressing and						
		ssistance for bed mobility and 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, Communication dated 11/6/15,						
		vsical therapy directed R46						
	receive the following	g: "Please ambulate Pt						
		regular walker), transfer belt, ((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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		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DAT	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	Continued From pa walker.	ge 47	F 2	280			
	through 10/1/16, di	es were reviewed 4/3/16, id not note that R46 had n services with floor staff.					
		ambulation program sheet in nt maintenance book.					
	R29 was not sched ambulation program	10:16 a.m. (NA)-E indicated uled on a list for an n. NA-E stated R29 could pivot couple steps but not walk any					
	assistant (PTA)-G in reached their goal i from therapy servic ambulation or lower to be completed by to maintain the prog therapy. PTA-G ver from therapy and s times a day up to 2 tolerated. PTA-G in to be walking with F program should cor a decline, hospitaliz if a decline were to be re-screened. PT	10:32 a.m. physical therapy indicated residnets who had in therapy were discontinued es and then continued with a r extremity exercise program the nursing assistants in order gress which was made in ified R46 had been discharged should be currently walking two 00 feet or as far as R46 dicated she would expect staff R46 in the hall and the ntinue unless the resident had eation or pain. PTA-G indicated occur the resident should then A-G indicated ambulation into d not be enough steps to be ng program.					
	(CM)-B indicated sh ambulate. CM-B in therapy was received	52 a.m. the clinical manager ne had never seen R46 dicated when a referral from ed for an ambulation program rogram it would be written on a					

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

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

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

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

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

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

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

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

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00730

PRINTED: 12/15/2016

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

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

Facility ID: 00730

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATI	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	(LPN)-B stated R44 program for twice a stated R44 liked to was not assisted wi enough staff on the On 10/21/16, at 10: on a walking progra walk twice a day. R to 3 times a day and was walked once a told her they were to not receive her amb that had been happ several months. R4 around the entire bl perimeter around th time would get a bit like she should. R44 was not as steady of R44 stated she fear to walk if she did no program of twice a On 10/21/16, at 10: (RN)-A confirmed F program twice daily walker and gait belt R44 was routinely r program and stated answer the question On 10/21/16, at 10: therapy assistant (O been referred to nu program last year a	 was on a ambulation day in the am and pm. LPN-B walk and felt the times R44 th ambulation was due to not floor. 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. 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	F 2	282			

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		AND HUMAN SERVICES				FORM	APPROVED
			(X2) MUL	TIPL			0938-0391 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 RAZEE, MN 56544		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	-	PROVIDER'S PLAN OF CORRECTION	٨	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION DATE
F 282	Continued From po	ao 62		000			
1 202	Continued From pa 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. expected staff to routinely					
	complete ambulation	on/maintenance programs for					
	resident.						
	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 I and bladder and wore an					
	incontinent brief . T	he care plan listed					
		included to assist R18 to turn y 2 hours and prn, keep skin					

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

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

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

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

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

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

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

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		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION 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 66's care plan directed her to stated she was not aware if hts or if R66 was supposed to					
	her recliner in her ro on her chest, right h	10 p.m. R66 was seated in oom with both hands resting hand in fist, left hand curled in id not have hand splints on					
	interview, NA-B star receive range of mo	30 a.m., during follow up ted R66 presently did not otion services or presently was orative nursing program.					
	nursing stated she had been disconting she questioned if th indicated she felt R	5 a.m. assistant director of was not aware if R66's splints ued in the past and indicated he splints bothered R66 and 66 was not anymore en she was admitted.					
	(RN-A) stated R66 impairment and wa all cares. She state on a ROM program today, or had declir extremities. She sta ROM and wore her	38 a.m. registered nurse had severe cognitive s totally dependent on staff for d she was unaware if R66 was wore her arm splints before hed in ROM to her upper ated R66 should have received arm splints according to the dations and confirmed ROM 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 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	fragile skin, not beir immobile and was to plan also identified the bed or wear she feet, and was to be according to her tur care plan further ide and was to be check hours. Review of the Aide 10/17/16, identified with cares, was to be every 2 hours, and or wear sheepskin I On 10/19/16, at 7:0 dark, and her door dressed in a hospita her back in bed. Re and her body was of legs were straight, a on her mattress. Sh boots. R66's sheep be piled up on R66' 7:19 a.m. R66 was bed, her eyes were loud mouth breathin the mattress and was boots. At 7:39 a.m. in her bed with her continued to be dire wearing her sheeps	and pressure ulcers related to any pressure ulcers related to any able to turn herself, was bed and chair bound. The care R66 was to suspend heels off eepskin boots to protect her turned and repositioned rning and positioning plan. The entified R66 was incontinent ked and changed every 2 Care Plan, Group B, dated R66 required total assistance be turned and repositioned was to float heels off the bed boots. D0 a.m. R66's bedroom was was fully open. R66 was al gown, and was asleep on 66's arms rested on her chest covered with a blanket. R66's and her heels rested directly he was not wearing sheep skin skin boots were observed to s dresser across the room. At in the same position in her now open, continued with ng and heels rested directly on as not wearing her sheep skin R66 was in the same position eyes closed. R66's heels ectly on her bed and was not	F	282			
	entered R66's room	a. LPN-A stated R66's heels d and she was not wearing					

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

Facility ID: 00730

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

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

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 309 SS=D	apply sheep skin bo reposition R66 ever ulcers. She stated s needed more educat floating of heels. A facility policy titleo 4/1/08, identified res admission and as n program including a identified residents highest level of funct A facility policy titleo Management dated facility's policy to en or bladder incontine treatment and servi functioning. The pol an individual toiletin residents and noted 483.25 PROVIDE O HIGHEST WELL BI Each resident must provide the necessa or maintain the high mental, and psycho accordance with the and plan of care. This REQUIREMEN by: Based on observat	 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 I, Restorative Program, dated sidents would be assessed on eeded for a restorative imbulation. The policy further would be supported and their ctioning maintained. 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. CARE/SERVICES FOR EING receive and the facility must ary care and services to attain test practicable physical, social well-being, in a comprehensive assessment NT is not met as evidenced ion, interview and document 		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 highest well-being of residents)r	

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		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	blood sugar checks reviewed who were Findings include: Review of R61's qu (MDS) dated 7/24/1 cognitively intact ar included, insulin de heart failure (CHF) identified R61 requ staff with dressing. received insulin inje Review of R61's an (CAA) dated 1/22/1 diagnoses of depre grateful for anything was content to stay others. The CAA fu to feel self pity in ge R61 had a diagnos requiring insulin an checked 4 times a related to erratic lev R61 received Lantu insulin accordingly. Review of R61's cu 1/27/16, did not add diabetes, blood sug On 10/19/16, at 1:0 wheelchair in her ro face (evident by, fu jaw line). R61 state that morning. R61 st	routine medical treatments of a for 1 of 2 resident (R61) insulin dependent. harterly Minimum Data Set 16, identified R61 was nd had diagnoses which pendent diabetes, congestive and anxiety. The MDS ired extensive assistance from The MDS also identified R61 ections daily. mual Care Area Assessment 6, revealed R61 had ession and anxiety, was g that was done for her and r in her room with visits from rther revealed R61 "appeared eneral." The CAA revealed is of diabetes mellitus, d R61's blood sugars were day and as needed (prn) vels. The CAA further revealed us insulin and a sliding scale	F	309	 R 61 is having her blood glucos levels checked according to the physicians order. All residents with a physician o routine blood glucose monitoring ha potential to be affected in this area. of residents with routine blood gluc monitoring physician orders will be generated and to assess each is re blood glucose monitoring and documentation according to the physicians order. Mandatory nursing and activity education was provided on Novem and 17, 2016 educating the staff or procedure titled, Glucometer blood Testing and Medication Administrat Record with a focus on the need fo licensed staff to perform blood gluco level monitoring per physician orde An audit will be developed to m physicians orders for blood gluco monitoring and documentation on t MAR/TAR according to physician o The audit will be completed by the or designee, weekly X 4 weeks, the monthly X 2 months. Audit findings provided monthly x 3 months to the committee with follow-up to commi- recommendations. Deficient practice will be correct December 14, 2016 	rder for ave the A list ose eceiving staff ber 16 the Sugar ion r sose rs. nonitor se he rders. DON, en s will be e QA ttee	

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PRINTED: 12/15/2016 FORM APPROVED

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

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

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

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

Facility ID: 00730

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CENTER STATEMENT 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 S P F		FORM / MB NO. (X3) DATE COMI 10/2	12/15/2016 APPROVED 0938-0391 E SURVEY PLETED 24/2016 24/2016
F 309	R61's blood sugars R61's care plan sho On 10/24/16, at 10: stated R61 was a c focus on her medic R61 had reported to that not all the nurs SW stated she did medications, treatm followed. SW stated times she was afrai working, though did she felt it was just s upsetting R61 and SW stated she had how a nurse was do should tell that nurs stated her usual pra- nurse regarding res medications and tre SW stated R61 ten and felt R61 had ar issue. A facility policy titled April 1, 2008, reveal directed staff to che prior to insulin adm sugars as needed of A facility policy titled 1, 2008, revealed a included the right to with reasonable aco needs and preferen- residents right to ch	 a to be routinely checked and build be followed. 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 d Insulin Administration, dated aled a facility policy which eck resident physician orders inistration and to check blood or ordered. 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, 	F	309	DEFICIENCY)		

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

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TATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION	· · /	E SURVEY 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 FRAZEE, MN 56544	OX 96	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 310	performance and w plan. The CAA did R38's admission M R38 was not steady human assistance and facing opposite identified R38 had assistance from sta R38's ADL CAA da required assistance and transfer. The C receiving therapies independence in ho R38's Behavioral C R38's Behavioral C R38's goal was to c order to return hom On 10/18/16, at 1:3 the facility hallway, propelling herself to feet. R38 propelled opened the daily ne the paper. On 10/20/16, at 1:3 wheeled herself int to the toilet seat to was able to comple liked to be as indep proceeded to prope utilizing both feet to activity. At 3:08 p.m wheelchair in the a	vould be addressed on care not address R38's ambulation. MDS dated 5/24/16, identified y, only able to stabilize with for walking and turning around e direction while walking. The ambulated with limited aff. ted 5/24/16, identified R38 e from staff to safely ambulate CAA revealed R38 was and her goal was to return to opes of returning home.	F 31	 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. 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. Deficient practice will the December 14, 2016 	d, Restorative a focus on the ent on staff for ulated n/therapy d to monitor tion programs inticipation and review of ms will be done audit will be designee onthly X 2 be provided QA committee	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 12/15/2016 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION	(X3) DATE	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 310	On 10/20/16, at 1:5 (NA)-F stated R38 in and was able to pro- destinations. NA-F with all of her perso- maintain her independ not think R38 was a assisted R38 to am nursing assistants was residents who were and stated she did in ambulation program On 10/20/16, at 2:3 not assisted R38 with the past. NA-B state units were responsi- programs, after the determined by occu- therapies (PT). NA- both PT and OT up months and indicate been placed on the stated she felt R38 could R38 ambulate unit often times cou- their ambulation pro- NAs on the floor. On 10/20/16, at 3:1 (LPN)-B stated the responsible to ambu- ambulation program she was unsure if F program at present clinical record, conf	 a during observations. 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. 0 p.m. NA-B stated she had th ambulation at any time in ed the NA on the individual ble for residents walking 	F3	310			

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		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY 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 PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 310	to be assisted with walker and one-per LPN-B stated she d assisted to ambulat On 10/21/16, at 10: (RN)-A stated she w ambulation program seen R38 ambulate On 10/21/16, at 11:: assistant (PTA) state physical and occup admission to the fac stated R38 was disc in July 2016, with a be placed on an am staff. PTA stated R3 one assist and a fro feet consistently, wh PTA stated she had residents' ambulatio being completed co there was not enou- to complete ambula programs on a rout On 10/21/16, at 11:: no longer able to wa move about the fac walking when she w had worked with the stated nursing staff ambulation since th months ago. R38 st which affected her a	 ambulation twice daily with a son assistance up to 40 feet. did not think R38 had been te since therapy ended. 35 a.m. registered nurse was unaware if R38 was on an n and indicated she had not with staff in the past. 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 	F	310			

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

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

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

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

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

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		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY 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 PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 311	(MDS) dated 7/31/- cognitively intact ar included generalized disorder and anxiet required limited ass corridors and was i mobility and walkin further identified R4 wheelchair for mob was steady at all tir walking and when to opposite direction. Review of R44's ac Functional/Rehabilit Assessment dated required assistance unable to ambulate related to an unstea R44 ambulated with walker and a gait b Review of R44's Fa identified R44 had rising from a seated ambulation and am Review of R44's cu 9/25/15, revealed F mobility in a wheeld with ambulation wit plan directed staff t meals. Review of Aide Car 10/17/16, listed var	arterly Minimum Data Set 16, identified R44 was and had diagnoses which ed osteoarthritis, depressive ty. The MDS identified R44 sistance to ambulate in the ndependent in transfers, bed g in her room. The MDS 44 used a walker and a sility. The MDS revealed R44 mes during transitions, while surning around and facing the extivity of daily living (ADL) itation Potential Care Area 1/29/16, identified R44 e with some ADL's and was any distance independently ady gait. The CAA identified h one nursing assistant (NA) a	F	311	 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. 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. Deficient practice will be correct December 14, 2016 	en in and ected ntation eeded. tion I 17, prative on the taff for 0 ulation e audit esignee 2 ided mittee		

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PRINTED: 12/15/2016 FORM APPROVED

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

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

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		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 311	Continued From pa	ige 94	F3	811			
		rsing progress notes from , revealed the following:					
	-5/14/16, revealed I staff.	R44 ambulated in the hall with					
	-10/15/16, revealed with staff.	I R44 ambulated in the hall					
		ntatio of R44's ambulation lation status was found in ress.					
	(NA)-F stated R44 cares on her own. N assistance to ambu on an ambulation p am and in the pm. I	9 p.m. nursing assistant was able to complete most NA-F stated R44 required ulate in the hallways and was rogram for twice a day in the NA-F stated there were days assisted to ambulate due to u staff on the floor.					
	required limited ass and ambulation. NA ambulation program residents ambulation	4 p.m. NA-B stated R44 sistance with ADL's of dressing A-B stated R44 was on an n for twice a day. NA-B stated on/maintenance programs ne as they should due to not is included R44.					
	(LPN)-B stated R44 program for twice a stated R44 liked to was not assisted wi 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 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	on a walking progra walk twice a day. R to 3 times a day and was walked once a told her they were to not receive her amb that had been happ several months. Ra around the entire bl perimeter around th time would get a bit like she should. R4 was not as steady of R44 stated she feat to walk if she did no program of twice a therapy assess her R44 stated she felt working so hard and burden and request On 10/21/16, at 10: (RN)-A confirmed F program twice daily walker and gait belt R44 was routinely r program and stated answer the question On 10/21/16, at 10: therapy assistant (O been referred to nu program last year a daily to 200 feet wit walker. OTA stated maintain her ability program was consis	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 being routinely for the last 44 stated she was able to walk lock (200 feet square he nursing station,) but at the t winded due to not walking 4 stated she felt as though she on her legs as she used to be. red she would lose her ability of continue with her ambulation day. R44 agreed to having ability to walk at that time. bad the nursing staff was d did not want to add to their t to be walked. 18 a.m. registered nurse R44 was on an ambulation to 200 feet with assist of one, t. RN-A did not comment if eceiving her ambulation d R44 would be best person to	F	311			

Facility ID: 00730

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		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 311	nursing staff. COTA responsible for corr ambulation/mainter busy to consistently program. COTA sta wished they were a programs though w enough staff. On 10/21/16, at 10: assistant (PTA) ass hallway with a gait t assistance. R44 ha steps. R44 stated s and stated that had she walked. R44 a and sat down with of At that time R44 sta short on air when s getting walked as fa proceeded to remov PTA for the walk. On 10/21/16, at 10: R44's ability to amb as when she had la as she was aware f recent and likely du her ambulation prog noticed residents w their ambulation/ma not enough staff. P' residents on mainter them referred back to a decline. PTA st not enough staff to residents programs were responsible for	A stated the NA's were ppleting residents ance programs and were too y complete each residents ted NA's had verbalized they ble to complete residents rere unable to due to not 46 a.m. physical therapy sisted R44 to ambulate in the belt, walker and contact guard d a steady gait and even the was getting, "short on air," I been happening lately when mbulated 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 50 a.m. PTA stated she felt bulate the distance the same ast seen her. PTA stated as far R44's shortness of breath was te to not consistently receiving gram. PTA stated she had rere not consistently receiving aintenance programs due to TA stated she had placed enance programs and has had to therapy for treatment due tated she felt this was due to consistently carry out a. PTA stated the facility NA's	F	311			

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		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	stated she had void residents ambulation nursing and admini- medicare meeting a ago. PTA stated the was the staff were g On 10/21/16, at 11: nursing (ADON) co consistently receivin ADON stated she e complete ambulation resident. ADON state ambulation/mainter done due to staffing the NA's did not have residents programs she did not feel R44	Ugh NA'S on the floor. PTA eed her concerns about on/maintenance programs to stration during the weekly as recently as a month or so e response she had received going to "talk" to the NA's. 13 a.m. assistant director of nfirmed R44 was not ng her ambulation program. expected staff to routinely on/maintenance programs for the she felt the facility's nance program was not getting g concerns and stated she felt we the time to complete all s, including R44. ADON stated 4 had lost any ability to d ask R44 how often she	F3	311			
	as directed by phys nursing assistant gr nursing assistance for residents). R29's Order Summ	eceiving ambulation services ical therapy and per the roup sheet (a reference used regarding specific care ary form dated 9/16/16, diagnoses which included					
	muscle weakness, R29's admission N	malaise, and psychosis. Iinimum Data Set (MDS) dated R29 had severe cognitive					

