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: SQMJ
Facility ID: 00730

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

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

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

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **11/01/2004**

6. DATE OF SURVEY **01/30/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

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

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **74** (L18)

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

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	74			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 02/12/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/17/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **11/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **02/03/2015** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245299

February 17, 2015

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

Dear Mr. Huhta:

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

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

Effective January 15, 2015 the above facility is certified for or recommended for:

74 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 74 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

February 12, 2015

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

RE: Project Number S5299026

Dear Mr. Huhta:

On December 30, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard extended survey, completed on December 12, 2014 that included an investigation of complaint number . This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On January 30, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 12, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 15, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 12, 2014, effective January 15, 2015 and therefore remedies outlined in our letter to you dated December 30, 2014, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245299	A. Building B. Wing	1/30/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0160 Reg. # 483.10(c)(6) LSC	01/15/2015	ID Prefix F0170 Reg. # 483.10(i)(1) LSC	01/15/2015	ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	01/15/2015
ID Prefix F0226 Reg. # 483.13(c) LSC	01/15/2015	ID Prefix F0241 Reg. # 483.15(a) LSC	01/15/2015	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	01/15/2015
ID Prefix F0309 Reg. # 483.25 LSC	01/15/2015	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	01/15/2015	ID Prefix F0329 Reg. # 483.25(l) LSC	01/15/2015
ID Prefix F0334 Reg. # 483.25(n) LSC	01/15/2015	ID Prefix F0371 Reg. # 483.35(i) LSC	01/15/2015	ID Prefix F0428 Reg. # 483.60(c) LSC	01/15/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GA/mm	02/11/2015	28034	01/30/2015
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/12/2014			

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PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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Facility ID: 00730

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(L1) **245299**

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(L3) **FRAZEE CARE CENTER**
(L4) **219 WEST MAPLE AVENUE, PO BOX 96**
(L5) **FRAZEE, MN** (L6) **56544**

4. TYPE OF ACTION: **2** (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
8. Full Survey After Complaint
9. Other

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2004**

6. DATE OF SURVEY **12/12/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited, 1 TJC, 2 AOA, 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	74			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Denise Erickson, HFE NEII — 01/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 01/30/2015 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
11/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 02/03/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0952
December 30, 2014

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

RE: Project Number S5299026

Dear Mr. Huhta:

On December 12, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6**

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Licensing and Certification Program
Health Regulations Division
Telephone: (218)332-5158 Fax: (218)332-5196
Enclosure
cc: Licensing and Certification File

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 20, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 20, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 11, 2015 (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 June 11, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring

P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

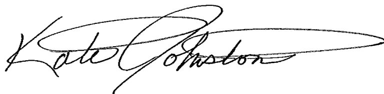
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING ______ B. WING ______	12/12/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	GA 1/21/15	
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final	F 160	Policies and procedures were reviewed regarding residents receiving personal funds within 30 days of death.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrew C. Hukta
TITLE: Executive Director
(X6) DATE: 01/09/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING ______ B. WING ______	12/12/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 160	Continued From page 1 accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure personal funds were conveyed within the appropriate time frame for 4 of 7 discharged residents (DR1, DR2, DR3, and DR4)accounts reviewed. Findings include: DR1 expired 4/15/ 2014. Review of the Resident Trust Account Balance report printed on 12/11/14, revealed DR1 had $26.67 currently in the account, 241 days after DR1 expired. DR2 expired on 9/12/14. Review of the Resident Trust Account Balance report printed on 12/11/14, revealed DR2 had $197.20 currently in the account, 90 days after DR2 expired. DR3 expired on 10/7/14. Review of the Resident Trust Account Balance report printed on 12/11/14, revealed DR3 had $21.29 currently in the account, 65 days after DR3 expired. DR4 expired on 11/9/14. Review of the Resident Trust Account Balance report printed on 12/11/14, revealed DR4 had $1170.88 currently in the account, 32 days after DR4 expired. During an interview on 12/11/14, at 2:15 p.m. the facility secretary indicated she was the accounts receivable manager. The secretary stated that trust account funds were held until the end of the	F 160	SSD has been educated on the policy and procedure and timely disbursement of personal funds, and will coordinate with the Business Office Manager and Administrator to ensure that all residents that have passed away, will have timely 30 day refunds. DR1, DR2, DR3 and DR4's funds were all dispersed and paid out. Administrator to audit all d/c residents to assure reimbursements have been made after discharge. QAA will review and monitor for compliance for 3 months.. Responsible parties: Administrator, Social Services Director, and Business Office Manager. Date of completion: 1-15-2015	

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	245299	A. BUILDING ______ B. WING ______	12/12/2014

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F 160	Continued From page 2 month after a resident death to be sure all hair care and drug store bills had been paid. Trust fund account balances were returned to the resident families if the resident was private pay. If the resident was not private pay, an affidavit would be sent to the county and the funds would be returned to the county or to the funeral home. The secretary stated social services designee (SSD) sent the notices to the county when the resident passed away. During an interview on 12/11/2014, at 2:23 p.m. the SSD verified the accounts with balances remaining greater than 30 days after the resident had expired. The SSD identified the usual protocol for resident funds had been as follows; when a resident expired Monday through Friday, a letter was sent to notify the county, weekend deaths would be sent the following week. The SSD verified DR1's trust account balance continued to be in a facility account since April, 241 days after the resident expired, and should have been sent to DR1's family member who was the power of attorney. The 3 other accounts would be sent to the county or funeral homes. The SSD identified a facility lack of communication and follow up with resident trust fund accounts. During an interview on 12/11/14, at 3:23 p.m. the SSD clarified an email was sent to the county after a resident death, then the "caseworker and the county do what they need to" and then the affidavit is sent to us. The SSD verified DR1,DR2, DR3, and DR4, had trust fund account balances with the facility that had not been conveyed with in the 30 day time frame. The SSD verified no further follow up is routinely done with the expired	F 160		

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F 160	Continued From page 3 residents trust accounts, and stated, we do not "send a second e-mail." During and interview on 12/12/14, at 4:30 p.m. the director of nursing (DON) verified the SSD was responsible for conveyance of trust fund accounts following resident expiration. The DON verified she was aware accounts were to be conveyed within a certain amount of time; however, was unaware of the exact time frame. The DON indicated the SSD was in charge of the trust fund accounts and would know the time frame. The facility policy titled Resident Personal Accounts, dated revision 8/2005, identified in Procedure #6 Upon the death of a resident... Dispersal of said funds will be made within 30 days of the resident's death.	F 160		
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure that residents received their personal mail on Saturdays. This deficient practice had the potential to affect all 64 residents in the facility. Findings include: During interview on 12/11/14, at 9:42 a.m. the	F 170		1/15/15

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final	F 160		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrew C. Hukta
TITLE: Executive Director
(X6) DATE: 1/9/2015

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.

1/21/15 OK

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JAN 15 2015
MN Dept of Health
Fergus Falls

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F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure that residents received their personal mail on Saturdays. This deficient practice had the potential to affect all 64 residents in the facility. Findings include: During interview on 12/11/14, at 9:42 a.m. the	F 170	**F170** Policies and procedures were reviewed regarding the mail distribution policy, including the right of residents to have their mail delivered on Saturday's. Activity Staff has been educated on the policy and procedure of mail distribution on 1/8/15. Education included ensuring resident's receive mail on Saturdays. The activity staff will coordinate, and distribute all Saturday mail.	

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F 170	Continued From page 4 resident council representative (R1) reported that the facility does not deliver mail to residents on Saturdays. During interview on 12/11/4, at 9:50 a.m. the activity director (AD) confirmed that the facility does not deliver mail to residents on Saturday, even though the postal service delivers the mail to the facility on Saturday. The AD reported the activity staff pick up the mail from the front office on Monday and delivers the mail to the residents. The AD confirmed the mail is not delivered to the residents within 24 hrs of the postal service delivering the mail on Saturday. During interview on 12/11/14, at 10:05 a.m. the administrator reported the front office receives the mail, and then the activity department staff deliver the mail to the residents. The administrator was not certain if the mail was delivered to the residents on Saturdays. During interview on 12/11/14, at 10:06 a.m. the front receptionist confirmed the postal service does deliver resident mail to the facility on Saturdays and the mail is kept in the office until Monday morning then the activity department staff picks up the mail and delivers it to the residents. The undated mail distribution policy, indicated staff are expected to deliver the mail to residents within 24 hours.	F 170	Activity Director and/or Designee will complete weekly audits for 6 weeks to ensure that residents are receiving their mail on Saturday. Results of audits will be reported at the QA meetings and resident council meetings for further review and recommendations. Date of completion: 1/15/15	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have	F 225	**F225** Policies and procedures were reviewed regarding reporting an injury of unknown source, including	

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F 225	Continued From page 5 been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an incident of potential	F 225	immediate reporting to the Common Entry Point (CEP)/ State Agency (SA). IDT team has been educated on the facility policy on VA 1/9/15. Education included facility Vulnerable Adult (VA) policy, investigating events and reporting events to the Administrator immediately. Any reported cases will be reviewed daily during IDT meetings to assure proper reporting and investigation has taken place and proper interventions are in place. A log of events will be kept for tracking. Administrator / designee will complete Random audits x 6 weeks of tracking logs to assure results will be reported at the QA meetings for further review and recommendations. Date of completion: 1/15/15	

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F 225	Continued From page 6 abuse/neglect immediately to the State agency (SA) for 1 of 3 residents (R77) reviewed for potential abuse/neglect. Findings include: R77 was admitted to the facility on 5/2/14 with diagnoses including: dementia, depression, and anxiety per the facility face sheet. The quarterly minimum data set (MDS) assessment dated 11/5/14 indicated R77 required extensive assistance with bed mobility, transfer, walk in room, dressing, eating, toilet use, and personal hygiene. The brief interview for mental status (BIMS) scored 99 indicating R77 was unable to complete the assessment. The staff assessment for cognition indicated R77 had long and short term memory problems and severe impairment related to cognitive skills for daily decision making. Review of the facility's incident reports revealed an incident dated 7/27/14 at 2:55 p.m. involving R77. The incident description indicated: "I found resident sitting on floor right outside her doorway..." The physical assessment findings indicated: "No scrapes or bruising, but resident unable to bear weight without pain." The report further indicated there were no witnesses to the incident. Review of the nurses notes revealed an entry dated 7/27/14 at 10:45 p.m. indicating: "Found resident sitting outside of doorway @ (at) 2.55 p.m. No witnesses to what happened. When asked, resident stated "I fell"." The note further indicated the resident had increased right hip pain and was unable to bear weight on right side without pain. The nurse practitioner was notified and order received to transfer R77 to the emergency room (ER) for further evaluation. The	F 225		

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F 225	Continued From page 7	F 225		

resident was subsequently admitted to the to the hospital with diagnosis of left hip fracture.