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

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

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

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

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

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

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

Facility ID: 00730

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		AND HUMAN SERVICES & MEDICAID SERVICES	FORM APPROVED OMB NO. 0938-0391					
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY 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 FRAZEE, MN 56544				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 312	Continued From pa and oral hygiene.	ge 105	F 312	2				
	by: Based on observat review the facility fa were completed in a residents (R18) rev and on who were of program. Findings include: Review of R18's qu (MDS) dated 7/26/1 cognitive impairmer communicate with s included, dementia, MDS identified R18 for activities of daily staff for assistance hygiene and toiletin was frequently inco The MDS identified program for bowel of Review of R18's an identified R18 was fa ADL's. The MDS identified incontinent of bowel identified R18 was fabowel or bladder into Review of R18's Co Area Assessment (M	staff and had diagnoses which depression and anxiety. The was totally dependent on staff living (ADL's) and required 2 with bed mobility, personal g. The MDS identified R18 ntinent of bowel and bladder. R18 was not on a toileting or bladder incontinence. nual MDS dated 4/26/16, totally dependent on staff for entified R18 was frequently I and bladder. The MDS not on a toileting program for continence. ognitive Loss/ Dementia Care CAA) dated 4/26/16, identified		 F 312 Assistance with ADLs provided pendent residents 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. 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 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	y ay be an will nt ance pe ents be for an eded. ion 17 on tily timely ladder ually, us. ponitor l sidents rine			
	bowel or bladder ind Review of R18's Co Area Assessment (R18 had cognitive la	continence. ognitive Loss/ Dementia Care		residents through observations and documentation review to ensure re-	l sidents rine 1 every			

Facility ID: 00730

PRINTED: 12/15/2016

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

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

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

Facility ID: 00730

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

Facility ID: 00730

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

				FORM	12/15/2016 APPROVED 0938-0391
OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY 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 FRAZEE, MN 56544		
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) BE	(X5) COMPLETION DATE
On 10/20/16, at 3:2 (LPN)-B stated R18 staff of for all of her was not able to verf needed to anticipate was at risk for skin incontinence and in On 10/21/16, at 1:3 interview ADON sta to routinely reposition timely manner, such shortages. ADON sta able to fill in for sick when the facility we schedule. A facility policy titled Management dated facility's policy to er or bladder incontine treatment and servi functioning. The po an individual toiletin	 8 p.m. licensed practical nurse 8 was totally dependent on r needs. LPN-B stated R18 balize her needs and staff e them. LPN-B stated R18 breakdown due to nmobility. 7 p.m. during a follow up ated she felt staff were unable oning and toilet residents in a h as R18, due to staffing stated they were not always c calls and there were times ere unable to fill holes in the d Bowel and Bladder 4/1/08, revealed it was the nsure each resident with bowel ence would receive appropriate ices to maintain normal licy directed staff to develop ng schedule for all incontinent 	F 31			
PREVENT/HEAL P Based on the comp resident, the facility	RESSURE SORES prehensive assessment of a must ensure that a resident	F 31	14		12/14/16
	RS FOR MEDICARE OF DEFICIENCIES OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER CARE CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa On 10/20/16, at 3:2 (LPN)-B stated R18 staff of for all of her was not able to verl needed to anticipate was at risk for skin incontinence and in On 10/21/16, at 1:3 interview ADON stat to routinely reposition timely manner, such shortages. ADON stat to routinely reposition to routinely reposition the schedule. A facility policy timely Management dated facility's policy to error or bladder incontine the schedule. A fasility of the schedule to the sche	IDENTIFICATION NUMBER: 245299 PROVIDER OR SUPPLIER CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 111 On 10/20/16, at 3:28 p.m. licensed practical nurse (LPN)-B stated R18 was totally dependent on staff of for all of her needs. LPN-B stated R18 was not able to verbalize her needs and staff needed to anticipate them. LPN-B stated R18 was at risk for skin breakdown due to incontinence and immobility. On 10/21/16, at 1:37 p.m. during a follow up interview ADON stated she felt staff were unable to routinely repositioning and toilet residents in a timely manner, such as R18, due to staffing shortages. ADON stated they were not always able to fill in for sick calls and there were times when the facility were unable to fill holes in the schedule. A facility policy titled Bowel and Bladder Management dated 4/1/08, revealed it was the facility's policy to ensure each resident with bowel or bladder incontinence would receive appropriate treatment and services to maintain normal functioning. The policy directed staff to develop an individual toileting schedule for all incontinent residents and noted on resident care plans.	AS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 245299 PROVIDER OR SUPPLIER 245299 B. WING CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 3: Continued From page 111 On 10/20/16, at 3:28 p.m. licensed practical nurse (LPN)-B stated R18 was totally dependent on staff of roall of her needs. LPN-B stated R18 was not able to verbalize her needs and staff needed to anticipate them. LPN-B stated R18 was at risk for skin breakdown due to incontinence and immobility. F 3: On 10/21/16, at 1:37 p.m. during a follow up interview ADON stated she felt staff were unable to routinely repositioning and toilet residents in a timely manner, such as R18, due to staffing shortages. 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F 3: 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES F 3: Based on the comprehensive assessment of a resident, the facility must ensure that a resident F 3: <td>MENT OF HEALTH AND HUMAN SERVICES O SFOR MEDICARE & MEDICAID SERVICES O OP DEFICIENCIES (X1) PROVIDERSUPPLERCIA DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING PROVIDER OR SUPPLER 245299 B CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, IMN 56544 SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTOR ALTONY ON LSC IDENTIFINING INFORMATION) P PROVIDER'S PLAN OF CORRECTIO FRAZEE, IMN 56544 SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTOR ACTION SOLUTION (FACH CORRECTOR ACTION SOLUTION) P PROVIDER'S PLAN OF CORRECTIO FRAZEE, IMN 56544 Continued From page 111 On 10/20/16, at 3:28 p.m. licensed practical nurse (LPN)-B stated R18 was totally dependent on staff of for all of her needs. LPN-B stated R18 was and table to verbalize her needs and staff needed to anticipate them. 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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. ADON stated they were not always able to fill in for sick calls and there were times when the facility spolicy timed Rowell are discording and the for sick calls and there were times when the facility spolicy to ensure each resident with brewell or blacker incontinence would receive appropriate treatment and services to maintain normal trunctionign. The policy directed staff to develop an individual toileting schedule for all incontinent residents in a timely manner. Such as F18, due to staffing shortages. ADON stated they were apportate treatment and services to maintain normal trunctionign. The policy directed staff to develop an individual toileting schedule for all incontinent expression more times. 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 DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING PROVIDER OR SUPPLER 245299 B CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, IMN 56544 SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTOR ALTONY ON LSC IDENTIFINING INFORMATION) P PROVIDER'S PLAN OF CORRECTIO FRAZEE, IMN 56544 SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTOR ACTION SOLUTION (FACH CORRECTOR ACTION SOLUTION) P PROVIDER'S PLAN OF CORRECTIO FRAZEE, IMN 56544 Continued From page 111 On 10/20/16, at 3:28 p.m. licensed practical nurse (LPN)-B stated R18 was totally dependent on staff of for all of her needs. LPN-B stated R18 was and table to verbalize her needs and staff needed to anticipate them. 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Facility ID: 00730

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &					FORM A	12/15/2016 APPROVED 0938-0391
	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	SURVEY 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 RAZEE, MN 56544		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
 individual's clinical corthey were unavoidable pressure sores receive services to promote he prevent new sores from this REQUIREMENT by: 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	ssure sores unless the ndition demonstrates that e; and a resident having res necessary treatment and ealing, prevent infection and on developing. T is not met as evidenced n, interview and document facility failed to complete or residents on a turn and and who were assessed to e ulcers for 2 of 4 residents for pressure ulcers. terly Minimum Data Set identified R18 had severe was unable to aff and had diagnoses which epression and anxiety. The ras totally dependent on staff ving (ADL's) and required 2 th bed mobility. The MDS risk for developing pressure entions in place which educing device for the chair	F 3	314	 F 314 Treatment/Services to preven pressure sores 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. 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. 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 	or care ll be e of re ted in risk essure ed for dents isted heir ew on 17, oning ur	

Facility ID: 00730

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY 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 FRAZEE, MN 56544	X 96	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 314	Area Assessment (R18 had cognitive I was unable to cohe The CAA revealed spite of her inability R18's Communicat needs must be anti Pressure Ulcer CAJ potential for skin br incontinence, decret to make her needs R18 could move ind required staff assis sitting position. The regular schedule of relieving cushion in Review of a Compr dated 7/26/16, reve skin breakdown bas (assessment for pro of 14 and a tissue t revealed interventio included, gel cushio required turning an change every 2 hou Review of R18's ph 10/6/16, revealed F routine nursing hon R18 had severe de	am. ognitive Loss/ Dementia Care CAA) dated 4/26/16, identified oss related to dementia and erently verbalize her needs. R18's needs were to be met in to make her needs known. ion CAA identified R18's cipated by facility staff. R18's A identified R18 had a eakdown related to eased mobility and her inability known. The CAA revealed dependently in bed but tance to reposition when in a e CAA identified R18 required a turning and had a pressure wheelchair. ehensive Analysis of Skin form ealed R18 was at high risk for sed on a Braden scale edicting pressure sores) score olerance test. The form ons were put in place which on in wheelchair and R18 d repositioning with check and urs and as needed (PRN). eysician progress note dated R18 had been seen for a ne visit. The note revealed mentia and Alzheimer's ependent on facility staff for	F 31	 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. 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. 5. Deficient practice will be December 14, 2016 	t for dmission and d repositioning esident mentation of ograms will be n off as rt audit has skin are planning n integrity, ons including ositioning, eduction, n with dietician sician orders ion and ies, and also tation on the kly RN wound oblection be completed ekly X 4 onths. Audit nthly x 3 y-up to	

		AND HUMAN SERVICES				FORM	: 12/15/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	 was unable to communicative theorem particular dependent or repositioning needs skin breakdown. The interventions which and reposition every clean and dry and a wheelchair. On 10/19/16, from T continuous observation following: At 7:03 a.m. R18 wa a gel cushion, fully bed was stripped of hung forward in a c eyes were closed. At 7:21 a.m. R18 re wheelchair in her reenter R18's room. 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. 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	municate her needs and was n staff for toileting, s and had a potential risk for ne care plan listed included to assist R18 to turn by 2 hours and prn, keep skin	F	314			

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

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

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		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	small amount of sto surface which had of pink creases and w peri-rectal area. NA R18 to complete to back in her wheelch On 10/19/16, at 10: thought R18 was la a.m. and stated she others with cares to and toileting needs. supposed to be rep checked/changed e NA-E stated R18 w needs and staff was On 10/20/16, at 2:3 needs must be anti- dependent on 2 sta repositioning and to required routine eve toileting. NA-B state red at times, but co areas on R18's butt On 10/20/16, at 3:2 (LPN)-B stated R18 staff for all of her ne not able to verbalize to anticipate them. for skin breakdown immobility. On 10/21/16, at 1:3 interview the ADON unable to routinely for in a timely manner,	 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	F	314			

Facility ID: 00730

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

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
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. 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. 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 her identified R66 was at high pressure ulcers related to her rself or ask for help when she , and staff were to anticipate ure she was repositioned. The ed R66 required a special lchair cushion, and required a turning and repositioning to red 2/18/16, identified R66 was be pressure ulcers related to ng able to turn herself, was bed and chair bound. The care R66 was to suspend heels off eepskin boots to protect her turned and repositioned ming and positioning plan. The entified R66 was incontinent ked and changed every 2 Care Plan, Group B, dated R66 required total assistance be turned and repositioned was to float heels off the bed boots. an note dated 12/31/15, heel was at risk for e ulcers, Eucerin cream was els twice a day and heels were	F	314			

		AND HUMAN SERVICES				FORM	: 12/15/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	10/5/16, identified F heels off of her bed alteration in skin int R66's comprehensi 1/4/16, identified R6 admission and had precaution. R66's Braden Scale pressure sores) dat at high risk for deve document also ider mattress, heels wer R66 continued to no had special cushior R66 had a history of R66's tissue tolerar resident could be in skin damage) dated required 2 hour rep ulcers. R66's progress not 10/17/16 identified: 2/3/16, R66 had a 2 right shin and ankle PROFO boot, staff heels. R66's wheeld relief pedals. 2/4/16, R66 had an ankle 2/6/16, Family expr	R66 had orders to suspend her levery shift for preventing regrity. ive analysis of skin dated 66 had pink heels on been free floated for e (assessment for predicting ted 7/13/16, identified R66 was eloping pressure ulcers. The ntified R66 had a special re to be kept off the bed and eed to be repositioned and n in her wheelchair because of pressure ulcers. nce test (length of time n the same position without d 7/13/16, identified R66 ositiong to prevent pressure es reviewed from 12/31/15 to 2 cm X 0.5 cm area on her e from possible rubbing on removed boot and floated her chair had built-in pressure intact blister on her right essed concern with R66's right ned areas were from boot and	F	314			

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	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION 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 her inner ankle fron	perficial, abraded/scraped om profo boot and a blister to n being up in her wheelchair suspected foot rubbed on foot					
	2/10/16, blister hea	ling, heels free floated					
	2/13/16, areas to rig resolved.	ght foot/ankle and right shin					
	dark, and her door dressed in a hospita her back in bed. Re and her body was o legs were straight, a on her mattress. Sh boots. R66's sheep be piled up on R66' 7:19 a.m. R66 was bed, her eyes were loud mouth breathin the mattress and wa boots. At 7:39 a.m. in her bed with her	00 a.m. R66's bedroom was was fully open. R66 was al gown, and was asleep on 66's arms rested on her chest covered with a blanket. R66's and her heels rested directly he was not wearing sheep skin skin boots were observed to 's dresser across the room. At in the same position in her now open, continued with ng and heels rested directly on as not wearing her sheep skin R66 was in the same position eyes closed. R66's heels ectly on her bed and was not skin boots.					
	entered R66's room were not free floate sheep skin boots. I heels were, "kind of	ed practical nurse (LPN)-A n. LPN-A stated R66's heels d and she was not wearing LPN-A stated she felt R66's f," floated by the bubbles in A then pulled a flat pillow down					

Facility ID: 00730

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PRINTED: 12/15/2016

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATI	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	to approximately on however it did not li LPN-A laid R66's he immediately left the At 8:03 a.m. the reg walked in to R66's n out, towards the nu remained in the sar asleep. R66 remain heels floated, or sh a.m. At 10:03 a.m. LPN- developing pressure think R66 had press stated R66 sometin and sometimes the bed. LPN-A stated I pressure mattress a repositioned and ch hours. LPN-A confir been repositioned v that morning. At 10 observation (3 hour confirmed both R66 and R66 had not we heels and bottom w R66's room and as morning cares. At 10:33 a.m. NA-E last time R66 was r was supposed to b checked and chang she would have to o see when she reposi-	ie inch under R66's calves ft R66's heels off the mattress. eels directly on the bed, and	F	314			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	ulcers, but she didn problems. NA-E sta bed because R66 h and had an air bed. didn't wear her shee her current care she sheepskin boots. N room after R66 was floated by a pillow of On 10/19/16, at 10: didn't know if R66 w pressure ulcers, or her to do for R66's special mattress, ar would be at risk. NA R66 had a history o aware of any sheep stated she did not r and stated she thou been repositioned w by the night staff. On 10/19/16, at 12: recliner in front of h heels floated on a p sheep skin boots. F the foot rest of her n On 10/19/16, at 1:0 interview NA-E stat on staff for cares, a tell what R66's cogr	 ¹t think R66 had any skin ted R66 heels could be on the had no breakdown at this time NA-E further stated R66 ep skin boots. NA-E confirmed eet did not direct the use of A-E and LPN-A left R66's in her recliner with her heels on the footrest of the recliner. 40 a.m. NA-D stated she vas at risk for developing what R66's care plan directed skin. She stated R66 had a nd stated she assumed R66 A-D stated she didn't know if f pressure ulcers and wasn't o skin boots for R66. NA-D eposition R66 this morning, ught the last time R66 had vas at approximately 630 a.m. 10 p.m. R66 was seated in er TV. R66 did not have her billow and was not wearing her R66's heels rested directly on 	F 314	4		

Facility ID: 00730

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	On 10/19/16, at 1:1 back, legs straight of directly on her bed. floated with a pillow skin boots. On 10/19/16, at 1:1 interview, LPN-A sta dependent on staff R66 was clearer so stated she thought she was clearer. On 10/19/16, at 1:3 totally dependent of she didn't think R66 ulcers, and didn't kr ulcers in the past. N rested directly on he wearing sheepskin Aide Care Sheet an had sheepskin boot sheet, but R66's he and R66 was suppor 2 hours. On 10/24/16, at 10: (RN)-A stated R66 impairment and was cares. She stated F pressure ulcers bed had ever had any si R66's heels were si her bed, and the NA R66 every 2 hours.	11 p.m. R66 laid in bed on her out with her heels resting . R66 did not have her heels w, and was not wearing sheep 16 p.m. during follow up tated R66 was totally for cares, and stated she felt ome day's versus others and R66 understood them when 84 p.m. NA-B stated R66 was in staff for cares, and stated R66's cognition. She stated 6 was at risk for pressure now if R66 had pressure NA-B confirmed R66's heels her bed and she was not boots. NA-B confirmed R66's and stated she didn't know R66 its as they weren't on her eels were supposed to floated osed to be repositioned every :38 a.m. registered nurse had severe cognitive is totally dependent on staff for R66 was at risk for developing cause she couldn't reposition she didn't remember if R66 skin problems. She stated supposed to be floated off of A's were supposed reposition	F 3	;14			