When interviewed on 12/11/2014, at 10:02 a.m. the director of nursing (DON) confirmed R77's fall resulting in a fracture had not been reported to the SA. The DON stated the staff were following the care plan and would have to check the record to see the circumstances of the fall as to whether it was witnessed or not.

When interviewed at 12/11/2014, at 5:08 p.m. the DON confirmed that R77's fall had not been witnessed by staff. The DON stated that though the resident had severe cognitive impairment she was able to state she had fallen when asked though was unable to report the circumstances surrounding the fall.

The facility's policy titled, Abuse Prevention/Resident Treatment, revised November 2011, included: "It is the policy of this facility to take appropriate steps to prevent the occurrence of:
Abuse
Neglect
Misappropriation of resident property
It is also the policy of this facility to take appropriate steps to ensure that all alleged violations of federal or state laws which involove mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property ("alleged violations") are reported immediately to the administrator of the facility. Such violations are also reported immediately to state agencies in accordance with existing state law. The facility investigates such alleged violation thoroughly and reports the results of all investigations to the administrator, as well as to state agancies as

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F 225	Continued From page 8 required by state and federal law."	F 225	**F226**	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their policies to ensure that an allegation of potential abuse/neglect was immediately reported to the State agency (SA) for 1 of 3 residents (R77) reviewed for potential abuse/neglect. Findings include: The facility's policy titled, Abuse Prevention/Resident Treatment, revised November 2011, included: "It is the policy of this facility to take appropriate steps to prevent the occurrence of: Abuse Neglect Misappropriation of resident property It is also the policy of this facility to take appropriate steps to ensure that all alleged violations of federal or state laws which involove mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property ("alleged violations") are reported immediately to the administrator of the facility. Such violations are also reported immediately to state agencies in	F 226	The Vulnerable Adult Policy (VA) was reviewed related to injuries of unknown origin and our investigation process, which includes immediate reporting to the CEP/SA. IDT team has been educated on the Vulnerable Adult Policy and reporting guidelines on 1/9/15. Education includes facility VA policy, investigating events and reporting events to the Administrator immediately. Any reported cases will be reviewed daily during IDT meetings to assure proper reporting and investigation has taken place and proper interventions are in place. A log of events will be kept for tracking. Administrator / designee will complete Random audits x 6 weeks of tracking logs to assure results will be reported at the QA meetings for further review and recommendations. Date of completion: 1/15/15	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 9 accordance with existing state law. The facility investigates such alleged violation thoroughly and reports the results of all investigations to the administrator, as well as to state agancies as required by state and federal law." R77 was admitted to the facility on 5/2/14 with diagnoses including: dementia, depression, and anxiety per the facility face sheet. The quarterly minimum data set (MDS) assessment dated 11/5/14 indicated R77 required extensive assistance with bed mobility, transfer, walk in room, dressing, eating, toilet use, and personal hygiene. The brief interview for mental status (BIMS) scored 99 indicating R77 was unable to complete the assessment. The staff assessment for cognition indicated R77 had long and short term memory problems and severe impairment related to cognitive skills for daily decision making. Review of the facility's incident reports revealed an incident dated 7/27/14 at 2:55 p.m. involving R77. The incident description indicated: "I found resident sitting on floor right outside her doorway..." The physical assessment findings indicated: "No scrapes or bruising, but resident unable to bear weight without pain." The report further indicated there were no witnesses to the incident. Review of the nurses notes revealed an entry dated 7/27/14 at 10:45 p.m. indicating: "Found resident sitting outside of doorway @ (at) 2.55 p.m. No witnesses to what happened. When asked, resident stated "I fell"." The note further indicated the resident had increased right hip pain and was unable to bear weight on right side without pain. The nurse practitioner was notified and order received to transfer R77 to the emergency room (ER) for further evaluation. The	F 226		

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F 226	Continued From page 10 resident was subsequently admitted to the to the hospital with diagnosis of left hip fracture. When interviewed on 12/11/2014, at 10:02 a.m. the director of nursing (DON) confirmed R77's fall resulting in a fracture had not been reported to the SA. The DON stated the staff were following the care plan and would have to check the record to see the circumstances of the fall as to whether it was witnessed or not. When interviewed at 12/11/2014, at 5:08 p.m. the DON confirmed that R77's fall had not been witnessed by staff. The DON stated that though the resident had severe cognitive impairment she was able to state she had fallen when asked though was unable to report the circumstances surrounding the fall.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified dining experience for 6 of 6 residents (R55, R4, R59, R43, R9, and R20) observed during the meal. Finding include:	F 241	**F241** POC for R55, R4, R59, R43, R29, and R9 have been reviewed and updated if needed related to resident individual meal assistance needed. Staffing around meal times has been reviewed and changes made as needed to assure meal service is completed in a dignified manner. Education for nursing staff has been completed on 1-06 and 1-07 to ensure that all residents are treated with dignity and have a pleasant dining experience.	