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		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	stated R66 had sev was dependent on a was supposed to be her heels were supp bed, or R66 was to had a history of pre remembered R66 had remembered R66 had fev and that's when the implemented floatin confirmed R66's mod directed staff to floa wear sheep skin bo R66 every 2 hours. to follow R66's care apply sheep skin bo reposition R66 ever ulcers. She stated s needed more educa floating of heels. On 10/24/16, at 1:4 (NP)-A confirmed R pressure ulcers on physician's order to 12/31/15. NP-A com physician's or nursii boots. On 10/25/16, at 5:0 stated R66 had dev shin, and about a q of her ankle on her facility. She stated th boot rubbing on her tight. She stated sh R66 didn't move her	rere cognitive impairment and staff for cares. She stated R66 e repositioned every 2 hours, posed to be floated off of her wear sheepskin boots. R66 ssure ulcers. She stated she had a blister on her heel in ofo boot or splint she wore, ey discontinued the boot and ng R66's heels. UM-A ost recent care plan which at R66's heels off the bed or oots, and turn and reposition She stated she expected staff e plan and float her heels or oots to R66's feet, and ry 2 hours to prevent pressure she felt nursing assistants ation on repositioning and 5 p.m. nurse practitioner R66's left heel was at risk for admission, and there was a float R66's heels since offirmed there was not a ng order to use the sheepskin 5 p.m. family member (FM)-A arely move her arms now. She reloped a deep ulcer on her uarter size blister on the inside right foot after she got to the they told her it was from her r skin, and the boot was too e questioned them because er legs and feet enough to stated no staff went into	F3	314			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY 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 FRAZEE, MN 56544) BOX 96	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 314 F 318 SS=G	Review of facility po Integrity/Wound Ma determined at risk f receive the proper t included specific ph pressure reliving ec per resident assess 483.25(e)(2) INCRE IN RANGE OF MO Based on the comp resident, the facility with a limited range appropriate treatme	blicy, Pressure Ulcer/Skin anagement identified residents or loss of skin integrity would creatment/services which hysician ordered treatments, quipment, and repositioning sment. EASE/PREVENT DECREASE TION orehensive assessment of a must ensure that a resident of motion receives ent and services to increase d/or to prevent further	F 3			12/14/16
	by: Based on observat review the facility fa motion (ROM) servi prevent further decl extremities for 1 of ROM. This deficient harm for R66. Findings include: R66's quarterly Min 7/13/16, identified F included traumatic I and diabetes. The N severe cognitive im	NT is not met as evidenced ion, interview and document iled to provide range of ices and hand splints to line in ROM for upper 4 residents (R66) reviewed for t practice resulted in actual imum Data Set (MDS) dated R66 had diagnoses which brain injury, seizure disorder MDS identified R66 had pairment, and was totally for assistance with all		 F 318 Increase/Preventation 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. All residents have the affected in this area. A coded on the MDS as here. 	ed by therapy with e nursing staff nity ROM and L scores will be referrals to Facility team has been meeting monthly (, 2016; team will from Nursing and he potential to be 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 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		LE CONSTRUCTION	(X3) DATE	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	Continued From pa	ge 128	F3	818			
	12/31/15, indicated non-weight bearing mechanical lift, and R66's Admission As R66's hand grasps Review of R66's Re Interdepartmental O 1/12/16, identified of complete R66's pas to both upper extrem (AROM) to left hand have R66 open and R66 squeeze staff's to maintain strength Review of a second therapy dated 2/18/ splint wearing sche 2 hours on, 2 hours at night. R66's progress note 10/17/16 identified: -1/3/16, R66 reacher remote with her left remote in her left ha -1/21/16, R66 was or remote. R66's progress note documentation rega	had elbow contractures. ssessment form indicated had not been assessed. esident Referral Communication form dated directions for nursing to ssive range of motion (PROM) mities, active range of motion d, and included instruction to d close fingers and to have s hand with her left hand daily n. d Resident Referral from (16, identified R66's hand dule as for R66 to wear splints s off throughout the day and on es reviewed from 1/3/16 to ed over and grabbed the TV c hand and could hold her TV and. changing TV channels with					

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PRINTED: 12/15/2016

		AND HUMAN SERVICES			FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	Continued From pa	uge 129	F 318			
	upper extremity mo function.	tion, exercises, or decline in				
	Review of R66's ph 2/9/16 to 10/16/16 i	nysician progress notes from identified:				
	injury in 12/14, had care facility, but fan closer to their home communicate verba did not communica push her call light b	R66 suffered a traumatic brain been in a former long term nily had requested a transfer e. R66's could not ally. Nursing had reported R66 te verbally but was able to button and could change the with her TV remote.				
	which involved the physician would ma	R66 still had some movement left upper extremity, and the ake sure therapy had a len from a contracture and point for R66.				
	-10/6/16, identified with left hand.	R66 could squeeze his fingers				
	On 10/19/16, obser a.m. were conducte	rvations from 7:00 a.m. to 9:47 ed:				
	back in bed, with he arms were bent at t in a fist position on was in a "C" shaped and hand slightly til devices were not of hands, and the split in her room.	was observed lying on her er eyes closed. Both R66's the elbow, her right hand was her chest, and her left hand d position with fingers bent ted away from her body. Splint bserved on either of R66's nt devices were not observed				
1	-7:49 a.m. licensed	practical nurse (LPN)-A			1	

		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 318	entered R66's room (artificial opening at confirmed R66 was stated R66 had not recent past because uncomfortable for F and did not apply R -8:03 a.m. the nurs room and immediat station. R66 remain her hands and arms splints observed. -8:20 a.m. R66 rem same position with and her hands reste position. No hand s hands and splints w room. -9:47 a.m. R66 rem bed, no hand splints present in R66's roo On 10/19/16, at 10: had not worn hand wear the splints "at aware when R66 la indicated she thoug past. LPN-A left roo splints to R66. On 10/19/16, at 10: (NA)-E confirmed F hand splints, and st the last time R66 has provided a copy of the second content of the second second second second provided a copy of the second second second second cond second second second second second second second second provided a copy of the second secon	n to provide her trachea t windpipe) site care. She a not wearing hand splints and been wearing them in the e she thought the splints were R66. LPN-A exited R66's room 66's hand splints. See consultant walked in R66's tely walked down to the nurses hed on her back in bed, with s in the same positron, no nained lying in bed in the R66's arms bent at her elbows ed on her chest in the same plints were observed on R66's were not observed in R66's	F	318	3		

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 318	wear hand splints. S aware R66 was to w LPN-A exited R66's hand splints. On 10/19/16, at 10: not aware of how R care for R66. She s R66 had hand splin wear them. On 10/19/16, at 12: her recliner in her re on her chest, right R a "C" shape. R66 d either hand. On 10/20/16, at 9:3 interview, NA-B sta receive range of mo not receiving a rest On 10/20/2016, at 9 interview, NA-D sta her hands and was stiffness had gotter not aware if R66 wa received range of m reviewed the therap assistant reference and stated she felt not current, and R6 motion services and since the screen wa	age 131 She stated she had not been wear hand splints. NA-A and s room and did not apply her :40 a.m. NA-D stated she was R66's care plan directed her to stated she was not aware if nts or if R66 was supposed to :10 p.m. R66 was seated in com with both hands resting hand in fist, left hand curled in lid not have hand splints on 30 a.m., during follow up tted R66 presently did not otion services or presently was torative nursing program. 9:36 a.m., during follow up ated R66 did not routinely use a not aware if R66's hand n worse. She stated she was as on a restorative program or notion services. NA-D py referral in the nursing e book at the nursing station R66's therapy screening was 56 did not need range of d did not need to wear splints as old (February 2016) She e R66 got enough range of	F	318			
		15 a.m. assistant director of was not aware if R66's splints					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATI	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 318	had been discontinues she questioned if the indicated she felt R contracted than whe On 10/20/16, at 10: (OT)-A stated R66 I time of admission, a aware if R66 had con- confirmed R66's the 2/18/16, and indicat 2/18/16, was complet the style of splint for stated a comprehen- contractures had not the facility did not h consult. She stated baseline for her cor- not include measures stated the ROM and recommended for F contracture and dis OT-A stated the face providing ROM serve applying R66's splint had a book of recor- programs at the num- was unable to move independently. She fingers were tighter was slightly limited, limitations were with she felt R66's hand high tone. She confi splints were recomm- high tone. She states wear the splints all	ued in the past and indicated le splints bothered R66 and 66 was not anymore en she was admitted. 03 a.m. occupational therapist had worn hand splints at the and indicated she was not ontractures on admission. She erapy screens on 1/12/16 and ted the therapy screen on leted after the facility changed r R66 per family request. She nsive assessment of R66's of been completed because ave a physician order for a she was not aware of R66's ntractures as the screen did ements of limitations and	F	318			

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		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245299	B. WING	i		10/2	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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	12/31/15, and shou services since 1/12. At approximately 10 room and OT-A ask splints. NA-B looked locations and found underneath blanket R66 should have be according to the scl functional decline. N the hand splints in a sure why R66 had r On 10/20/16, at 10: R66's care plan did program or ROM th confirmed R66's ca services were not o R66 had never used R66's ROM, "Was On 10/20/16, at 10: therapy assistant (0 stated their usual pl ROM program for re therapy screen and recommended ROM manager (CM.) She the plan she was ep program with NAs a ADL Worksheet," in ROM provided. Sh documentation that for R66 in her medi She confirmed R66 services since 1/12.	Ald have received ROM 2/16. 0:10 a.m., NA-B entered R66's ked her to locate R66's hand id in R66's bedroom in various d them on R66's wheelchair ts and equipment. OT-A stated een wearing her hand splints hedule to prevent further NA-B stated R66 had not worn awhile, and stated she was not not been wearing them. 35 a.m. LPN-A stated she felt I not include a restorative hat she knew of. She are plan and stated that ROM on R66's care plan. She stated d hand splints, and she felt about the same." 37 a.m. certified occupational COTA) rocess for implementing a residents was to complete a	F	318	3		

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

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		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
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		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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	8.5 X 11" white pie instructions and har was observed poste across from her rec show preferences. On 10/21/16, at 2:5 pathologist (SLP) si with R66 on commu assessed her ability in the past. SLP rep assessment of R66 SLP held "Yes and chest. SLP instructe answered her ques motion hand toward use her eyes to lood questions. R66 was assessment at all. I ended assessment success today, whe 60% of her question On 10/24/16, at 9:5 she was not aware and stated she did TV remote or use it On 10/24/16, at 10: might be able to us you put them in her On 10/24/16, at 10: (RN-A) stated R66 impairment and wa all cares. She state on a ROM program today, or had declin	ce of paper with both typed nd-written notes, dated 8/3/16, ed on R66's bedroom wall cliner and identified R66's TV 5 p.m. speech language tated she had been working unication techniques and y to use her hands and elbows beated her functional 5. R66 was reclined in bed and No" flash cards above R66's ed R66 to point at the card that tions. R66 unable to point or d cards. SLP instructed R66 to k at either card to answer her s unable to participate in the R66 began crying and SLP . SLP confirmed R66 had 0% ere R66 responded correctly to ns during a past assessment. 0 a.m. NA-B stated at present, if R66 could use her call light , not know if R66 could hold a	F	318			

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

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

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

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		& MEDICAID SERVICES		T 10			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO 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 ailed to comprehensively a falls to determine whether should have been implemented k of further falls for 1 of 3 viewed for accident hazards. ice resulted in harm for R78 p fracture with a fall.			 F 323 Free of accidents/hazards/supervision/Dev tual harm G 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. 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. 	as er 17, sment 016; d gs. hly for to be ents s will be nt, and	
	R78's quarterly MD R78 had intact cog assistance to trans personal hygiene, v urine, continent of t toileting plan. R78's significant ch identified R78 had impairment, was to transfers, dressing	PS dated 9/14/16, identified nition, required limited fer, walk, toilet and for was occasionally incontinent of bowel and was not on a nange MDS dated 10/3/16,			 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. System change: Daily review of all incidents and accidents by facility management. 	l 17, need assess d to	
	not on a toileting pl R78's Care Area As 10/3/16, identified F	an. ssessment (CAA) dated			4. An audit was developed to mor risk assessments, fall prevention c plan interventions for residents ide at risk for falls, post fall incident rep timely reporting of falls to administr	are entified ports,	

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

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

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		AND HUMAN SERVICES					FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION		(X3) DATE	E SURVEY 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 FRAZEE, MN 56544	96		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 323	 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	nges to the care plan (which was currently in use vention). .m. R78 was found lying face nead against night stand. indicated R78 had stated he to the bathroom. R78 ion to the right eyebrow 2.5 cm on to the left side bridge of his neident note identified a mat xt to R78's bed, when resident feet and slipped on the mat. the fall on 3/14/16 (2 days	F	323				

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		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 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 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Resident was unab doing. The nurses r reviewed the fall on should use call ligh will add a lipped ma perimeters. (6) 7/27/16- 6:20 p. residents room and in bed. The form idd inititated at time of fall a IDT on 8/2/16 (6 da (7) 9/19/16-5:20 a.r occurred in room an sleeping. The note identified-found lyin bathroom door, res The notes indicated forgetful and had a awareness. The no interventions to be fall for R78. The ID on 9/27/16 (8 days (8) 9/22/16-8:15 a.r to room by roomma sideways on floor o finished going and s note indicated R78' underneath residen Further, the inciden have BM (bowel mo prior to fall. The pos identified R78 comp motion of left leg ar be shorter than the	le to identify what he had been notes also indicated the IDT n 7/15/16, did not remember he nt to alert staff for assistance, attress to bed to define 	F	323			

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

PRINTED: 12/15/2016

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

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

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

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

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

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

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

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ND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED 10/24/2016	
		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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
F 334				34			
	R83's undated Imm	unization Record, indicated 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 offered the PCV-13 mmended by the CDC.			3. Mandatory nursing staff education was provided on November 16 and 17, 2016 on the procedure titled, Immunizations: Pneumococcal Vaccine	a	
	When interviewed on 10/24/16, at 2:00 p.m. unit manager (UM)-B who was responsible for the facility's infection control program confirmed the facility was aware of the CDC recommendation related to PCV13 vaccination. UM-B reported she had discussed the PCV13 vaccination guidelines with the medical director at the last quarterly				focus on the CDC recommendations for all nursing home residents to receive two pneumococcal vaccinations that include the PCV 13 and PSSV23 according to a recommended schedule.		
	quality meeting, but orders on implement recommendations. did not have an act	t did not get any direction or nting the CDC UM-B confirmed the facility ive plan in place to offer or /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 encouraged to obta PCV13 and PPSV2 contraindicated. Th resident was offere education of risks a with the resident; if refusal would be do	in both the pneumococcal			vaccination. Immunization records will be reviewed bi-monthly to identify timing of needed subsequent recommended/ordered vaccinations. The audit will be completed by the infection control nurse or designee weekly X 4 weeks, then monthly X 2 months. Audit findings will be provided monthly x 3 months to the QA committee with 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 December 14, 2016	12/14/16	

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

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

Facility ID: 00730

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

Facility ID: 00730

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		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	including transfers, personal hygiene. On 10/17/16, at 6:4 believed the facility because she had to R27 identified she of go to the bathroom have had to wait an she had told staff at assistance; howeve she had told. R27 in urine because of th R27 stated,"it make had not told staff ho R61's quarterly Min 7/24/16, identified F had diagnoses whic diabetes, congestiv anxiety. The MDS is extensive assistant The MDS also iden injections daily. On 10/20/16, at 10: had concerns and r only use her call lig working. R61 stated (NA) would walk pa was on and others of shut the light off and	5 of Daily Living (ADL's,) dressing, toileting and 7 p.m. R27 indicated she did not have enough staff o wait for staff to get to her. often waited for assistance to or go to bed. R27 stated,"I n hour or more." R27 indicated bout the long wait times for er, did not remember whom indicated being incontinent of e long wait for assistance. e me feel miserable;" however	F	353			
	about her call light,	she had voiced her concerns baths and blood sugars to nferences and her son and					

Facility ID: 00730

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

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & N					FORM	12/15/2016 APPROVED 0938-0391
) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY 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 ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
 falls, such as R78. 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,)	me large amount of resident m. NA-F stated the facility ght the last 5 months. In feel there was sufficient utinely meet resident basis. NA-F stated the she and residents complain tes. NA-F stated she had resident falls, skin rashes, viors. NA-F stated she felt due to working too many e felt residents who (such as R18, R26, R15, ould not/would not R61) were the residents received the cares they m. NA-B stated she felt ic insufficient staffing which the last year. NA-B stated ble to routinely meet insufficient staffing. NA-B stall-ins on at least a weekly ot able to replace the staff. sidents were not receiving bileting, ambulation, ROM R27, R37, R18, R47, R66, tated she had spoken with ximately ago a month ng. NA-B stated she felt staffing e were times R51 would bor to get staffs attention.	F 3	353			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391	
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE SURVEY 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 FRAZEE, MN 56544			
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	ULD BE COMPLÉTIO		
F 353	assistant (PTA) stat with residents ambu programs being cor stated felt there was the facility to compl maintenance progra confirmed a decline stated residents sur routinely receive the On 10/21/2016, at 1 interview, NA-B stat increase in skin irrit not receiving cares staff. On 10/21/2016, at there was not an ac meet resident need had not been suffic needs for the last s there were times wi working for the eve be 5 on the shift. No weekly. NA-J stated done in a timely ma repositioning, ambu consistent basis. No administrator and D needs not being me unaware of any acti DON had taken to i	 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. 1:35 p.m. during a follow up ted she felt R37 had an ation from incontinence due to routinely because of short 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 	F	353	3			

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PRINTED: 12/15/2016

		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 353	and repositioning w or timely. NA-A stat call light to alert sta however due to insu- get assistance time NA-A also stated sh assistance with her program. On 10/21/16, at 2:5 representative of fa felt there was not e meet all of the resid was at the facility er residents call lights long periods of time few days ago her fa been soiled and cor stated she continue nursing staff about of her family memb staff cut corners to concerns at a famil 2016. FM-B stated not the place to voic had been directed t FM-B stated she be of staff. FM-B state concerns about suf conference for her told again the facilit stated she felt she f members linens an daily basis. On 10/24/16, at 9:3 not heard any recer	age 160 vere not being done routinely red she felt R46 would use her ff of her toileting needs, ufficient staffing R46 would not ely and would be incontinent. The felt R44 did not receive to care planned ambulation and unily council (FM)-B stated she nough staff in the facility to dents needs. FM-B stated she very day and often saw other had gone unanswered for the FM-B stated has recent as a amily members bedding had vered with a blanket. FM-B ed to reported concerns to the soiled linens and wheelchair ther. FM-B stated she felt the save time had verbalized her y council meeting in August, she had been told that was ce concerns about staffing and to fill out a grievance form. Seen told the facility had "plenty" d she had also voiced her ficient staffing in the last care family member and had been ty had plenty of staff. FM-B had to make sure her family d wheelchair were clean on a 45 a.m. NM-A stated she had nt staffing complaints from members. NM-A stated she had ht staffing complaints from members. NM-A stated she	F	353			

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

		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE	E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 353	On 10/24/16, at 2:4 (MR)-B staff indicat scheduled is detern for the shift. If there number of staff to s the administrator. M 52 residents in hour five NA's for the da evening shift, and the Review of the facilit from 9/5/16 to 10/20 varied number of st consistently have the had identified as ap inconsistencies wer - the day shift did not determined by the a days - the evening shift did determined by the a days - the night shift did determined by the a days - the night shift did determined by the a on these two night s was scheduled rath and then 56 resider -9/26/16, one NA to increase in licensed On 10/24/16, at 3:0 interview, LSW stat family council meet LSW stated the fac members had quit g they did not want to decorating. LSW st	O p.m. the medicals records ted the number of staff nined by the resident census is a question regarding the schedule MR-B would consult <i>I</i> R-B indicated at this time with se she attempted to schedule ay shift, five NA's for the wo NA's for the overnight shift. ties daily assignments sheets 0/16, revealed the facility had taff scheduled and did not ne staffing ratios the facility opropriate. The following re found: ot have the staffing administrator for 20 out of 48 did not have the staffing administrator for 2 of 48 days, shifts one nursing assistant ner than two for 55 residnets nts. o care for 55 residents-no	F3	353	3		

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

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		AND HUMAN SERVICES				FORM	12/15/2016 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATI	(X3) DATE SURVEY 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 FRAZEE, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 353	problem was with fu stated the facility ha open, 4 NA position that time he had no plans for staffing, th recruitment plan fro to work on employe implemented at tha On 10/24/16, at 4:0 (AD) stated she bro from resident count meetings to all depa concerns were alwa quality assurance in sometimes she fille Concern Follow-up nursing, or put the f stated nursing com to her before the ne meeting. On 10/24/16, at 5:0 stated she had new with R66 for her ha didn't know if they e received ROM all th this facility. She sta why R66 did not ge she had been told to not working enough stated she R66 cou could before she ca one full calander ye light, the TV remote word mom. FM-A st	of staff and stated he felt the ull and part time ratios. He ad 4 licensed nursing positions is at that time. FA stated at it implemented any action hough had just received a staff om HR. FM stated he planned be relations, though had not it time. 08 p.m. the activities director ought up resident concerns cil verbally during morning artment heads, and resident ays brought up at monthly neetings. She stated id out a Resident Council form, and delivered it to form in their mailboxes. She pleted and returned the form ext scheduled resident council 5 p.m. family member (FM)-A er seen staff do any exercises nds and arms, and stated she ever had. She stated R66 ne time before admission to ted she had asked facility staff t ROM exercises and stated by staff they felt her brain was n for them to do that. FM-A ald no longer do things she ame to the facility (less than ear ago,) such as using her call e and write her name and the tated she felt there were not facility to ensure R66's needs	F	353	3			

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		AND HUMAN SERVICES				FORM	: 12/15/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 353	Continued From pa	ge 165	F	353			
		council meeting minutes from mber 2016, revealed the					
	revealed 8 resident and a concern over hours was voiced. A resident council res had completed call and there had been response also reve	hinutes dated 7/27/16, s had attended the meeting call light wait time of up to 2 An undated and unsigned sponse note revealed nursing light monitoring and audits n room for improvement. The aled nursing staff had been and department heads had concern.					
	revealed 11 resider and voiced concern response from nurs	hinutes dated 8/31/16, hts had attended the meeting his over call light wait time. The sing dated 8/31/16, revealed hen communicated to nursing gional director.					
	revealed 10 resider and voiced concern averaged 30 to 60 r occurred at all hour response from nurs 10/6, and 10/7/16, o completed regardin placement. The not	ninutes dated 9/28/16, nts had attended the meeting is over call light wait times had minute wait time which had is of the day. An undated sing form revealed on 10/5, call light audits had been ig response and call light the further revealed FA and d been informed of the					
		mily council meeting minutes September 2016, revealed no sufficient staffing.					