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F 241	Continued From page 11 R55's care plan (CP) dated 12/15/14, identified R55 had diagnoses which included congestive heart failure, cerebrovascular disease and depression. R55's CP identified she had alteration in cognitive and required assistance from staff to complete all activities of daily living (ADL's). Further review of the CP directed staff to provide extensive assistance with meals. R4's CP dated 12/8/14, identified R4 had diagnoses which included quadriplegia, chronic respiratory failure and anxiety . R4's CP identified he was cognitive and required assistance from staff to complete all activities of daily living ADL's. Further review of the CP directed staff to provide extensive assistance with meals. R59's CP dated 11/11/14, identified R59 had diagnoses which included depression, psychosis, and anxiety. R59's CP identified she had alteration in cognition and required assistance from staff to complete all activities of daily living ADL's. Further review of the CP directed staff to provide extensive assistance with meals. R43's CP revised on 6/17/14, identified R43 had diagnoses which included dementia, depressive disorder and macular degeneration. R43's CP identified she had alteration in cognition related to dementia and required assistance from staff to complete all activities of daily living ADL's. Further review of the CP directed staff to provide extensive assistance with meals. R9's CP dated 10/10/12, identified R9 had diagnoses which included Alzheimer, dementia, and anxiety. R9's CP identified she had alteration in cognition and required assistance from staff to complete all activities of daily living ADL's. Further	F 241	DON/Designee will complete weekly audits X3 months and monthly X3 months to ensure that residents are treated with dignity Results of audits will be reviewed at QA meetings for further review and recommendations Date to be completed: 1/15/15	

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F 241	Continued From page 12 review of the CP directed staff to provide extensive assistance with meals. R20's CP dated 5/8/13, identified R20 had diagnoses which included Alzheimer, dementia, and anxiety. R20's CP identified she had alteration in cognition and required assistance from staff to complete all activities of daily living ADL's. Further review of the CP directed staff to provide extensive assistance with meals. During continual observation of the supper meal on 12/8/14 at 6:20 p.m. R4, R55, R20, R59 were seated at a large round table near the entrance of the main dining room with various food items in front of them. Licensed practical nurse (LPN-B) was observed standing next to the table, in between R59 and R55, she was assisting R55 on her right side to eat portions of her food using a silver spoon to give her bites of her supper while walking around and visiting with other residents in the area at the same time. At 6:21 p.m. nurses aid (NA-E) was observed standing next to the table, in between R4 and R20, she was assisting R4 to the right of her and R20 to her left of her by giving them bites of their food using a silver spoon one at a time. At 6:23 p.m. LPN-B and NA-E continue to stand and feed R4, R55, R20, and R59. At 6:24 p.m. LPN-B left the table and walked over to the sink in the dining area and washed her hands, then returned to the table a short while later and assisted R59 to the left of her by giving R59 her medication and then proceeded to give R55 to the right of her a bite of her supper using a silver spoon, while NA-E continues to stand while assisting R4 and R20 with eating.	F 241		

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F 241	Continued From page 13	F 241		

At 6:25 p.m. LPN-B left the table again and went to the kitchen and asked for some toast for another resident sitting at the table. At 6:27 p.m. LPN-B continues to deliver food and assist other residents in the dining room area. At 6:28 p.m. R4 is done eating and left the dining room area while staff continue to stand and assist other residents in the dining room. At 6:29 p.m. LPN-B came back over to R59 to see if she is done eating and continued to give R55 more bites of her food using a silver spoon, then proceeded to take R59 out of the dining room and back to her room, while NA-E continued to stand and assist R20 with eating until 6:34 p.m. when she took R20 out of the dining room while R55 remained at the table.

At 6:35 NA-E returned to the dining room and walked over to another table in the dining room adjacent to the other table and was observed standing next to the table assisting R43 to eat by giving her bites of her supper using a silver spoon, then proceeded to walk across the table to the other side and assisted R9 with her supper as well. At 6:36 p.m. NA-E walked back across the table to the other side to assist R43 with eating, then knelt down on her knees, while she leaned up against the table with her right arm, and continue to feed R43 her supper.

At 6:39 p.m. NA-E asked R9 if she was ready to go home and R9 said yes, then NA-E proceeded to take R9 back to her room. Mean while R55 and R43 continued to sit at their tables in the dining room with their food still in front of them.

At 6:46 p.m. assistant director of nursing (ADON)

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F 241	Continued From page 14 sat down at the round table and started to assisting R55 to finish her supper. During continual observation of the supper meal LPN-B and NA-E continued to stand the entire time while assisting R4, R55, R20, R59, R9, and R43 from 6:20 p.m. to 6:39 p.m. During interview on 12/11/14 at 2:25 p.m. NA-E confirmed that she stood the entire time while assisting residents to eat in the dining room and stated, "Its wrong and its not dignified to stand while you are feeding people". NA-e also verified that she does bounce around to feed people because there is not enough staff to help all the residents eat. During interview on 12/11/14 at 2:35 p.m. LPN-B confirmed that she stood the entire time while assisting residents to eat in the dining room and stated, "I do not feel it is dignified to give them food and then come back". LPN-B also verified that they do not have enough help in the dining room to help feed the residents. During interview on 12/11/14 at 2:59 p.m. director of nursing (DON) confirmed staff should not be standing while they are feeding residents and verified staff should be feeding one or two residents at a time and not be going back and forth between residents. The DON also stated "I do not feel this is dignified to stand and feed several residents." Review of facility policy titled, Dignity Quality Of Life dated 4/1/2008, indicated staff to promote car for residents in a manner and in an environment that maintains or enhances each residents dignity	F 241		

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F 241	Continued From page 15 and respect by assisting and promoting independence in eating and dining.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a care plan to address the coordination of hospice services for 1 of 1 resident (R62) who was reviewed for hospice care. In addition, the facility failed to develop a care plan for 1 of 5 residents (R71) receiving anti-psychotropic medication. Findings include:	F 279	**F279** Plan of Care (POC) for R62 and R71 has been reviewed and updated POC for residents on Hospice and residents on anti-psychotropic medications have been reviewed and updated as needed Education for nursing staff has been completed on 1-06 and 1-07 to ensure those residents on Hospice services and who are on Anti-psychotropic medications DON/Designee will complete Audits weekly X3 and monthly X3 to ensure that residents receiving Hospice services POC addresses areas of concern SW will complete Audits weekly X3 and monthly X3 to ensure that residents receiving Anti-psychotropic medications POC addresses areas of concern	

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F 279	Continued From page 16 R62 had a diagnosis from the hospice agency's initial certification form, dated 11/11/14, which included a terminal diagnosis of senile degeneration of brain with coexisting diagnoses of generalized pain and loss of weight. Review of the physician orders dated 11/11/14 included an order to admit to hospice with standing orders. The orders also included, "6. Morphine concentrate 2.5 mg buccal every 1 hour as needed for pain. 7. lorazepam concentrate .25 mg buccal every 4 hours as needed for anxiety. 8. Glycopyrrorate 1 mg buccal every 8 hours as needed for secretions. 9. #6-8 above to be initiated by HRRV (Hospice Red River Valley) only." Review of R62's facility care plan last revised 11/13/14 indicated, "I am now receiving hospice services." The care plan did not include end of life care provided by facility staff or the hospice care givers including interventions for pain. When interviewed on 12/11/14, at 4:45 p.m. the director of nursing (DON) confirmed that the facility care plan was not integrated with the hospice care plan, including a delineation of services and lines of communications between the two entities. Review of R71's current care plan with revision date of 12/8/14,identified the care plan lacked identification of the use of an antipsychotic medication, the target behaviors displayed by the resident, any non-pharmacological interventions, and possible side effects of the medication. R71 had diagnoses which included dementia with	F 279	Results of Audits will be reported at QA meetings for further review and recommendations Date of completion: 1-15-15	

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F 279	Continued From page 17 out behavioral disturbance. R71's current medication orders signed 11/18/14, identified Seroquel (an antipsychotic medication) 25 mg (milligrams) at bedtime for Psychosis, with a start date of 10/13/14. The quarterly MDS (Minimum Data Set) dated 9/22/14, identified R71 had a diagnosis of dementia, a brief mini mental status (BIMS) identified severe cognitive impairment, and had displayed behaviors not directed towards others 1 to 3 days during the assessment period. During an interview on 12/12/2014, at 1:40 p.m. registered nurse (RN)-A verified R71's current care plan and the lack of focus, goals and interventions regarding resident behaviors and Seroquel use. RN-A verified the facility's usual practice for antipsychotic use would include a care plan which identified target behaviors of the resident and possible side effects of the medication. During an interview on 12/12/2014, at 12:38 p.m. the director of nursing (DON) verified R71's current care plan did not address R71's use of Seroquel. The requested facility policy was not provided.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	**F309** Resident # 62 has been assessed by therapy for proper chair seating. Resident # 18 has been assessed by RN with no negative effects for LN not receiving annual in service on dialysis.	

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F 309	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain comfortable wheelchair positioning for 1 of 1 resident (R62) reviewed for positioning. In addition, the facility failed to provide licensed staff education regarding peritoneal dialysis for 1 of 1 resident (R18). Findings include: On 12/08/2014, at 5:22 p.m. R62 was observed seated in a Broda wheelchair (w/c) in her bedroom. R62 was positioned with the back of the chair upright and the legrest positioned straight downward which offered no support to R62's legs or feet; the chair did not have an actual footrest attached to it. R62's feet were observed to be dangling approximately 10 inches from the floor. On 12/08/2014, at 5:50 p.m. until approximately 6:30 p.m. R62 was continually observed in the dining room during the supper meal. R62 was seated in a Broda w/c positioned with the back of the chair upright and the legrest positioned straight downward. R62's heels were observed resting in between the webbing on the legrest of the wheelchair. R62 required total assistance from staff with eating and was not observed to be repositioned throughout the entire observation. On 12/08/2014, at 7:52 p.m. and 12/9/14 at 9:34 a.m. R62 was observed in her bedroom seated in a Broda w/c with the backrest positioned upright,	F 309	All residents not sitting propely in a w/c may be affected by this practice. The facility only has one dialysis patient in the facility. Education for nursing staff has been completed on 1-06 and 1-07 on dialysis care to assure that staff provide cares to promote highest well-being. Staff received education to report if a resident is not sitting properly in w/c to have a therapy screen completed DON/Designee will complete weekly audits for X3 months and the monthly X3 to assure highest well being is being met in all residents Results of audits will be reviewed at QA Meetings for further review and recommendations Date to be completed 1-15-15	1/21 residents w/c & Broda chair audit any dialysis pts in the future by staff training