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

Event ID:LSCM11

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

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

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

Facility ID: 00730

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	FORM /	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE	SURVEY 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distril	compartments for storage of ed in Schedule II of the ug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the inimal and a missing dose can	F 4	131			
	by: Based on observat review, the facility fa labeled with open o opened for 2 of 5 re addition, the facility for consistent and ti discontinued narcot diversion in 2 of 2 r medication storage. Findings include: On 10/24/16, at 1:0 observed to have the drops were opened the discard date con -R31's Timolol Male dispensed on 6/4/10 -R43's Latanoprost on 8/8/16.	ics to prevent loss or potential medication rooms reviewed for 0 p.m. medication cart B was the following bottles of eye without a date identified so uld be determined: the PF Solution 0.5%, 5. Solution 0.005%, dispensed			 F 431 Drug records, Proper Label/Storage of Drugs & Biologicals 1. R31 (date unlabeled) eye drop Ti Maleate PF Solution 0.5% was replace R42 (date unlabeled) eye drop Latanoprost Solution 0.555% was replaced . Discontinued Narcotic medications si in A wing medication room have beer destroyed by 2 facility nurses. 2. All residents receiving medication with specific expiration dates can be negatively affected by this deficient practice. All residents that receive eye medications will have their eye drops prescriptions review for date opened. All residents who receive narcotic medication have the potential to be negatively affected in this area. 3. Mandatory nursing staff education 	imolol ced. tored n ns ye s	
	Solution 0.5% Solut	prescribed Timolol Maleate PF ion, 1 drop in left eye one time , with an ordered start date of			 Mandatory nursing staff educatio was provided on November 16 and 1 2016 to educate staff on the procedu 	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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 431	Continued From pa 4/16/16. R43's signed physic	age 171 cian orders dated 10/6/16,	F 40	31	titled, Drugs and Biological Storage-Labeling, Medications-Dis of Discontinued Controlled	position	
	indicated R43 was Solution 0.005%, 1	prescribed Latanoprost drop in both eyes at bedtime an ordered4 start date of			Medication-Discontinued narcotics deceased or discharged residents focus on the need to date all medic with specific expiration dates; i.e. e bottles, with date opened . Staff	with a cations eye drop	
	(RN)-D confirmed t were not dated whe stated they should she did not work or but stated any nurs	rvation, registered nurse the eye drop medication bottles en they were opened, and have been. RN-D reported in the B medication cart often, se can date the drops when			also educated on Medication: Nard medication with a focus on the new two nurses to destroy narcotic med timely upon discontinuation of narc documenting destruction in the na leather bound book.	ed for lication otic,	
	pharmacist comes the medication cart	RN-D also reported a to the facility monthly to review s for expired medications.			 Observational audits of staff has soiled linens has been started and Medication carts will be audited for 	proper	
	of nursing (ADON) date the eye drops have been done. T	36 p.m. the assistant director stated the expectation was to when opened, and it should The ADON then stated she was nacist did not flag the undated nedications.			labeling of medications of date of and removal of discontinued medic from medication carts. Narcotic si areas will be audited for timely disp and documentation of disposed na The audits will be completed by the	ations torage oosal rcotics. e DON	
	Medicine dated 3/1 the dating of medic	or Labeling and Storing 4 and 4/15, did not address ation bottles or indicate when 6 medications once they were			or designee weekly X 4 weeks, the monthly X 2 months. Audit findings provided monthly x 3 months to the committee with follow-up to commi recommendations.	s will be e QA ttee	
	Expiration Guidelin expired 28 days aft	Specialty Pharmacy Eye Drop es indicated Timolol would be er opened, and Latanoprost weeks after opened.			5. Deficient practice will be correc December 14, 2016	cied by	
	conducted of the fa	7 p.m. observations were cility's medication storage licensed practical nurse					

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

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

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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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PRINTED: 12/15/2016

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

Facility ID: 00730

PRINTED: 12/15/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES

						0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY 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 FRAZEE, MN 56544	96	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	facility's infection or monthly infection for thoroughly for each stated in her lack o incomplete. UM-B tracked infections w antibiotics, and cor currently in place to viral illnesses's suc gastroenteritis or in she was assigned in control program, sh or direction on what the program. UM-F has not had any out Review of the facility maintained an infect program that provid comfortable environ	who was responsible for the ontrol program, confirmed the ogs were not completed a resident identified. UM-B f time the logs were also stated the facility only which were treated with of firmed there was no system o track and trend any other thas the common cold, offluenza. UM-B stated when responsibility of the infection ne did not receive any training t should have been included in B confirmed the facility luckily	F 44	 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. 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). Deficient practice will be constructed with a construction of the construction of	with stion Control acking and ucility treated with audit was of linens, lance within ending of nfections are planning n the CNA t will be ntrol Nurse s, then dings will be to the QA ommittee s, patterns going) gs.	
	(MDS) dated 7/26/ cognitive impairme communicate with included, dementia MDS identified R18	uarterly Minimum Data Set 16, identified R18 had severe nt, was unable to staff and had diagnoses which , depression and anxiety. The 3 was totally dependent on staff y living (ADL's) and required 2				

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

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			O	FORM. MB NO.	12/15/2016 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		E SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	and had fecal matter up to her first knuck her thumb. R18's ri- leg also had smear entire hand. R18 be covered right hand that time the director down the hall and w At 3:41 p.m. nursing R18's room and as the bathroom, R18 reached up with hel hair. NA-H took a p and cleansed R18's reached down with soiled area on her so obtaining clean clot would re-wipe R18's reach down and ha times. At that time I dependent on 2 sta frequently incontine 3:44 p.m. NA-H req cares. R18 continue re-soiling her right h pant leg and NA-H the wipes. -At 3:53 p.m. NA-H requested assistant were times when sh another staff memb requiring 2 staff assis stated she had bee when the DON pullo 3:56 p.m. NA-H left out assistance with	er on her right hand, covering kles on all of her fingers and ght upper (thigh height) pant ed fecal matter the size of her egan to move her fecal towards the front of her. At or of nursing was walking vas notified of R18's condition. g assistant (NA)-H entered ked R18 if she wanted to use lifted her head out of her shirt, r right hand and touched her ackaged pre-moistened wipe s right hand. R18 repeatedly her hand and touched the slacks while NA-H was hes from her closet. NA-H s hand, and R18 would again ndle the soiled slacks several NA-H stated R18 was totally ff for all of her cares and was int of bowel and bladder. At uested assistance with R18's ed to repeat the process of hand with the bowel on her would re-wipe her hand with used her walkie talkie and ce, NA-H then stated there he had to wait a long time for her to help with residents sistance, including R18. NA-H n assigned to another wing ed her into R18's room. At R18's room to physically seek out covering the bowel on 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 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 PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 179	F4	41			
	in a grape sized am the floor near R18's as she approached hands with a washo NA-F backed away gait belt across R18 R18's room, both N R18 from the whee the bathroom. NA-F incontinent brief wh and bladder and bla incontinent brief in soiled slacks on the shirt and placed it of slacks. NA-F and N cleansing, applied a clothing for R18. N cushion and stated the floor with a wipe shirt and slacks and floor with her gloved entered the soiled h R18 with a baby do room. On 10/17/16, at 4:1 usual practice to pla floor. NA-F stated th place the soiled ho she was unaware of assisted with toiletin get a report from th resident cares were not that day. NA-F	entered R18's room, stepped nount of bowel which was on a front right wheelchair wheel R18. NA-F washed R18's cloth. R18 pushed NA-F away, , reproached R18, donned a B's torso and NA-H entered IA-F and NA-H transferred Ichair, assisted R18 to walk to F removed R18's slacks and ich were saturated with bowel adder. NA-F discarded R18's the garbage and placed R18's on the floor next to R18's soiled IA-H assisted R18 with a clean brief and donned clean A-H checked R18's seat she felt it was clean, washed a. NA-F picked up R18's soiled d soiled washcloths from the d hands, left the room and nopper room. NA-H provided II, her call light and left R18's 7 p.m. NA-F stated it was not aced soiled clothing on the he usual practice would be thing in a bag and bring the opper room. NA-F also stated of the last time R18 had been ng. NA-F stated she used to e previous shift NA of when a last completed, though did stated she had not been the previous shift NA on a					

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PRINTED: 12/15/2016

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

Facility ID: 00730

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		AND HUMAN SERVICES & MEDICAID SERVICES			I	FORM /	12/15/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (>	(X3) DATE SURVEY 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 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	except insofar as su compliance of such requirements of this Good faith attempts and correct quality of a basis for sanction This REQUIREMEN by: Based on observat review, the facility O Assurance (QA&A) and implement app previously identified insufficient staffing, implementation and rehabilitative nursin ambulation and ran by physical and occ to develop and impl harm for 1 of 1 resid in range of motion (decline in ambulatio of multiple falls. Thi potential to affect al residing in the facilit Findings include: See F353 the facilit staffing was availab On 10/21/16, at 10: noticed residents w	Cords of such committee uch disclosure is related to the committee with the s section. The by the committee to identify deficiencies will not be used as s. NT is not met as evidenced ion, interview, and document Quality Assessment and committee failed to develop ropriate action plans for l areas of concern related to and the lack of l documentation of g services which included ge of motion cares as directed upational therapy. The failure ement action plans caused dent (R66) who had a decline ROM), (R38) who had a pn, (R78,) who had a pattern s deficient practice had the l 52 residents currently	F	520	 F 520 Quality Committee-members quarterly 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. 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. 3. Mandatory nursing staff educatio was provided on November 16 and 1 2016 to educate staff on the procedu titled, Quality Council Assurance a 	nt t each n y audit be ther ent ent ality nt for	

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

Facility ID: 00730

If continuation sheet Page 184 of 184

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 Y Y	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING		TE SURVEY 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 FRAZEE, MN 56544)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETIC DATE
K 000	INITIAL COMMEN	rs	КO	00		
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENTS A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.				
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departn Fire Marshal Divisi the time of this surr Main Building was compliance with T participation in Med	Survey was conducted by the nent of Public Safety, State on on November 18, 2015. At vey Frazee Care Center 01 found not in substantial he requirements for dicare/Medicaid at 42 CFR,				
	2000 edition of Nat Association (NFPA	Life Safety from Fire, and the ional Fire Protection) Standard 101, Life Safety 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 AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING (X3) DAT 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 FRAZEE, MN 56544 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PREFIX ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CACH CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CACH CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CACH CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CACH CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CACH CORRECTION (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 PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE	E SURVEY IPLETED
FRAZEE CARE CENTER 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CHOCK DEFICIENCY ON UST BE PRECEDED BY FULL PREFIX	19/2016
FRAZEE CARE CENTER FRAZEE, MN 56544 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (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) COMPLETION 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 & MEDICAID SERVICES			FORM	: 11/18/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING	(X3) DAT	E SURVEY 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 FRAZEE, MN 56544	K 96	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	(X5) COMPLETION DATE
	rated fire barriers. The facility is comp accordance with NI Installation of Sprim The facility has a fin detection throughout the common space NFPA 72 "The Nati edition). The fire all automatic fire depa areas have automat are on the fire alarr the Minnesota Stat the 1971 building is The facility has a c census of 53 at the NOT MET. NFPA 101 LIFE SA Doors protecting cor required enclosure hazardous areas s as those constructor core wood, or capa 20 minutes. Cleara and floor covering in fully sprinklered required to resist th no impediment to to open devices that pushed or pulled a provided with a me	a of 30 minutes and 90 minute letely sprinkler protected in FPA 13 Standard for the kler Systems (1999 edition). re alarm system with smoke ut the corridor system and in as installed in accordance with onal Fire Alarm Code" (1999 arm system is monitored for artment notification. Hazardous atic fire smoke detection that m system in accordance with e Fire Code (2007 edition). In a now fully sprinkler protected. apacity of 74 beds and had a e time of the survey. A 42 CFR, Subpart 483.70(a) is AFETY CODE STANDARD orridor openings in other than s of vertical openings, exits, or hall be substantial doors, such ed of 13/4 inch solid-bonded able of resisting fire for at least ince between bottom of door is not exceeding 1 inch. Doors smoke compartments are only ne passage of smoke. There is he closing of the doors. Hold release when the door is re permitted. Doors shall be eans suitable for keeping the	κo			11/17/16
	provided with a me door closed. Dutch					

Event ID: LSCM21

Facility ID: 00730

If continuation sheet Page 3 of 7

ATEMENT		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ON E CONSTRUCTION 01 - MAIN BUILDING	(X3) DATE SURVEY COMPLETED 10/19/2016	
		245299	B. WING			
	PROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE C	(X5) COMPLETIO DATE
K 018	with 8.2.3.2.1. Roll CMS regulations in 19.3.6.3 This STANDARD Based on observa facility failed to ma 1 resident room do (00) section 19.3.6 could affect the sal and an undetermin if smoke from a fire access corridors m Findings include: On the facility tour	her materials in compliance er latches are prohibited by all health care facilities. is not met as evidenced by: tion and staff interview, the intain the smoke resistance of or according to NFPA 101 LSC .3.1. This deficient practice fety of 13 of the 53 residents ed amount of staff and visitors, e were allowed to enter the exit	K 018	K 018 Resident room 106 door replaced o 11-17-2016 by maintenance.	'n	
K 029 SS=E	revealed the door of tightly in the frame This deficient cond Maintenance Supe NFPA 101 LIFE SA One hour fire rated fire-rated doors) of extinguishing syste and/or 19.3.5.4 pro- the approved auto option is used, the other spaces by sr doors. Doors are field-applied protect 48 inches from the permitted. 19.3. This STANDARD	on resident room 106 did not fit dition was confirmed by the ervisor. AFETY CODE STANDARD d construction (with o hour an approved automatic fire em in accordance with 8.4.1 btects hazardous areas. When matic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or ctive plates that do not exceed a bottom of the door are 2.1 is not met as evidenced by: 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 (X3) DATE SURV	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION 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 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMP	X5) PLETIOR ATE
K 029	NFPA Life Safety C 19.3.2.1. This defic event of a fire, allow throughout the com making them unter affect the exiting ca	age 4 the facility in accordance with code 101 (2000 edition) section tient conditions could in the w smoke and flames to spread ridor and adjacent areas hable, which could negatively apabilities for 23 of the 53 of indetermined amount of staff	K 029	cracks sealed with fire caulk on 10-21-2016 by the maintenance dir	rector.	
	on 10/19/2016 obs revealed a penetra in diameter in the k corridor. This deficient conc	between 8:00 am to 12:00 pm ervations and staff interview tion approximately 2.5 inches poiler room wall separating the lition was confirmed by the				
K 062 SS=E	Required automati continuously maint condition and are i periodically. 19. 9.7.5 This STANDARD Based on record r facility has failed to the automatic sprin with NFPA 101 Life 19.7.6, and 4.6.12 Sprinkler Systems for the Inspection, Water Based Fire deficient practice of	rvisor. NFETY CODE STANDARD c sprinkler systems are ained in reliable operating nspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25, is not met as evidenced by: eview and staff interview, the properly inspect and maintain hkler system in accordance a Safety Code (00), Section NFPA 13 Installation of (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This loes not ensure that the fire rould function properly in the	K 062	Ceiling title replaced by maintena director on 10-21-2016.		7/16

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

			F	TED: 11/18/2016 ORM APPROVED NO: 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			3) DATE SURVEY COMPLETED
	245299	B. WING		10/19/2016
		24	19 WEST MAPLE AVENUE, PO BOX 96	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
This deficient cond	lition was confirmed by the	K 072		
	RS FOR MEDICARE TOF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER CARE CENTER SUMMARY STJ (EACH DEFICIENC REGULATORY OR I Continued From pa This deficient cond	DF CORRECTION IDENTIFICATION NUMBER: 245299 PROVIDER OR SUPPLIER	RS FOR MEDICARE & MEDICAID SERVICES In of Deficiencies (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A BUILDING PROVIDER OR SUPPLIER 245299 B. WING PROVIDER OR SUPPLIER S CARE CENTER S SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX 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 OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY 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 MN 56544	ENUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	electronic receipt of consistent with the Health Informationa http://www.health.s obul.htm The Stat delineated on the M	FS: eed to participate in the f State licensure orders Minnesota Department of al Bulletin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are finnesota Department of				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 11/30/16

Electronically Signed

If continuation sheet 1 of 165

PRINTED: 12/15/2016 FORM APPROVED

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

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY 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 MN 56544	ENUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	(X5) COMPLE DATE
2 000	Time period for Con PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC	Method of Correction and rection. RD THE HEADING OF THE	2 000			
2 255	Assurance Commit A nursing home mu assessment and as of the administrator services, the medic designated by the r three other membe representing discip resident care. The assurance committ respect to which qu necessary and dev appropriate plans of quality deficiencies address, at a minim reporting, infection pharmacy services.	est maintain a quality surance committee consisting a director of nursing al director or other physician nedical director, and at least rs of the nursing home's staff, lines directly involved in quality assessment and ee must identify issues with ality assurance activities are elop and implement f action to correct identified . The committee must num, incident and accident control, and medications and	2 255			11/17/1
	review, the facility (Assurance (QA&A)	on, interview, and document Quality Assessment and committee failed to develop ropriate action plans for		corrected.		