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F 309	Continued From page 19 legrest positioned straight downward, and residents feet observed to be dangling approximately 10 inches from the floor without support to legs or feet. On 12/9/14, at 11:30 a.m. R62 was observed seated in a Broda w/c in her bedroom with the back of the chair positioned upright and the legrest positioned straight downward. R62 was observed with her knees bent and feet curled beside her on the seat of the chair On 12/09/2014, at 1:18 p.m. R62 was observed seated in a Broda w/c in her bedroom with the back of the chair positioned upright and the legrest positioned straight downward. R62's left foot was dangling and right knee was bent with the right foot resting on the upper legrest webbing towards the seat of the chair. On 12/10/2014 at 8:19 a.m. and 11:00 a.m. R62 was observed seated in a Broda w/c in her bedroom with the back of the chair positioned upright and the legrest positioned straight downward. During the 8:19 a.m. observation R62's feet were observed dangling approximately 10 inches from the floor with no support. During the 11:00 a.m. observation R62's heels were observed to be resting slightly on the webbing of the chair offering minimal support. On 12/11/2014, at 8:15 a.m. R62 was observed seated in a Broda w/c in the dining room being assisted by staff with eating breakfast. R62 was positioned with her back slightly reclined and the legrest positioned straight downward with R62's feet dangling approximately 10 inches from the floor.	F 309		

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F 309	Continued From page 20 Review of R62's significant change minimum data set (MDS) dated 11/17/14 indicated R62 was totally dependent on staff with transfer, dressing, toilet use, locomotion on unit, and eating and required extensive assistance with bed mobility and personal hygiene. The MDS further indicated R62 had severe cognitive impairment and received hospice services. On 12/11/2014, at 11:35 a.m. R62 was observed with the director of nursing (DON), registered nurse (RN)-A and RN-B. R62 was seated in a Broda w/c in her room with the back of the chair reclined slightly and the legrest raised supporting R62's legs/feet. The DON confirmed that this was proper positioning for R62 and also commented that this was the most comfortable R62 had looked in a long time. The DON confirmed that the legrest should by elevated on R62's w/c to support the legs/feet to prevent them from dangling. The DON stated that when R62 is eating in the dining room the w/c is not able to get under/up to the table when the footrest is elevated so during meals the footrest is put down and staff may forget to raise it again once the meal is over. The DON showed surveyor a laminated sheet with instructions of how the w/c should be positioned that was attached to the back of R62's w/c. The laminated sheet included a picture of the w/c when positioned properly and indicated, "Place chair in tilt not just the recline. Tilt is the lower handle. Also, elevate the legs." The picture also included a foot rest which was not included on R62's w/c. Below the picture of the w/c indicated, "38 degrees of seat tilt". The DON confirmed that the footrest had been removed from R62's w/c as her feet didn't reach it which would not give any support.	F 309		

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F 309	Continued From page 21 When interviewed on 12/11/2014, at 3:02 p.m. the occupational therapist-registered (OTR) confirmed that R62 should not be positioned sitting upright with her feet dangling. OTR further stated she had observed the resident positioned this way at times and addressed it with nursing staff. OTR stated nursing staff indicated sometimes not having enough help to take the time to reposition the resident. OTR further stated she had provided a diagram to nursing as to how the chair should be positioned which was laminated and hanging on the back of R62's w/c. OTR stated feeling that the footrest should still be attached to the w/c even though the resident's feet don't reach it as a reminder to staff on proper positioning. R18's peritoneal dialysis exchanges were completed by staff who were not trained by the dialysis provider (Davita). R18's quarterly Minimum Data Set (MDS) dated 10/16/14, identified diagnoses which included diabetes mellitus type 2, and received specialized treatments including dialysis. R18's current care plan included peritoneal dialysis care related to end stage renal disease. The facility form titled Dialysis Policy and Procedure identified R18 began in house peritoneal dialysis at the facility on 4/15/14. Review of the dialysis in-service training logs identified the most recent training had been completed 7/18/13. The DON stated licensed practical nurse (LPN)-C and RN-C had performed dialysis exchanges for R18 and provided their orientation checklists. LPN-C was oriented to	F 309		

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	245299	A. BUILDING ______ B. WING ______	12/12/14 12/11/2014

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F 309	Continued From page 22 dialysis on 12/4/13, by a facility employee but not from a Davita Dialysis employee. RN-C had not received training from a Davita Dialysis employee, completed orientation on 4/7/14, and had been orientated to dialysis according to the check list, by a facility employee. During an interview on 12/10/2014, at 1:36 p.m. registered nurse (RN)-A stated dialysis training for licensed staff was completed by the Davita Dialysis company when a new resident came to the facility; however, if a new nurse started, training would be completed by the nurse working that shift. During and interview on 12/11/2014, at 10:17 a.m. licensed practical nurse (LPN)-A verified an inservice was provided by Davita Dialysis from Moorhead for a previous resident who had the same dialysis cycler (machine used for dialysis treatment), but had not specifically trained staff for R18. LPN-A verified new nurses had been orientated by the current nurse working the shift the dialysis exchange was performed. During an interview on 12/11/2014, at 1:27 p.m. the director of nursing (DON) verified new staff training for dialysis procedure had been completed during orientation by the nurse on the shift when the exchange was performed. The DON verified she was in charge of the education regarding dialysis, and at this time the hands on training of the dialysis procedure was done with the nurse working the floor that day. During a phone interview on 12/12/14, at 3:43 p.m. the primary dialysis nurse stated that Davita staff were expected to train new staff for	F 309		