LSCM11

If continuation sheet 3 of 165

	NT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY 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 , MN 56544	NUE, PO BOX 96			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 255	Continued From par previously identified insufficient staffing, implementation and rehabilitative nursin ambulation and ran by physical and occ to develop and imp harm for 1 of 1 resi in range of motion decline in ambulation of multiple falls. Th potential to affect a residing in the facilit Findings include: See F353 the facilit staffing was availab On 10/21/16, at 10 noticed residents witheir ambulation/main not enough staff. P residents on mainter them referred back to a decline. PTA si not enough staff to residents programs were responsible for ambulation/mainter there were not eno stated she had void residents ambulation	age 3 d areas of concern related to , and the lack of d documentation of ng services which included nge of motion cares as directed cupational therapy. The failure lement action plans caused ident (R66) who had a decline (ROM), (R38) who had a decline (ROM), (R38) who had a pattern is deficient practice had the II 52 residents currently ity. ty failed to ensure sufficient ble to meet resident needs. :50 a.m. 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 tated she felt this was due to consistently carry out s. PTA stated the facility NA's	2 255	DEFICIENC			
	was the staff were	e response she had received 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 TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T		COMPLETE 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 , 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 OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY 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 MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 255	Continued From pa	age 5	2 255			
	staffing concerns in recruitment and ref committee had also pressure ulcers. D current action plan areas: sufficient sta services for ambula DON confirmed the monitoring and had to ensure residents indicated the facility admissions to the f Suggested Method administrator could designee, medical update polices and and develop impro- administrator and D ensure resident ne	of Correction: The I work with the DON or director, and governing body to procedures, identify issues				
2 555	days.	rrection: Twenty-one (21) 5 Subp. 1 Comprehensive	2 555			11/17/16
	must develop a cor each resident withi completion of the c assessment as def comprehensive pla by an interdisciplina	elopment Plopment. A nursing home mprehensive plan of care for n seven days after the comprehensive resident ined in part 4658.0400. The in of care must be developed ary team that includes the n, a registered nurse with				

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

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

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

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

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

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

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

NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY 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 TAG	CROSS-REFERENCED TO T	HE APPROPRIATE	COMPLET DATE
Continued From pa	ge 13	2 555			
desk with a front wh around R29's waist On 10/24/2016, at	neeled walker and a gait belt 9:57 a.m. R29 propelled her				
The facility form titled Resident Referral, Interdepartmental Communication dated 8/4/16, to nursing from physical therapy directed R29 receive the following: "Recommend Pt (patient) ambulate twice daily with fww (front wheeled walker), gait belt, and CGA (contact guard assist) x (times) 1. Pt has ambulated up to 150' in therapy. Pt may require verbal cues to maintain upright posture and take larger steps."					
through 10/23/16, the received therapy fo not note that reside nursing staff to amb day, nor was there	he notes identified R29 had r strengthening; however did ent had received the referral for pulate resident two times a documentation that R29 had				
assistant (PTA) stat with residents amb programs being cor stated felt there wa the facility to compl maintenance progra	ted she had serious concerns ulation and maintenance mpleted consistently. PTA s not enough nursing staff in ete ambulation and ams on a routine basis. PTA				
receive their ambul On 10/24/2016, at R29 was not on a w indicated R29 would	ation programs. 10:14 a.m. NA-I indicated valking program. NA-I d self transfer and staff would				
	PROVIDER OR SUPPLIER CARE CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa nurse (LPN)-C amb desk with a front will around R29's waist On 10/24/2016, at wheelchair in the ha The facility form title Interdepartmental C to nursing from phy receive the followin ambulate twice dail walker), gait belt, a x (times) 1. Pt has therapy. Pt may rec upright posture and R29's progress not through 10/23/16, t received therapy fo not note that reside nursing staff to amb day, nor was there received ambulatio R29 did not have a the nursing assistant On 10/21/16, at 11: assistant (PTA) sta with residents ambu programs being con- stated felt there wa the facility to compli- maintenance progra- stated residents su receive their ambul On 10/24/2016, at R29 was not on a w indicated R29 woul	00730PROVIDER OR SUPPLIERSTREET ADCARE CENTERSTREET ADSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)Continued From page 13nurse (LPN)-C ambulated R29 past the nurses desk with a front wheeled walker and a gait belt around R29's waist.On 10/24/2016, at 9:57 a.m. R29 propelled her wheelchair in the hall with her feet.The facility form titled Resident Referral, Interdepartmental Communication dated 8/4/16, to nursing from physical therapy directed R29 receive the following: "Recommend Pt (patient) ambulate twice daily with fww (front wheeled walker), gait belt, and CGA (contact guard assist) x (times) 1. Pt has ambulated up to 150' in therapy. Pt may require verbal cues to maintain upright posture and take larger steps."R29's progress notes were reviewed 6/30/16, through 10/23/16, the notes identified R29 had 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 FRAZEE, MN 56544 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS.REFERENCE) TO DEFICIENC Continued From page 13 2 555 PROVIDER'S TAMENT OF DEFICIENCIES (EACH DEFICIENCIES) D PREFIX Continued From page 13 2 555 D PROVIDER'S PLAN OF CROSS.REFERENCED TO DEFICIENC D PREFIX Continued From page 13 2 555 D PROVIDER'S PLAN OF CROSS.REFERENCED TO DEFICIENC Continued From page 13 2 555 D PREFIX Continued From page 13 2 555 Continued From page 13 2 555 Continued From page 14 PACE PROVIDER'S PLAN OF CROSS.REFERENCED TO D 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 Preceive the following: "Recommend PI (patient) ambulate wise data therapy discident R29 receive the following: "Recommend PI (patient) 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 (EACH CORFICIENCY MUST BE PRECEDED BY ULL REGULATORY OF LSCIDENTFYING INFORMATION) ID PREFIX PREFIX Continued From page 13 2 555 CONTINUE (LPN)-C ambulated R29 past the nurses desk with a front wheeled walker and a gait belt around R29's waist. 2 555 Continued From page 13 (D) 24/2016, at 9:57 a.m. R29 propelled her wheelchair in the hall with the retargy directed R29 receive the following: "Recommend Pt (patient) ambulate twice daily with fww (front wheeled walker), gait belt, and CGA (contact guard assist) x (times) 1. Pt has ambulated up to 150 in therapy. Pt reay require verbal cues to maintain upright posture and take larger steps." R29's progress notes were reviewed (A)0/16, through 10/23/16, the notes identified R29 had received therapy for strengthening; however did not note that resident two ifferral for nursing staff to ambulate resident two ifferral for nursing staff to ambulate resident two iffersal day, nor was there documentation that R29 had received ambulation program sheet in the nursing assistant maintenance book. Not 10/21/16, at 11:20 a.m. physical therapy assistant (PTA) stated she had serious concerns with residents ambulation and maintenance programs being completed consistently. PTA stated resident such as R29 did not routinely receive their ambulation programs. On 102/216, at 10:14 a.m. NA-1 indicated 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 TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLETI 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 reached their goal i from therapy servic ambulation or lower to be completed by to maintain the prog therapy. PTA-G ver therapy in August o currently walking tw PTA-G indicated an	10:32 a.m. physical therapy ndicated residnets who had n therapy were discontinued es and then continue with a r extremity exercise program the nursing assistants in order gress which was made in ified R29 was discharged from f 2016, and should be to times a day up to 150 feet. nbulation into the bathroom gh steps to be considered a				
	(CM)-B indicated R program for one sta hallway with use of was unaware how of verified R29's Resid Interdepartmental C to nursing from phy following: "Recomm twice daily with fww belt, and CGA (care has ambulated up t require verbal cues and take larger step have a form which of program in the NA grou current care plan an	52 a.m. the clinical manager 29 had an ambulation aff to walk the full length of the a gait belt and a walker. CM-B often R29 ambulated. CM-B dent Referral, Communication dated 8/4/16, rsical therapy directed the nend Pt (patient) ambulate r (front wheeled walker), gait e giver assist) x (times) 1. Pt o 150' in therapy. Pt may to maintain upright posture os." CM-B verified R29 did not directed the ambulation maintenance book. CM-B up sheet was part of R29's nd the group sheet did indicate assistance with ambulation				
	two times a day wit	h CGA of one and a FWW. nout documentation or				

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

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY 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 MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET 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 dy gait and weakness, SBA one for transfer and with				
	through 10/1/16, d	tes were reviewed 4/3/16, id not note that R46 had 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 luled on a list for an n. NA-E stated R29 could pivo couple steps but not walk any				
	assistant (PTA)-G i reached their goal from therapy servic ambulation or lowe to be completed by to maintain the pro therapy. PTA-G ver from therapy and s times a day up to 2 tolerated. PTA-G in to be walking with I program should co a decline, hospitaliz	t 10:32 a.m. physical therapy indicated residnets who had in therapy were discontinued ces and then continued with a r extremity exercise program r the nursing assistants in order gress which was made in rified R46 had been discharged should be currently walking two 200 feet or as far as R46 indicated she would expect staff R46 in the hall and the ntinue unless the resident had zation or pain. PTA-G indicated				
	be re-screened. PT	occur the resident should ther A-G indicated ambulation into d not be enough steps to be ng program.				
	On 10/24/16, at 10 repartment of Health	:52 a.m. the clinical manager				

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

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

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

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

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

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

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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE	•		
FRAZEE	CARE CENTER		۲ MAPLE AVE MN 56544	NUE, PO BOX 96			
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2 555	•	-	2 555				
	walking. The summ	naving difficulty standing and ary further revealed R38 was or acute rehab due to lower S.					
	8/2/16, revealed R3 (MD) had seen her revealed R38 had p was ambulating usi revealed R38's dau	ysician progress note dated 38's primary medical doctor at the clinic. The note also lateau in therapy, however, ng a walker. The note further ghter had concerns that R38 ssion after therapy was					
	10/6/16, revealed R another practitioner a wheelchair for lon and OT during the s	ysician progress note dated 38 had established care with 5. The note revealed R38 used g distances, had received PT spring and summer, and at reased care needs R38 was long term patient.					
	Interdepartmental C revealed therapy ha a ambulation progra daily with front walk 40 feet. The form a	form titled, Resident Referral Communication dated 7/8/16, ad referred R38 to nursing for am to include ambulation twice er and one assistance up to lso identified R38 has nee pain and if nursing had II.					
	record lacked furthe ambulation status o	edical record revealed the er documentation of R38's or progress and lacked acility forms maintenance ADL					
		otes were reviewed from 6, revealed the following:					

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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 38's ambulation and decline n status.					
	nursing (ADON) co ambulation/mainter been implemented R38's referral for an program directed s a front wheeled wa ADON stated she w program to be impl	7 p.m. the assistant director of nfirmed R38's nance program had never in July. ADON confirmed mbulation maintenance taff to ambulate with R38 with lker up to 40 feet twice daily. vould expect R38's ambulation emented to maintain and line her ambulation.					
	stated she had und had been assisting stated she was not ambulate. NM-A st	27 a.m. nurse manager (NM)-A lerstood the nursing assistants R38 with ambulation. NM-A aware R38 could not longer ated she was not sure why maintenance program had not					
	4/1/08 identified res admission for a res ambulation. If a am identified need, a p	d, Restorative Program, dated sidents would be assessed on torative program such as bulation program was an lan would be individualized to ls and goals. The policy further					

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2 555	identified residents	age 25 would be supported and their ctioning maintained.	2 555			
	Review of facility po Plans-Comprehens facility would revise	blicy, Care sive, dated 4/1/08 identified the the resident's comprehensive he resident's mental and s as identified by				
	The director of nurs review and revise p to ensuring the care resident is revised nursing or designed	THOD OF CORRECTION: sing (DON) or designee could policies and procedures related e plan for each individual and followed. The director of e could develop a system to a monitoring system to ensure e.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 560	MN Rule 4658.040 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			11/17/16
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The c must include the inc	of plan of care. The n of care must list measurable etables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	This MN Requirem by:	ent is not met as evidenced				

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FRAZEE	CARE CENTER		T MAPLE AV , MN 56544	'ENUE, PO BOX 96		
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2 560	Continued From pa	age 26	2 560			
	review the facility fa which included a th motion (ROM) proc	ion, interview and document ailed to develop a plan of care herapy recommended range of gram for 1 of 4 residents (R66) decline in her upper		corrected		
	7/13/16, identified I included traumatic and diabetes. The severe cognitive im dependent on staff activities of daily liv identified R66 had of motion on both s extremities, and did or restorative nursi R66's annual MDS	himum Data Set (MDS) dated R66 had diagnoses which brain injury, seizure disorder MDS identified R66 had pairment, and was totally for assistance with all ring (ADLs). R66's MDS functional limitations in range sides, upper and lower d not receive therapy services ng services. dated 1/11/16, identified R66 ve impairment, and was totally				
	dependent on staff The MDS identified on both sides, uppe	ve impairment, and was totally for assistance with all ADLs. I R66 had functional limitations er and lower extremities, and rapy services or restorative				
	1/11/16, identified F all ADLs related to	ssessment (CAA) dated R66 was dependent on staff for traumatic brain injury over the difficulty with mobility, d cognition.				
	aphasic (non verba and was unable to care plan also iden	ted 2/18/16, identified R66 was al) due to traumatic brain injury, make her needs known. R66's tified R66 was to wear hand on and 2 hours off during the				

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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 TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 560	Continued From pa	ge 27	2 560				
	care plan failed to id and did not identify	ar the splints all night. R66's dentify R66 had contractures, a ROM or a restorative r R66 to prevent further					
	10/17/16, identified with cares and was off every 2 hours du on all night. The Aic R66 had contracture	Care Plan, Group B dated R66 required total assistance to wear hand splints on and uring the day and leave them le Care Plan did not identify es or that she required a ROM ng program to prevent further					
	12/31/15, indicated non-weight bearing mechanical lift, and R66's Admission As	sessment form dated R66 was non verbal, was , transferred with a had elbow contractures. sessment form indicated had not been assessed.					
	1/12/16, identified d complete R66's pas to both upper extrem (AROM) to left hand have R66 open and	Communication form dated lirections for nursing to ssive range of motion (PROM) mities, active range of motion d, and included instruction to I close fingers and to have s hand with her left hand daily					
	therapy dated 2/18/ splint wearing sche	l Resident Referral from 16, identified R66's hand dule as for R66 to wear splints off throughout the day and on					

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FRAZEE	CARE CENTER		ST MAPLE AVE , MN 56544	INUE, PO BOX 96			
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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 t hand and could hold her TV and.					
	-1/21/16, R66 was remote.	changing TV channels with					
	techniques and lac	tes lacked further arding communication skills or ked any documentation of otion, exercises, or decline in					
	Review of R66's pt 2/9/16 to 10/16/16	nysician progress notes from identified:					
	injury in 12/14, had care facility, but far closer to their hom communicate verb did not communica push her call light t	R66 suffered a traumatic brain I been in a former long term mily had requested a transfer e. R66's could not ally. Nursing had reported R66 te verbally but was able to button and could change the with her TV remote.					
	which involved the physician would ma	R66 still had some movement left upper extremity, and the ake sure therapy had a nen from a contracture and point for R66.					
	-10/6/16, identified with left hand.	R66 could squeeze his fingers	5				
	On 10/19/16, obse a.m. were conduct	rvations from 7:00 a.m. to 9:47 ed:	,				

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RAZEE	CARE CENTER		ST MAPLE AVE , MN 56544	NUE, PO BOX 96			
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2 560	Continued From pa	age 29	2 560				
	back in bed, with h arms were bent at in a fist position on was in a "C" shape and hand slightly ti devices were not o	was observed lying on her er eyes closed. Both R66's the elbow, her right hand was her chest, and her left hand d position with fingers bent lted away from her body. Splin bserved on either of R66's int devices were not observed	t				
	entered R66's room (artificial opening a confirmed R66 was stated R66 had not recent past becaus	I practical nurse (LPN)-A n to provide her trachea t windpipe) site care. She s not wearing hand splints and t been wearing them in the se she thought the splints were R66. LPN-A exited R66's room R66's hand splints.					
	room and immedia station. R66 remain	se consultant walked in R66's tely walked down to the nurses ned on her back in bed, with is in the same positron, no	5				
	same position with and her hands rest position. No hand s	mained lying in bed in the R66's arms bent at her elbows ed on her chest in the same splints were observed on R66's were not observed in R66's					
		nained in the same position in ts were observed on R66 or om.					
	had not worn hand	:03 a.m. LPN-A confirmed R66 splints and stated R66 did not all." She stated she was not					

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

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RAZEE CAR	E CENTER	NUE, PO BOX 96					
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assi and not mot stat mot On nurs had she india con On (OT time awa con 2/18 2/18 the stat con the con 0 n (OT time awa con 2/18 2/18 the stat con 0 On On (OT time awa con 2/18 2/18 the stat con 0 On (OT time awa con 2/18 2/18 the stat con 0 On (OT time awa con 2/18 the stat con 0 On (OT time awa con 2/18 the stat con 0 On (OT time awa con 2/18 the stat con 0 On (OT time awa con 2/18 the stat con 0 On (OT time awa con 2/18 the stat con 0 On (OT time con 0 On (OT time con 2/18 con 0 On (OT time con 2/18 the stat con 0 On (OT time con 0 On (OT time con 2/18 con 0 On (OT time con 0 Stat con 0 On (OT time con 0 Stat Con Stat Con Stat Con Stat Con Stat Con Stat Con Stat Con Stat Con Stat Stat Con Stat Stat Con Stat Stat Con Stat Stat Stat Stat Stat Stat Stat Sta	stated she felt current, and R6 ion services and e the screen wa ed she was sure ion when they d 10/20/16, at 9:4 sing stated she been discontine questioned if th cated she felt R tracted than whe 10/20/16, at 10:)-A stated R66 lad of admission, a ure if R66 had co firmed R66's the 8/16, and indical 8/16, was completed tractures had no facility did not h sult. She stated eline for her cor include measure of the ROM and ommended for F tracture and dis A stated the fact viding ROM serving a book of recor- grams at the nut	book at the nursing station R66's therapy screening was 6 did not need range of d did not need to wear splints as old (February 2016) She e R66 got enough range of		DEFICIENC	τ,		

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

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

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

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

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

	ota Department of He NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING			
		00730	B. WING		10/24/2016	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
FRAZEE	E CARE CENTER		T MAPLE AVE MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET 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 OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DATE SURVEY COMPLETED
		00730	B. WING		10/24/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
RAZEE	CARE CENTER		T MAPLE AV MN 56544	ENUE, PO BOX 96	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET
2 560	Continued From pa	ge 38	2 560		
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one			
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		11/17/16
		omprehensive plan of care I personnel involved in the t.			
	by: Based on observation review the facility factor plan interventions we preferences for 1 or for choices, ambulation implemented and re- residents (R44) revealed addition the facility plan interventions we assessed reposition for 1 of 1 resident for incontinence and for	ent is not met as evidenced ion, interview and document ailed to ensure resident care vere implemented for bathing f 3 residents (R61) reviewed ation programs were outinely followed for 1 of 4 viewed for ambulation. In failed to ensure resident care vere implemented for oning, personal cares needs (R18) reveiwed for urinary or repositioning for 2 of 2 66) at risk for development of		corrected	
	Findings include:				
	Bathing Preference	S:			
		rrent care plan revised R61 required assistance of one			

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

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

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY 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 , MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET 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 identified R44 had received her ambulation program 13 out of 31 days in the am and 20 days out of 31 in the pm.				
	R44 had received I	une 2016, worksheet identified her ambulation program 8 out m and 24 out of 30 days in the				
	R44 had received I	uly 2016, worksheet identified her ambulation program 7 out m and 12 out of 30 days in the				
	identified R44 had	ugust 2016, worksheet received her ambulation 1 days in the am and pm.				
	identified R44 had	September 2016, worksheet received her ambulation ut of 30 in the am and 8 days				
	identified R44 had	October 2016, worksheet received her ambulation It of 17 in the the am and 0 It pm.				
	assessment dated discharged from th placed on the nurs program) and was	pational Therapy (OT) 3/12/15, revealed R44 was erapy services and had been ing gait list (ambulation to ambulate with a front th stand by assistance.				
	(NA)-F stated R44	59 p.m. nursing assistant was able to complete most NA-F stated R44 required				

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

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

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY 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 PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET 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. -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 (DA)brought R18 h plate on the table i At that time nursin approached R18, p and verbally promp opened her eyes a R18 to begin eating R18 ate 100% of h independently whil	remained seated in the lining room. A dietary aid her breakfast plate, left the n front of her and walked away ng assistant (NA)-G blaced a hand on her shoulder bted her to wake up. R18 and NA-G verbally prompted g and handed her a spoon. her breakfast foods e seated in the wheelchair. ted in the wheelchair at the				
	wheelchair at the c	remained seated in her Jining room table, had made no om the table. R18 had				

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

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		00730	B. WING		10/24/2016	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻			
FRAZEE	CARE CENTER		ST MAPLE AVE , MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET 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 remained seated ir removed the clothi	approached R18 and assisted naining fluids, while R18 her wheelchair. NA-H ng protector from R18's neck, shirt and covered her face with ition.				
	room while seated to her room and ha NA-H attached the and left R18's roon	assisted R18 out of the dining in her wheelchair, brought her anded R18 a stuffed bear. call light to R18's wheelchair n. NA-H was not observed to cares, including repositioning				
		D was observed to walk past 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 her wheelchair for a minutes. At that tim required assistance checking and chan confirmed R18 was ADON went to R18	stant director of nursing ed R18 had remained seated ir an observed 3 hours and 36 ne the ADON confirmed R18 e with repositioning and uging every 2 hours. ADON s at risk for skin breakdown. 3's room while requesting 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 IDENTIFICATION NUMBER:	. ,			E SURVEY 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 , MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	gait belt across R1 assisted R18 to sta ambulate to the ba slacks and incontin amount of urine in amount of bowel. A buttocks surface w had deep blush pin surrounding her pe blanchable. NA-E a complete toileting r back in her wheelc R18 had remained of 3 hours and 36 r staff were observed repositioning. On 10/19/16, at 10 thought R18 was la a.m. and had state helping others with repositioning and to R18 was supposed checked and chang needed. NA-E state verbalize hers and R18's needs. On 10/20/16. at 2:3 needs must be ant dependent on 2 sta repositioning and to required routine ev toileting. NA-B state	8's torso, NA-E and ADON and from the wheelchair, throom and removed R18's nent brief. R18 had a moderate her brief as well as a small ADON confirmed R18's entire hich had contact with the brief ak creases and was moist pri-rectal area, though was and ADON assisted R18 to needs and assisted R18 to needs and assisted R18 to sit hair. in a seated position for a total minutes, during that time no d to offer R18 assistance with :39 a.m. NA-E stated she ast repositioned around 6:45 d she had been too busy cares to assist R18 with oileting needs. NA-E stated d to be repositioned and ged every 2 hours and as ed R18 was not able to staff needed to anticipate aff for her needs, including oileting. NA-B stated R18 icipated and was totally aff for her needs, including oileting. NA-B stated R18 ery 2 hour repositioning and ed R18's buttocks would get ould not recall any recent open			1	
nnesota D		28 p.m. licensed practical nurse 8 was totally dependent on	e			

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

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

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If continuation sheet 50 of 165

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

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

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

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

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

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

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

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00730	- 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 MN 56544	NUE, PO BOX 96			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG	(EACH DEFICIENCY	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO ⊺ DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 690	Continued From pa	ge 57	2 690				
	revealed R103 was independent in mobility and was full weight bearing. R103's Individual Resident Care Plan dated 10/20/16, identified R103 was alert and oriented and was independent with activities of daily living (ADL's) including ambulation.						
		urses progress notes from 6 revealed the following:					
	facility, was indeper	o.m. R103 was admitted to the ndent with ambulation, had the facility and was forgetful at					
		. R103 was alert, asked and s appropriately and ate poorly l.					
	short periods of tim stomach ache and	a.m. R103 had only slept for e. R103 requested Tums for a Melatonin (supplement used ad been up to the bathroom 3 yht.					
	attempted to reach had left a message had been wandering been fluctuating. R consultant and had the staff member at had verbally threate been sitting on a dir occupied by other r the facility. The note nurse spoke with R	.m. nursing staff had R103's medical doctor, and with the MD's nurse. R103 g constantly and his mood had 103 had yelled at a nurse physically hit the door when ttempted to assist him. R103 ened to kill the nurse and had hing room table which was esidents, threatening others in e identified at 8:40 a.m. the 103's MD and an order was 103 back to the hospital.					

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

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

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6899

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

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

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

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:		<u> </u>	(X3) DATE S 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 PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
Continued From pa	ge 64	2 800			
related to a pattern	of multiple falls due to				
assistant (PTA) stat residents had not b programs including insufficient staffing. some residents lose in ambulation and F due to not receiving stated she had voic management in we which both the facil of nursing (DON) w had been told by bo DON they were wor she had voiced con last 4-5 months and	ted she had concerns een receiving restorative ROM and ambulation due to PTA stated she had seen their abilities and/or decline ROM including R66 and R38 restorative services. PTA ed her concerns to facility ekly medicare meetings, ity administrator and director ould attend. PTA stated she oth the administrator and the king on staffing. PTA stated cerns about staffing for the had not seen any				
nursing (ADON) sta working on staffing ADON stated the ac nursing (DON) and been working on sta ADON stated she h meetings as she ha that role due to hav another registered of felt call ins were a p number of staff as a facility had used nu September, howeve staff from any agen half. ADON stated s	ated the facility had been concerns since last year. dministrator, director of human resources (HR) had affing with weekly meetings. ad not been attending those ad been trying to back out of ing to work nights along with hurse (RN.) ADON stated she problem as well as not enough a whole. ADON stated the rsing pool staff last in er they had been unable to find cy in the last month and a she felt there were times the				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa R78 did not receive related to a pattern nsufficient staffing, On 10/21/16, at 11:: assistant (PTA) stat residents had not b orograms including nsufficient staffing. some residents lose n ambulation and F due to not receiving stated she had voice management in we which both the facil of nursing (DON) w had been told by bo DON they were wor she had voiced con ast 4-5 months and mprovement with s On 10/21/16, at 1:4 nursing (ADON) stated mursing (DON) and peen working on staffing ADON stated the ad nursing (DON) and peen working on staffing ADON stated the ad nursing (DON) and peen working on staffing ADON stated she h meetings as she hat that role due to hav another registered n felt call ins were a p number of staff as a facility had used nu September, however staff from any agen half. ADON stated she	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 64 R78 did not receive accurate assessments related to a pattern of multiple falls due to nsufficient staffing, see F323. On 10/21/16, at 11:20 a.m. physical therapy assistant (PTA) stated she had concerns residents had not been receiving restorative orograms including ROM and ambulation due to nsufficient staffing. PTA stated she had seen some residents lose their abilities and/or decline n ambulation and ROM including R66 and R38 due to not receiving restorative services. PTA stated she had voiced her concerns to facility management in weekly medicare meetings, which both the facility administrator and director of nursing (DON) would attend. PTA stated she had been told by both the administrator and the DON they were working on staffing. PTA stated she had voiced concerns about staffing for the ast 4-5 months and had not seen any mprovement with staffing. On 10/21/16, at 1:43 p.m. the assistant director of nursing (ADON) stated the facility had been working on staffing concerns since last year. ADON stated the administrator, director of nursing (DON) and human resources (HR) had been working on staffing with weekly meetings. ADON stated she had not been attending those meetings as she had been trying to back out of that role due to having to work nights along with another registered nurse (RN.) ADON stated she felt call ins were a problem as well as not enough number of staff as a whole. ADON stated the facility had used nursing pool staff last in	FRAZEE, MN 56544 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 64 2 800 R78 did not receive accurate assessments related to a pattern of multiple falls due to nsufficient staffing, see F323. 2 800 On 10/21/16, at 11:20 a.m. physical therapy assistant (PTA) stated she had concerns residents had not been receiving restorative programs including ROM and ambulation due to nsufficient staffing. PTA stated she had seen some residents lose their abilities and/or decline n ambulation and ROM including R66 and R38 due to not receiving restorative services. PTA stated she had voiced her concerns to facility management in weekly medicare meetings, which both the facility administrator and director of nursing (DON) would attend. 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ADON stated she felt there were times the VA were unable to complete tasks in a timely	HAZEE, MN 56544 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG ID PREFIX CROSS-REFRENCED TO TH DEFICIENCY) Continued From page 64 2 800 R78 did not receive accurate assessments related to a pattern of multiple falls due to nsufficient staffing, see F323. 2 800 On 10/21/16, at 11:20 a.m. physical therapy assistant (PTA) stated she had concerns residents had not been receiving restorative orgrams including ROM and ambulation due to nsufficient staffing. PTA stated she had seen some residents lose their abilities and/or decline n ambulation and ROM including R66 and R33 due to not receiving restorative services. PTA stated she had voiced her concerns to facility management in weekly medicare meetings, which both the facility administrator and director of nursing (DON) would attend. PTA stated she had been told by both the administrator and the DON they were working on staffing. PTA stated she had voiced concerns about staffing for the ast 4-5 months and had not seen any mprovement with staffing. On 10/21/16, at 1:43 p.m. the assistant director of nursing (ADON) stated the facility had been working on staffing with weekly meetings. ADON stated the administrator, director of nursing (DON) and num resources (HR) had been working on staffing with weekly meetings. ADON stated she had not been attending those meetings as she had been trying to back out of that role due to having to work nights along with another registered nurse (RN.) ADON stated she felt call ins were a problem as well as not enough number of staff as a whole. ADON stated the facility had used nursing pool staff last in September, however they had been unable to find staff from any agency in the last month and a	FRAZEE, WN 55544 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ORPROPRIATE TAG Continued From page 64 2 800 R78 did not receive accurate assessments related to a pattern of multiple falls due to nsufficient staffing, see F323. On 10/21/16, at 11:20 a.m. physical therapy assistant (PTA) stated she had concerns residents had not been receiving restorative programs including ROM and ambulation due to nsufficient staffing, TA stated she had seen some residents lose their abilities and/or decline n ambulation and ROM including R66 and R38 Jue to not receiving restorative services. PTA stated she had voiced her concerns to facility management in weekly medicare meetings, which both the facility administrator and director of nursing (DON) would attend. PTA stated she had been toid by both the administrator and the DON they were working on staffing. TA stated she had voiced concerns about staffing for the ast 4-5 months and had not seen any mprovement with staffing. On 10/21/16, at 1:43 p.m. the assistant director of nursing (DON) stated the facility had been working on staffing concerns since last year. ADON stated she had not been attending those meetings as she had been trying to back out of that role due to having to work nights along with another registered nurse (RN.) ADON stated she felt call ins were a problem as well as not enough number of staff as a whole. ADON stated the facility had used nursing pool staff last in September, however they had been number to itstaff sa whole to axong to work nights along with analf. ADON stated she fith there were times the NA were unable to c

STATEME	Dta Department of He NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
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RAZEE	CARE CENTER		T MAPLE AVEN MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	insufficient staffing. the other nurse mai provide oversight of according to care p ADON stated she fe care plans were not a consistent basis of ADON stated she h residents and staff ADON stated NA ha cares were not con- staffing concerns. A together in an atten however was difficu ADON stated she w restorative program implemented or sta complete the requir basis. ADON stated she w restorative program implemented or sta complete the requir basis. ADON stated the fa admissions though look at acuity. R27's annual MDS was cognitively inta assistance Activities including transfers, personal hygiene. On 10/17/16, at 6:4 believed the facility because she had to go to the bathroom have had to wait an	ADON stated she felt she and nagers (NM) were unable to f cares to ensure cares were lans and completed timely. elt resident assessments and t completed and/or updated on due to insufficient staffing. ad routine complaints from regarding sufficient staffing. ad reported to her resident sistently completed due to ADON stated the staff worked npt to meet residents needs, alt due to insufficient staffing. vas aware the facility is had not been consistently rted due to not enough staff to red programs on a routine d she felt there had been in shes due to insufficient staffing. acility continued to take would screen residents to dated 8/17/16, identified R27 ct, required extensive s of Daily Living (ADL's,) dressing, toileting and 7 p.m. R27 indicated she did not have enough staff o wait for staff to get to her. often waited for assistance to or go to bed. R27 stated,"I hour or more." R27 indicated bout the long wait times for				

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2 800	Continued From pa	ige 66	2 800				
	R27 stated,"it make	e long wait for assistance. e me feel miserable;" however ow it made her feel.					
	7/24/16, identified F had diagnoses whic diabetes, congestiv anxiety. The MDS i extensive assistance	imum Data Set (MDS) dated R61 was cognitively intact and ch included, insulin dependent re heart failure (CHF) and dentified R61 required ce from staff with dressing. tified R61 received insulin					
	had concerns and r only use her call lig working. R61 stated (NA) would walk pa was on and others shut the light off an be back. R61 stated return. R61 stated s about her call light, staff at her care con	03 a.m. R61 stated when she needed assistance she would ht when certain staff were d some nursing assistants ast her room when the call light would come into her room, d leave stating that they would d most of the time they did not she had voiced her concerns baths and blood sugars to inferences and her son and had spoken with staff.					
	nurse (LPN)-C state census was 52. LP usual staff schedule and five nursing as there were four NA indicated the facility staffing and as rece short staffing on bo LPN-C indicated sh incidents of short st	8:50 a.m. licensed practical ed at that time the facility N-C indicated the day shift e included three floor nurses, sistants (NA), however today 's. At 9:17 a.m. LPN-C y did not have sufficient ent as last weekend there was th the day and the night shift. he had reported the recent taffing to the facility scheduler c stated the facility had a lot of					

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2 800	Continued From pa	ge 67	2 800			
	in for scheduled shi	staff did not consistently come ifts. LPN-C stated she was Iministration had planned for				
	On 10/19/2016, at 1:01:33 p.m. house keeping staff (HC)-A indicated at that time the nursing assistants (NA) were working short. HC-A stated when there were not enough staff to answer call lights, she would answer them and inform the residents the NA were busy and would have to wait longer. HC-A stated she felt when the facility was short staffed it took longer to attend to resident needs.					
	(NM)-B indicated s past year. NM-B sta the floor and was u managerial work. N to continue to work time, they would ge lack of staff on the	10:11 a.m. nurse manager taffing had not improved in the ated she was often working on nable to routinely complete her IM-B stated she felt if staff had under the conditions at that t burned out. NM-B stated the floor must have had th the large amount of resident				
	had lost staff left ar NA-F stated she did staff in the facility to needs on a consiste had heard staff, fan about staffing short noticed an increase incontinence and be staff were burning of hours. NA-F stated	0 p.m. NA-F stated the facility ad right the last 5 months. d not feel there was sufficient o routinely meet resident ent basis. NA-F stated the she nily and residents complain ages. NA-F stated she had e in resident falls, skin rashes, ehaviors. NA-F stated she felt but due to working too many she felt residents who ist (such as R18, R26, R15,				