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F 309	Continued From page 23 resident's peritoneal dialysis exchanges. The undated facility policy titled Frazee Care Center Dialysis Policy and Procedure directed staff training to be provided by Davita staff.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility to provide routine personal grooming for 1 of 3 residents (R87) reviewed for activities of daily living (ADL's) who was dependent on staff for grooming. Findings include: On 12/8/14, at 5:23 p.m. R87 was observed with 2 long hairs approximately 1 centimeter (cm) in length and multiple shorter hairs visible on her chin. R87's chin hair continued to be present and observed all days of the survey. R87 was admitted to the facility on 12/5/14 with diagnoses including right hip fracture, dementia, and glaucoma per the facility face sheet. R87's temporary care plan dated 12/5/14 indicated the resident required assistance of 1-2 staff with showering, assist of one staff with dressing, and set-up assistance with verbal cues with grooming.	F 312	**F312** POC for R87 has been reviewed POC for other residents will be reviewed on an ongoing basis to assure that their desired grooming cares are met. Education for nursing staff has been completed on 1-06 and 1-07 to ensure that all residents requiring assistance with grooming are met. DON/Designee will complete weekly audits X3 months and then every month X3 to assure that grooming needs are met Results of Audits will be reported at The QA meetings for further review and recommendations. Date to be completed by: 1-15-15	

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F 312	Continued From page 24 The care plan further identified a diagnosis of dementia exhibiting forgetfulness and intermittent confusion. On 12/12/2014, at 1:01 p.m. R87 was observed seated in her wheelchair in her room receiving assistance with her television from nursing assistant (NA)-A. R87 continued to have facial hair present on her chin. Surveyor interviewed NA-A who confirmed that R87 had a shower that morning and that NA-A had been the staff who assisted her. NA-A confirmed that residents were usually offered to be shaved on their bath day and acknowledged that R87 had visible facial hair present. NA-A stated she had noticed it that morning when giving R87 the shower and stated, "Guess I just forgot". NA-A then asked R87 if she would like her to shave the facial hair and R87 agreed. When interviewed on 12/12/2014 at 1:14 p.m. registered nurse (RN)-A stated she would expect residents to be offered shaving on bath day and as needed. RN-A confirmed R87 should have been offered to be shaved when bathed.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	**F329** POC for R71 has been reviewed and updated All residents who receive anti-psychotropic medications have been reviewed to assure they have behavior monitoring sheets in place to address target behaviors and non pharmacological interventions	

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F 329	Continued From page 25 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify the clinical indications for the continued use of a anti-psychotic medication for 1 of 5 resident (R71) reviewed. Findings include: R71 received Seroquel (antipsychotic medication) 25 milligrams at bedtime without adequate indications for the use of the medication. In addition, the facility did not establish appropriate target behavior monitoring and care planning for the use of the medication. Review of R71's current care plan with revision date of 12/8/14, lacked identification of the use of an antipsychotic medication, the target behaviors displayed by the resident, any nonpharmacological interventions, or possible side effects of the medication.	F 329	Education for nursing staff has been completed on 1-6 and 1-7 to ensure that residents with anti-psychotic medications have interventions in place. SW/Designee will complete weekly audits for 3 months to ensure that residents have non pharmacological interventions as well as targeted behaviors if they are receiving anti-psychotic medications. Results of audits will be reported at the QA meetings for further review and recommendations. Date of completion: 1/15/15	

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F 329	Continued From page 26 R71 had diagnoses which included dementia with out behavioral disturbance. R71's current medication orders signed 11/18/14, identified Seroquel 25 mg at bedtime for Psychosis, with a start date of 10/13/14. The quarterly MDS (Minimum Data Set) dated 9/22/14, identified R71 had a diagnosis of dementia, a brief mini mental status (BIMS) identified severe cognitive impairment, and had a behaviors not directed towards others 1 to 3 days during the assessment period. During an interview on 12/12/14, at 1:40 p.m. registered nurse (RN)-A verified R71's record lacked behavior monitoring of target behaviors. RN-A stated, "We normally would have a behavior monitoring log for someone on Seroquel". During an interview on 12/12/2014, at 12:38 p.m. the director of nursing (DON) confirmed the lack of documented target behaviors or identified non-pharmacological interventions. The DON stated the behavior monitoring records were reviewed to review potential dosage reductions. The requested facility policy was not provided.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the	F 334	**F334** Resident #34 records for immunization requested from clinic and offer of immunization has been provided.	

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F 334	Continued From page 27 immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following:	F 334	Any resident admitted to Frazee Care Center is at risk for this practice. Education provided to LN to follow facility policy of obtaining records upon admission and offering influenza (October- February) and Pnuemovax if no records are available. NM will review all new admissions within 7 days of admission to assure records have been obtained or staff has offered vaccinated as outlined above. DON/ Designee will audit this practice for 3 months. Results of audits will be reported at the QA meetings for further review and recommendations. Date of correction is 1/15/15.	