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NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
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2 800	Continued From pa	age 68	2 800			
		ds (R61) were the residents ely received the cares they				
	the facility had a ch had been going on she felt it was impor- residents needs du stated the facility has basis and often we NA-B stated she fe routine repositionin and bathing, such a R44, and R61. NA- the interim DON ap about insufficient si been told it was like to just work togethe had gotten so bad	A3 p.m. NA-B stated she felt pronic insufficient staffing which for the last year. NA-B stated possible to routinely meet ue to insufficient staffing. NA-B ad call-ins on at least a weekly re not able to replace the staff. It residents were not receiving ug, toileting, ambulation, ROM as R27, R37, R18, R47, R66, B stated she had spoken with pproximately ago a month taffing. NA-B stated she had that everywhere and they had e that everywhere and they had er. NA-B stated she felt staffing there were times R51 would e floor to get staffs attention.				
	assistant (PTA) sta with residents amb programs being co stated felt there wa the facility to compl maintenance progr confirmed a decline stated residents su	20 a.m. physical therapy ted she had serious concerns ulation and maintenance mpleted consistently. PTA is not enough nursing staff in lete ambulation and ams on a routine basis. PTA in ambulation for R38 and ch as R44 and R29 did not eir ambulation programs.				
	interview, NA-B sta increase in skin irri	1:35 p.m. during a follow up ted she felt R37 had an tation from incontinence due to routinely because of short				
	On 10/21/2016, at	2:17 p.m. NA-J stated she felt				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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2 800		age 69 dequate amount of staff to	2 800				
	meet resident need had not been suffice needs for the last s there were times w working for the even be 5 on the shift. N weekly. NA-J states done in a timely ma repositioning, amb consistent basis. N administrator and I needs not being ma	ds. NA-J stated she felt there sient staff to meet residents several months. NA-J stated then only 3 NA's would be ening shift when there were to A-J stated that would occur d routine cares would not get anner such as toileting, ulation and baths on a A-J stated she felt the DON were aware of resident et consistently, but was tions the admininstrator or					
	felt staffing was ge would routinely wor were supposed to I stated she felt resid and repositioning w or timely. NA-A sta call light to alert sta however due to ins get assistance time NA-A also stated sh	s 2:32 p.m. NA-A stated she tting "tough." NA-A stated they rk with 3 or 4 NA's when they have 5-6 NA's on a shift. NA-A dents cares such as toileting vere not being done routinely ted she felt R46 would use her aff of her toileting needs, ufficient staffing R46 would not ely and would be incontinent. he felt R44 did not receive r care planned ambulation					
	representative of fa felt there was not e meet all of the resid was at the facility e residents call lights long periods of time	53 p.m. a family member and amily council (FM)-B stated she enough staff in the facility to dents needs. FM-B stated she every day and often saw other a had gone unanswered for e. FM-B stated has recent as a amily members bedding had					

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

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY 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 MN 56544	NUE, PO BOX 96				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE		
2 800	DM stated she had insufficient nursing director, NM's, DOI few months. DM st was aware of staffi though, has not see On 10/24/16, at 2:0 Registered Nurse/O Practitioner(NP)-A facility staff to asse to identify a pattern attempt to minimize she would expect ff care plans and pro- and exercise. NP-A recommended rest uncommon here." On 10/24/16, at 2:4 (MR)-B staff indical scheduled is detern for the shift. If there number of staff to s the administrator. M 52 residents in hou five NA's for the da evening shift, and t Review of the facilii from 9/5/16 to 10/2 varied number of s consistently have th had identified as ap inconsistencies we - the day shift did n	ring meals on a weekly basis. verbalized concerns about staff from residents to the HR N and administrator in the last ated she felt the administrator ng concerns in the facility en any improvement. 00 p.m. Advanced Practice Certified Nurse indicated she expected the ss falls routinely and attempt or reason for the falls in an e further falls. NP-A indicated loor staff to follow resident vide restorative ambulation a stated," Sadly not providing orative exercises is not 0 p.m. the medicals records ted the number of staff nined by the resident census a is a question regarding the schedule MR-B would consult AR-B indicated at this time with se she attempted to schedule ay shift, five NA's for the wo NA's for the overnight shift. ties daily assignments sheets 0/16, revealed the facility had taff scheduled and did not ne staffing ratios the facility poropriate. The following 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 NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
TRAZEE CARE CENTER 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, NN 56544 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLET DATE 2 800 Continued From page 72 2 800 2 800 determined by the administrator for 14 out of 48 days, on these two night shifts one nursing assistant was scheduled rather than two for 55 residents- and then 56 residents. 2 800 - - -9/26/16, one NA to care for 55 residents- and then 56 residents. -9/26/16, one At ocare for 55 residents-no increase in licensed staff for the shift. On 10/24/16, at 3:03 p.m. during a follow up interview, LSW stated she attended the facility's family council meetings when they had attendees. LSW stated the facility's routine family council members had quit going to the meeting and had been directed to fill out a grievance form versus discussing the concern at the meeting. LSW stated she kept a log of all grievances and 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 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY WILTS DE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE 2 800 Continued From page 72 2 800 2 800 determined by the administrator for 14 out of 48 days - the night shift did not have the staffing determined by the administrator for 2 of 48 days, on these two night shifts one nursing assistant was scheduled rather than two for 55 residents and then 56 residents. -9/26/16, one NA to care for 55 residents-no increase in licensed staff for the shift. On 10/24/16, at 3:03 p.m. during a follow up interview, LSW stated she attended the facility's family council meetings when they did not want to volunteer for remodeling or decorating. LSW stated a family member had started to complain about staffing at one meeting and had been directed to fill out a grievance form versus discussing the concern at the meeting. LSW stated she kept a log of all grievance sond the family member did not fill out a grievance	NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET DEFICIENCY 2 800 Continued From page 72 2 800 determined by the administrator for 14 out of 48 days - the night shift did not have the staffing determined by the administrator for 2 of 48 days, on these two night shifts one nursing assistant was scheduled rather than two for 55 residents and then 56 residents. -9/26/16, one NA to care for 55 residents-no increase in licensed staff for the shift. On 10/24/16, at 3:03 p.m. during a follow up interview, LSW stated she attended the facility's family council meetings when they did not want to volunteer for remodeling or decorating. LSW stated a family member had started to complain about staffing at one meeting and had been directed to fill out a grievance form versus discussing the concern at the meeting. 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 days - the night shift did not have the staffing determined by the administrator for 2 of 48 days, on these two night shifts one nursing assistant was scheduled rather than two for 55 residents and then 56 residents. -9/26/16, one NA to care for 55 residents-no increase in licensed staff for the shift. On 10/24/16, at 3:03 p.m. during a follow up interview, LSW stated she attended the facility's family council meetings when they had attendees. LSW stated the facility's routine family council members had quit going to the meetings when they did not want to volunteer for remodeling or decorating. LSW stated a family member had started to complain about staffing at one meeting and had been directed to fill out a grievance form versus discussing the concern at the meeting. LSW stated she kept a log of all grievances and the family member did not fill out a grievance	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	COMPLET
	2 800	determined by the a days - the night shift did determined by the a on these two night was scheduled rath and then 56 resider -9/26/16, one NA to increase in licensed On 10/24/16, at 3:0 interview, LSW stat family council meet LSW stated the fac members had quit they did not want to decorating. LSW st started to complain and had been direct versus discussing t LSW stated she ke	administrator for 14 out of 48 not have the staffing administrator for 2 of 48 days, shifts one nursing assistant her than two for 55 residnets nts. o care for 55 residents-no d staff for the shift. 13 p.m. during a follow up ted she attended the facility's tings when they had attendees. illity's routine family council going to the meetings when o volunteer for remodeling or rated a family member had about staffing at one meeting ted to fill out a grievance form he concern at the meeting. pt a log of all grievances and				

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

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

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

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

STATE FORM

LSCM11

If continuation sheet 77 of 165

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

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY 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 , MN 56544	NUE, PO BOX 96			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 830		age 78 nely check her morning blood	2 830				
	sugars. R61 stated during her last care few months ago, an improvement. R61	I she had voiced her concern e conference which had been a nd had not seen an stated she had been 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., m., 9:00 p.m. call if blood 0 or greater than 300 as a start dated 9/3/14.					
	inject per sliding sc = 1 unit; 201-250 = 301-350 = 4 units; units, > than 400 ca	100 units/ml (insulin aspart) cale: if 0-150 = 0 unit; 151-200 2 units; 251-300 = 3 units; 351-400 = 5 units; 401-500 = 6 all MD, sq 3 times a say for ugar lower than 100 or greater ern call MD.					
		100 units/ml (insulin aspart, inject 8 units one time a day					
	insulin) inject 22 ur	nsulin glargine, long acting hits subcutaneous (sq) one to diabetes, order was start					
		nsulin glargine,) inject 8 units ed to diabetes, order was start					
		edication administration n August 2016, to October					

STATE FORM

If continuation sheet 79 of 165

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

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 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 MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 830	concerns that a new the routine of seaso medication adminis R61 was given reas worker (SW) that st orientation and carn note revealed R61 intent to consider the reiterate her worry of note also revealed her medical concern children. On 10/20/16, at 9:3 (LPN)-B stated she supposed to have he times a day. LPN-B brittle diabetic and the have her blood sug LPN-B stated R61 with sugars and felt R61 she did not have her routine. On 10/20/16, at 9:4 nursing (ADON) state blood sugars were on a consistent base expected R61's phy as well as R61's car On 10/20/16, at 9:4 Practitioner (CNP) with R61 for 5 years R61's medical concern stated R61 required as it had been diffic sugars and required	 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 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 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 		DEFICIENC	·Y)	

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

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

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

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY 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 , MN 56544	NUE, PO BOX 96			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF (COBBECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	uge 84	2 830				
	toileting.						
	the room was dark R78's bed a thin gra the right side a thin square white perso grab bar attached t	5 a.m. R78 was lying in bed, and quiet. On the left side of ay fall mat on the floor and on brown fall mat was present. A nal alarm was secured to the o the right side of R78's bed as attached to the grab bar					
	nurse (LPN)-A prop in a wheel chair, the	9 a.m. licensed practical belled R78 to the dining room e white square personal alarm back of R78's wheel chair.					
	independently ate t	8:27 a.m. to 8:40 a.m. R78 he breakfast meal seated in a e personal alarm secured to eel chair.					
	wheelchair in the h 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 ented falls since R78 was 7, 2016:					
	beside his bed. Res stated,"I was going placed a bed alarm (IDT) reviewed the following the fall). T "Resident attempts	.m. R78 was found on floor sident interview indicated R78 to the bathroom." Staff initially . The interdisciplinary team fall on 3/18/16 (10 days The post fall findings identified, to self transfer to BRM 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 PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 830	Continued From pa	ge 85	2 830				
	staff to R78's room next to bed. R78 su elbow 1 cm (centim note identified R78 tried to get up. Inter as a result of the as mat, urinal placed. on 3/17/16 (8 days information/interver staff along with cha included: floor mat and not a new inter	. alarm sounded and alerted . R78 was found on floor mat istained a skin tear to the right neter) by 0.8 cm. The incident needed to use bathroom and rventions to be implemented sessment: Bed alarm, floor The IDT team reviewed the fal following the fall). Additional ntions to be communicated to inges to the care plan (which was currently in use vention). .m. R78 was found lying face					
	down on floor with I Resident interview was getting up to ge sustained a lacerati long and a lacerati nose 0.4 cm. The ir was on the floor ne got up he had bare The IDT reviewed following the fall). Ir implemented as a r	head against night stand. indicated R78 had stated he o to the bathroom. R78 ion to the right eyebrow 2.5 cm on to the left side bridge of his ncident note identified a mat xt to R78's bed, when resident feet and slipped on the mat. the fall on 3/14/16 (2 days					
	the floor mat on floo indicated he was go chair. The nursing a bathroom and to ge note indicated R78 mat by the bed was indicated R78 had a awareness, recently recommendations	n. R78 was found sitting on or next to bed. R78 had bing to get up and into wheel assistant assisted R78 to the et dressed for the day. The indicated he slipped on the s bare footed. The note a problem with safety y completed therapy and were to continue to receive ply and continues to attempt					

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

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

STATE FORM

LSCM11

If continuation sheet 88 of 165

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

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY 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 PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 89	2 830			
	and ambulation with from therapy. R78 r issues with safety a recommended R78 Review of R78's Nu Assessment dated Alzheimer's, and a assessment identifi impaired cognitive s decisions poor, cue	ed R78 had moderately skills for daily decision making, ss/supervision required, and sistance with transferring and				
	reports and progress the assistant directed The ADON verified was unsure what in place. The ADON ic fall the post- fall clir nursing, the admini reviewed the facility Assessment. The for nurse when resider reviewed for approp ADON indicated R7 to interpret what int following the falls. The believed the falls we appropriate intervent	7 p.m. a review of R78's fall as notes was conducted with or of nursing (ADON) present. R78's multiple falls, although terventions were currently in dentified following a resident's nical team which included strator and social services, of form titled Fall Risk Post- Fall orm was initiated by the floor nt falls occurred and the team priate interventions. The 78's fall reviews were difficult erventions were initiated The ADON indicated she ere fully assessed and ntions were initiated for R78's ned R78 had sustained a hip II on 9/22/16.				
	9/22/16, included va					

STATE FORM

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY 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 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 SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 90	2 830			
	resident. Resident transferred bed/cha Removed alarms a - 7/24/16, found on closet,minimal one -9/19/16, R78's roo on the floor. R78 for in front of the bathr stated he must of s socks on. -9/22/16, R78 fourn on buttocks and sta finished, stood up a much pain left hip v shortening of left le transport. The note a fractured hip and the following day. On 10/20/16, at 10 B stated she felt th the facility must ha large amount of res On 10/20/16, at 10 (NA)-I indicated R7 the bathroom by hi indicated since R76 assistance to go to R78 did not always wheel chair brakes on the wheel chair On 10/21/16, at 1:3 a recent decline be hip. NA-B verified F usually related to g coming back from	knees in front of	F			

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

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

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

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

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

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

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

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

	NT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00730	B. WING		10/24/2016	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
RAZEE	CARE CENTER		ST MAPLE AVE , MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 885	Continued From pa	age 99	2 885			
	care plan did not id 6/10/16.	lentify any updates past				
	dated 10/17/16, list included R38 was a toileting and ADL's therapy for walking	Care Plan Group C form, ted various interventions which assist of one for transfers, , and listed R38 received . The form did not list any for R38's ambulation.				
	Interdepartmental (revealed therapy has a ambulation progr daily with front walk 40 feet. The form a	form titled, Resident Referral Communication dated 7/8/16, ad referred R38 to nursing for ram to include ambulation twice ker and one assistance up to also identified R38 has knee pain and if nursing had all.	9			
	record lacked furth ambulation status of	edical record revealed the er documentation of R38's or progress and lacked acility forms maintenance ADL				
		notes were reviewed from 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 OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY 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 MN 56544	ENUE, PO BOX 96		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
2 885	Continued From pa	ge 100	2 885			
	documentation of F in R38's ambulatior	38's ambulation and decline n status.				
	nursing (ADON) co ambulation/mainter been implemented nurse managers we therapy referrals fo programs were star referred. ADON star responsible to initia Maintenance Activit worksheet which we type of assistance we needed and the fre program. ADON co ambulation mainter ambulate with R38 to 40 feet twice dail expect R38's ambulation not getting done du stated she felt the M complete all resider On 10/24/16, at 9:2 stated she had und	7 p.m. the assistant director of nfirmed R38's nance program had never in July. ADON stated the ere responsible to ensure r ambulation/maintenance rted once a resident was ted the nurse manager was te a facility form titled, ty of Daily Living (ADL) ould direct the NA on what with ADL the individual resident quency of the maintenance nfirmed R38's referral for nance program directed staff to with a front wheeled walker up y. ADON stated she would lation program to be intain and prevent further tion. ADON stated she felt the i/maintenance program was te to staffing concerns and NA did not have the time to nts programs, including R38.				
	stated she was not ambulate. NM-A st	aware R38 could not longer ated she was not sure why naintenance program had not				
	Practice Registered Practitioner (NP)-A	8 a.m. R38's Advanced d Nurse/Certified Nurse stated R38 had recently th her in early October. NP-A				

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

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

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY 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 PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 103	2 900			
	ulcers and had inte included a pressure	at risk for developing pressure erventions in place which e reducing device for the chair turning and repositioning				
	identified R18 was ADL's. The MDS ic developing pressur in place which inclu	nnual MDS dated 4/26/16, totally dependent on staff for lentified R18 was at risk for re ulcers and had interventions uded a pressure reducing r and R18 was on a turning and am.				
	Area Assessment (R18 had cognitive was unable to cohe The CAA revealed spite of her inability R18's Communicat needs must be ant Pressure Ulcer CA potential for skin be incontinence, decre to make her needs R18 could move in required staff assis sitting position. The	ognitive Loss/ Dementia Care (CAA) dated 4/26/16, identified loss related to dementia and erently verbalize her needs. R18's needs were to be met in / to make her needs known. tion CAA identified R18's icipated by facility staff. R18's A identified R18 had a reakdown related to eased mobility and her inability known. The CAA revealed dependently in bed but stance to reposition when in a e CAA identified R18 required a f turning and had a pressure n wheelchair.				
	dated 7/26/16, reve skin breakdown ba (assessment for pr of 14 and a tissue to revealed intervention included, gel cushing	rehensive Analysis of Skin form ealed R18 was at high risk for used on a Braden scale redicting pressure sores) score tolerance test. The form ons were put in place which on in wheelchair and R18 id repositioning with check and				

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

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

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

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

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

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

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET AD	ADDRESS, CITY, STATE, ZIP CODE				
RAZEE	CARE CENTER		T MAPLE AVE MN 56544	NUE, PO BOX 96			
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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 66 had pink heels on been free floated for					
	pressure sores) da at high risk for deve document also ider mattress, heels we R66 continued to n	e (assessment for predicting ted 7/13/16, identified R66 was eloping pressure ulcers. The ntified R66 had a special re to be kept off the bed and eed to be repositioned and n in her wheelchair because of pressure ulcers.					
	resident could be in skin damage) dated	nce test (length of time n the same position without d 7/13/16, identified R66 positiong to prevent pressure					
	R66's progress not 10/17/16 identified:	es reviewed from 12/31/15 to					
	right shin and ankle PROFO boot, staff	2 cm X 0.5 cm area on her e from possible rubbing on removed boot and floated her chair had built-in pressure					
	2/4/16, R66 had an ankle	i intact blister on her right					
		ressed concern with R66's right ined areas were from boot and r.					
	2/8/16, R66's areas					1	

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

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

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY 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 MN 56544	ENUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 113	2 900			
	 2 900 Continued From page 113 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. 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. 					
	recliner in front of h heels floated on a p	10 p.m. R66 was seated in er TV. R66 did not have her billow and was not wearing her R66's heels rested directly on recliner.				
	interview NA-E stat on staff for cares, a	3 p.m. during follow-up ed R66 was totally dependent and stated she couldn't really nition was since she didn't talk.				
	interview, NA-D sta staff for her cares,	6 p.m. during follow-up ted R66 was dependent on and stated she wasn't sure 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 out with her heels resting R66 did not have her heels , and was not wearing sheep				

STATEMEN	Ita Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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2 900	Continued From pa	age 114	2 900			
	interview, LPN-A st dependent on staff R66 was clearer so stated she thought she was clearer. On 10/19/16, at 1:3 totally dependent o she wasn't sure of she didn't think R66 ulcers, and didn't k ulcers in the past. N rested directly on h wearing sheepskin Aide Care Sheet ar had sheepskin boo sheet, but R66's he	6 p.m. during follow up ated R66 was totally for cares, and stated she felt ome day's versus others and R66 understood them when 84 p.m. NA-B stated R66 was n staff for cares, and stated R66's cognition. She stated 5 was at risk for pressure now if R66 had pressure NA-B confirmed R66's heels er bed and she was not boots. NA-B confirmed R66's nd stated she didn't know R66 ts as they weren't on her eels were supposed to floated posed to be repositioned every				
	(RN)-A stated R66 impairment and wa cares. She stated F pressure ulcers bed herself. She stated had ever had any s R66's heels were s her bed, and the N/ R66 every 2 hours. On 10/24/16, at 10 stated R66 had sev was dependent on was supposed to b	53 a.m. Unit Manager (UM-A) vere cognitive impairment and staff for cares. She stated R66 e repositioned every 2 hours,				
innesota D	her heels were sup bed, or R66 was to	posed to be floated off of her wear sheepskin boots. R66 essure ulcers. She stated she				

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

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

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
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RAZEE	CARE CENTER		T MAPLE AV , MN 56544	ENUE, PO BOX 96		
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2 915	Continued From pa	age 117	2 915			
	review, the facility f assistance with am recommended by p	ion, interview and document ailed to ensure consistent ibulation was provided as physical therapy (PT) for 3 of 4 9, R46) who required ibulation.		corrected		
	Findings include:					
	Review of R44's quarterly Minimum Data Set (MDS) dated 7/31/16, identified R44 was cognitively intact and had diagnoses which included generalized osteoarthritis, depressive disorder and anxiety. The MDS identified R44 required limited assistance to ambulate in the corridors and was independent in transfers, bed mobility and walking in her room. The MDS further identified R44 used a walker and a wheelchair for mobility. The MDS revealed R44 was steady at all times during transitions, while walking and when turning around and facing the opposite direction.					
	Functional/Rehabil Assessment dated required assistance unable to ambulate related to an unste	ctivity of daily living (ADL) itation Potential Care Area 1/29/16, identified R44 e with some ADL's and was any distance independently ady gait. The CAA identified h one nursing assistant (NA) a elt.				
	identified R44 had rising from a seate	alls CAA dated 1/29/16, difficulty with balance upon d position, when turning with abulating long distances.				
	Review of R44's cu	irrent care plan updated				

STATEMEN	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	TION SHOULD BE	(X5) COMPLET	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENC		DATE	
2 915	Continued From pa	ge 118	2 915				
	mobility in a wheelc with ambulation with	44 was independent with hair and required assistance h use of a walker. R44's care o offer to walk with R44 to all					
	10/17/16, listed vari included R44 was a directed staff to ass	e Plan Group C form, dated ous interventions which assist one for ADL's and sist R44 with ambulation twice th a rear wheeled walker and					
	standard wheelchai dining room and wh table. R44 verbalize obtained her food a a.m. R44 had eater	6 a.m. R44 was seated in a r, propelling herself into the neeled herself up to a circular ed her breakfast order, nd ate independently. At 8:34 n 100% of her meal and at that elf out of the dining room.					
	Worksheet from Ap identified R44's was twice a day (BID) lo with a walker and tr also indicated R44	form titled Maintenance ADL ril 2016, to October 2016, s on an ambulation program ng distances in the hallways ansfer belt. The worksheet was to be assisted to feet (ft.) R44's worksheets ng:					
	R44 had received h	pril 2016, worksheet identified er ambulation program 16 out n hours and 25 out of 31 days					
	identified R44 had r	ay 21016, worksheet received her ambulation 1 days in the am and 20 days					

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2 915	Continued From pa	age 119	2 915			
	R44 had received h	une 2016, worksheet identified her ambulation program 8 out m and 24 out of 30 days in the				
	R44 had received h	uly 2016, worksheet identified her ambulation program 7 out m and 12 out of 30 days in the				
	identified R44 had	ugust 2016, worksheet received her ambulation 1 days in the am and pm.				
	identified R44 had	eptember 2016, worksheet received her ambulation ut of 30 in the am and 8 days				
	identified R44 had	October 2016, worksheet received her ambulation t of 17 in the the am and 0 e pm.				
	assessment dated discharged from the placed on the nursi program) and was	pational Therapy (OT) 3/12/15, revealed R44 was erapy services and had been ing gait list (ambulation to ambulate with a front h stand by assistance.				
		ambulation/maintenance om OT was requested, the to provide.				
		re conference summary notes /16 revealed the following:				
	-8/16/16, did not ac program.	dress R44's ambulation				

STATE FORM

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

STATE FORM

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

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

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

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

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

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

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

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

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

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

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

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

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
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RAZEE	CARE CENTER		ST MAPLE AVE , MN 56544	NUE, PO BOX 96		
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2 920	-at 8:46 a.m. R18 r wheelchair at the d attempt to leave fro completed her mea juice and water in f attempt to reach fo spoon, and would r the lipped edge of her spoon. -at 9:01 a.m. R18 r wheelchair in the d attempts to leave th R18 and asked how respond, NA-H wal repeatedly run her of the plate, while s	age 134 remained seated in her lining room table, had made no om the table. R18 had al, had a glass of milk orange front of her though made no or them. R18 held onto her repeatedly run the spoon over her plate, periodically licking remained seated in her ining room, having made no he table. NA-H approached w her day was, R18 did not lked away. R18 continued to spoon around the lipped edge she periodically licked her ade no attempts to drink her	2 920			
	wheelchair in the d spoon on the table Shortly after R18's chin to chest positi assist R18 with rep -at 9:30 a.m. R18 r wheelchair in the d her eyes, looked an protector and cove	remained seated in her ining room. R18 had set the , and had closed her eyes. head dropped forward in a on. No staff had offered to positioning. remained seated in her ining room. R18 had opened round, took her clothing red her face it. R18 made no way from the table and held he	r			
	-at 9:37 a.m. NA-D awoke R18 and off awake, removed th face and allowed N	he clothing protector. entered the dining room, ered R18 her fluids. R18 he clothing protector from her IA-D to assist her to drink her 0% of her juice. NA-D then				

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

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

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE
2 920	Continued From pa	ge 137	2 920			
	(LPN)-B stated R18 staff of for all of her was not able to ver		e			
	interview ADON sta to routinely repositi timely manner, suc shortages. ADON s able to fill in for sick	7 p.m. during a follow up ated she felt staff were unable oning and toilet residents in a h as R18, due to staffing stated they were not always c calls and there were times are unable to fill holes in the				
	Management dated facility's policy to er or bladder incontine treatment and servi functioning. The po an individual toiletir	d Bowel and Bladder I 4/1/08, revealed it was the asure each resident with bowe ence would receive appropriate ices to maintain normal licy directed staff to develop ag schedule for all incontinent 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 (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375			11/17/16

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STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE 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 PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE
21375	Subpart 1. Infection home must establis control program de sanitary environme This MN Requirem	on control program. A nursing sh and maintain an infection signed to provide a safe and	21375			
	facility failed to esta program which incl surveillance of resid surveillance and invidentified. This had residents who resid the facility failed to soiled clothing and	r and document review, the ablish an infection control uded comprehensive dent symptoms, analysis of the vestigation of patterns the potential to affect all 52 ded in the facility. In addition, ensure proper handling of linens during personal cares (R18) observed for personal		 MN 144A.04 Tuberculosis Preve Control 1. Tuberculosis screening has b completed for R42 and R92. Tul Skin Testing has been completed Tuberculin skin testing has comp E1. Facility has completed an ar facility TB risk assessment. 2. All residents are at risk due to practice. 	een berculin d for R42. bleted for hnual	
	reviewed from 4/11 identified tracked o which antibiotics we surveillance process of the following: loc facility, if the infecti community associa onset of symptoms present, cultures per treatment provided resolved. Furtherm	ion Control Logs were /16, through 9/22/16. The logs nly residents with infections for ere prescribed. The facility's eses also lacked identification ration of the resident within the on was healthcare or tted, site of infection, date erformed/ organism identified, and the date the infection ore, the logs lacked analysis n of patterns identified.		 Mandatory staff education of f Tuberculosis Control Program wi provided November 30, 2016. In control nurse will be educated or completion of facility annual TB r assessment. All current employee and resin health/medical records have bee for 2 step TSTs. Newly hired em and newly admitted resident records be audited weekly x 3 months. Deficient practice will be correct December 14, 2016. 	II be ifection isk dent n audited ployee ords will	
	manager (UM)-B w	n 10/24/16, at 2:00 p.m. unit ho was responsible for the ontrol program, confirmed the				

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21375	monthly infection lo thoroughly for each stated in her lack o incomplete. UM-B tracked infections of antibiotics, and cor currently in place to viral illnesses's suc gastroenteritis or in she was assigned control program, sl or direction on wha the program. UM-I has not had any ou Review of the facilit Prevention and Co indicated the facility maintained an infe	bgs were not completed in resident identified. UM-B if time the logs were also stated the facility only which were treated with ifirmed there was no system to track and trend any other thas the common cold, ifluenza. UM-B stated when responsibility of the infection the did not receive any training it should have been included in B confirmed the facility luckily	21375			
	development and t Review of R18's qu (MDS) dated 7/26/ cognitive impairme communicate with included, dementia MDS identified R18 for activities of daily staff for assistance hygiene and toiletir was frequently inco The MDS identified	nment to help prevent the ransmission of infection. uarterly Minimum Data Set 16, identified R18 had severe nt, was unable to staff and had diagnoses which depression and anxiety. The was totally dependent on staf y living (ADL's) and required 2 with bed mobility, personal ng. The MDS identified R18 ontinent of bowel and bladder. d R18 was not on a toileting or bladder incontinence.				
		nnual MDS dated 4/26/16, totally dependent on staff for				

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

	ota Department of He NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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21375	R18's room and asl the bathroom, R18 reached up with hei hair. NA-H took a p and cleansed R18's reached down with soiled area on her s obtaining clean clot would re-wipe R18's reach down and ha times. At that time I dependent on 2 sta frequently incontine 3:44 p.m. NA-H req cares. R18 continue re-soiling her right h pant leg and NA-H the wipes. -At 3:53 p.m. NA-H requested assistant were times when sh another staff memb requiring 2 staff ass stated she had bee when the DON pull 3:56 p.m. NA-H left out assistance with R18's pant leg. R18 immediately after N -At 3:59 p.m. NA-F in a grape sized am the floor near R18's as she approached hands with a washo NA-F backed away gait belt across R18	ked R18 if she wanted to use lifted her head out of her shirt, r right hand and touched her ackaged pre-moistened wipe s right hand. R18 repeatedly her hand and touched the slacks while NA-H was thes from her closet. NA-H s hand, and R18 would again ndle the soiled slacks several NA-H stated R18 was totally ff for all of her cares and was ent of bowel and bladder. At juested assistance with R18's ed to repeat the process of nand with the bowel on her would re-wipe her hand with used her walkie talkie and ce, NA-H then stated there he had to wait a long time for per to help with residents sistance, including R18. NA-H n assigned to another wing ed her into R18's room. At t R18's room to physically seek out covering the bowel on B re-soiled her right hand	21375	DEFICIENC	Υ)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
	00730	B. WING		10/24/2016	
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FRAZEE CARE CENTER		T MAPLE AVE MN 56544	NUE, PO BOX 96		
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 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. 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. 	elchair, assisted R18 to walk to F removed R18's slacks and hich were saturated with bowel adder. NA-F discarded R18's the garbage and placed R18's e floor. NA-H removed R18's on the floor next to R18's soiled VA-H assisted R18 with a clean brief and donned clean VA-H checked R18's seat I she felt it was clean, washed e. NA-F picked up R18's soiled d soiled washcloths from the d hands, left the room and hopper room. NA-H provided oll, her call light and left R18's I7 p.m. NA-F stated it was not aced soiled clothing on the the usual practice would be othing in a bag and bring the opper room. NA-F also stated of the last time R18 had been ng. NA-F stated she used to he previous shift NA of when e last completed, though did stated she had not been the previous shift NA on a ue to short staffing. B7 p.m. the assistant director of as not usual practice to place he floor. ADON stated the to place soiled clothing in the closed bags into the e rinsed and placed in laundry tated she expected staff to			1	

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21375	Review of a facility dated 4/1/08, revea when handling, pro linens, staff were to prevent the spread directed staff to imm	ge 143 policy titled., Linens-Handling, led it was the facility's policy cessing and transporting o use specific procedures to of infection. The policy nediately remove soiled linens room and taken to a utility				
	The director of nurs develop and impler related to a compre- program, to include investigating all illne or designee could r proper infection cor cares and linen har assessment and as perform random au	THOD FOR CORRECTION: sing (DON) or designee could nent policies and procedures thensive infection control tracking, trending and esses in the facility. The DON eview and educate staff on ntrol practices for resident adling. The quality ssurance committee could dits to ensure compliance. R CORRECTION: Twenty (21)				
21426	MN St. Statute 144 Prevention And Con (a) A nursing home maintain a compreh infection control pro current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta	A.04 Subd. 3 Tuberculosis htrol e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease tion (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis	21426			11/17/16

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

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

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

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

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

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

STATE FORM

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

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

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

Minneso	ta Department of He	alth			FORM	APPROVED
STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY 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 MN 56544	ENUE, PO BOX 96		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETE DATE
21435	Continued From pa	ge 153	21435			
	TIME PERIOD FOF (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 part 6800.6300.				
	by: Based on observati review, the facility fa labeled with open o opened for 2 of 5 re addition, the facility for consistent and ti discontinued narcot	tics to prevent loss or potential medication rooms reviewed for		corrected		
	observed to have th	0 p.m. medication cart B was ne following bottles of eye without a date identified so uld be determined:				
	dispensed on 6/4/10	eate PF Solution 0.5%, 6. Solution 0.005%, dispensed				
	indicated R31 was Solution 0.5% Solut	cian orders dated 9/27/16, prescribed Timolol Maleate PF tion, 1 drop in left eye one time , with an ordered start date of				

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

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

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

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

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21805	Continued From pa	age 158	21805			
	and diabetes.					
	her bed, on her bad gown. Licensed pra nursing assistant (I room for morning of R66's white sheet a R66's body and se NA-E was position	:05 a.m. R66 was observed in ck and dressed in a hospital actical nurse (LPN)-A and NA)-E were present in her cares. LPN-A pulled away and white cotton blanket from t both off to R66's right side. ed on R66's right side and ned on R66's left side of her				
	several dried brown dried, yellow stain which extended to where LPN-A was R66. The stains we hand on the bed L with her torso and multiple browns str on R66's sheet. LP streaks and large y urine, covered the	heet was observed to have n streaks, and a large round, on her white cotton bed sheet the left edge of her bed sheet positioned to perform cares on ere next to R66's left arm and .PN-A leaned over R66's bed scrub top resting on the reaks and yellow stained areas 2N-A confirmed multiple brown vellow stain were feces and multiple stained areas with blanket and continued to ming cares.				
	facility practice was changed on reside linens became soil received a bath on was today. NA-E in how long R66's be	03 p.m. NA-E stated the usual s for resident's sheets to be nt bath days, and whenever ed. She stated R66 had Monday, and her next bath ndicated she was not aware d linens had been soiled, and ght night shift had last 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 IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 10/24/2016	
		00730				
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
FRAZEE	CARE CENTER		T MAPLE AVE , MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	ge 159	21805			
	day, or whenever th	ney had an "accident."				
	facility practice was changed whenever on bath days. She	6 p.m. LPN-A stated the usual s for resident's sheets to be the linens became soiled, and stated R66's soiled sheets changed right away when they				
	(CM)-A stated resic checked for cleanlin resident care. She be changed whene and routinely on the should have been v R66's sheets becar	53 a.m. clinical manager dent bed sheets should be ness when staff provide stated resident sheets should ver staff notice they are soiled eir bath days. She stated it very obvious to staff when me soiled, and she would nge the sheets right away.	,			
	3/1/14, identified so immediately remov and taken to the lau identified dirty laund person's body and handling dirty laund	blicy, Linens-Handling dated biled linen was to be ed from the resident's room undry room. The policy further dry should not be close to a hands were to be washed after fry and prior to handling clean the spread of infection.	r			
	The administrator of and revised policies staff on the residen promoted for each and social services	THOD OF CORRECTION: or social services could review s on dignity and in-service all ts rights so they can be resident. The administrator could monitor cares to ensure esidents in the facility.	,			
	TIME PERIOD FOR days.	R CORRECTION: Seven (7)				

		alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY 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 MN 56544	ENUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE CO	(X5) DMPLETI DATE
21870	Continued From pa	ge 160	21870			
21870	MN St. Statute 144 Residents of HC Fa	.651 Subd. 18 Patients & ac.Bill of Rights	21870		11/	17/16
	residents shall have	nsive service. Patients and the right to a prompt and se to their questions and				
	by: Based on interview facility failed to ens related to sufficient response times we	ent is not met as evidenced and document review the ure resident council concerns staffing and long call light re acted upon for 5 of 5 R2, R5, R45) who voiced ident council.		corrected		
	Findings include:					
	8/17/16, identified F required extensive	num Data Set (MDS), dated R27 had intact cognition and assistance from staff for Iressing, transferring and toilet				
	routinely attended r she had reported a she had waited free when she put her line stated she was beg something wrong a answer light for tha residents had also responses from sta	1 p.m. R27 stated she esident council meetings and t the resident council meetings quently for at least 2 hours ght on and needed help. R27 inning to feel like she did nd that was why staff didn't t long. She stated other complained of long call light ff and short staff in the elt the facility had not 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 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 MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21870	R27 stated she had staff, and long call I conferences. She s told her they will loo anything about it. Si weren't getting the o they were short staff director (AD) was a meeting and she wo to the ones she sho not doing any good. R27 stated she was who had brought up long call light wait ti had not given any e concern continued. telling resident cour the residents contin again, and again. Review of the reside from 7/27/16, 8/31/ -7/27, residents wer needs to have their than 2 hours -8/31, residents wer long to answer their further identified R2 morning at 8:00 a.m answered until 10:0 indicated R27 state long because she w morning activities. T	I also brought up the lack of ight waits during her care tated the facility had always ik into it, but they hadn't done he stated she felt residents care they needed because ffed. She stated the activities t every resident council buld tell residents she talked buld talk to, but evidently it was				

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

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

Minnesota Department of Health STATE FORM

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