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F 334	Continued From page 28 (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R23) were offered and/or received the influenza and pneumovax vaccination. Findings include: R23 was admitted to the facility on 10/23/14, and remained in the facility. No documentation was provided to indicate R23 was offered the influenza and pneumovax vaccination. During interview on 12/12/14, at 4:21 p.m. registered nurse (RN)-A confirmed no immunizations were recorded in R23's medical record as being administered or offered. On 12/12/14, at 4:24 p.m. RN-A asked R23 if she would like the influenza and pneumovax	F 334		

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F 371	Continued From page 30 the floor of the walk-in freezer. This had the potential to effect 63 of 64 residents residing in the facility. Finding include: During the initial kitchen tour on 12/8/14 at 1:08 p.m., dietary aid (DA-A) opened the large walk in freezer in the back room of the kitchen area. During the observation it was noted there was two large cardboard boxes sitting on the floor under the metal shelves on the left hand side of the freezer. One of the boxes was opened and contained three and a half rolls of 10 pound packages of ground beef and the other cardboard box sitting next to ground beef was still sealed and contained four 14 pound beef roasts. On 12/8/14 at 1:08 p.m. during the initial tour DA-A verified the rolls of ground beef and the beef roast were on the floor of the walk in freezer and stated, "It is not to be on the floor." On 12/8/14 at 1:08 p.m. during the initial tour DA-B verified the rolls of ground beef and the beef roast were on the floor of the walk in freezer and stated, "Nothing is suppose to be on the floor." On 12/10/14 at 1:21 p.m. dietary manager (DM) confirmed that no meat or any food should be left on the floor of the walk in freezer. The DM stated, "The meat could potentially get contaminated and this is unsanitary." Review of facility policy titled, Food Storage, dated January 2013, indicated all food items served to residents and clients will be stored under sanitary conditions, stored six inches	F 371	The Dietary Manager or designee will complete Proper Food Storage Audits weekly for 3 months to ensure sanitary storage of resident food. Results of audits will be shared with dietary staff at monthly dietary staff meetings, and also reported at the QA meetings for further review and recommendations. Date to be completed by: 1/15/15	

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F 371	Continued From page 31 above the floor, not exposed to floor moisture and stored properly as soon as they are delivered.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist reported medication irregularities to the attending physician and the director of nursing for 1 of 5 resident (R71)who's medications were reviewed. Findings include: R71 had diagnoses which included dementia with out behavioral disturbance. R71's current medication orders signed 11/18/14, identified Seroquel (antipsychotic medication) 25 mg (milligrams) at bedtime for Psychosis with a start date of 10/13/14. The quarterly MDS (Minimum Data Set) dated 9/22/14, identified R71 had a diagnosis of dementia, a brief mini mental status (BIMS) identified severe cognitive impairment, and had	F 428	**F428** The consultant Pharmacist has reviewed resident # 71 for GDS suggestions. Any resident at the facility is at risk for not having medication irregularities reviewed. DON contacted consultant pharmacist to provided education on reviewing R71 medication and importance of following up on medications irregularities. The LN and SW were educated on the need to have targeted behavior sheets in place for any residents requiring anti-psychotics. SW/Designee will complete weekly audits for 3 months to ensure that residents have non pharmacological interventions as well as targeted behaviors if they are receiving anti-psychotic medications.	

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F 428	Continued From page 32 behaviors not directed towards others 1 to 3 days during the assessment period. The facility form titled Pharmacist's Drug Regimen Review indicated the consulting pharmacist reviewed R71's medications on 10/30/14, 17 days after the start date of the Seroquel and then again on 11/24/14, without identifying the lack of monitoring, target behaviors, or identified interventions for the Seroquel use. During an interview on 12/12/2014, at 1:40 p.m. registered nurse (RN)-A verified R71's record lacked behavior monitoring including identification of target behaviors and non- pharmacological interventions. RN-A stated "we normally would have a behavior monitoring log for someone on seroquel". During an interview on 12/12/2014, at 12:38 p.m. the director of nursing (DON) confirmed no documentation was found regarding target behaviors and identified non- pharmacological interventions. The DON stated the consulting pharmacist reviewed resident medications for possible reductions and stated "we look at pharmacy recommendations for (medication) reductions" and would use behavior documentation to review the behaviors. During an interview on 12/12/14, at 3:31 p.m. the consulting pharmacist verified the expectation that R71 would have behavior monitoring of target behaviors when receiving Seroquel. The consulting pharmacist indicated being unaware these were not in place.	F 428	DON/Designee will audit pharmacy reviews monthly to assure resident med irregularities are being reviewed. Results of audits will be reported at the QA meetings for further review and recommendations. Date of completion: 1/15/15	

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F 428	Continued From page 33 The requested facility policy was not provided.	F 428		

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	245299	A. BUILDING **01 - MAIN BUILDING** B. WING ______	**12/10/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Frazee Care Center 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The facility was inspected as one building: Frazee Care Center was constructed at three different times. The original building was constructed in 1971, is 1-story without a basement and was determined to be of a Type II(111) construction. In 1979 the north 200 wing addition was built. It is 1-story without a basement, was determined to be of a Type II (000) construction, and is separated with 2- hour fire barriers from the main building. Additions to the 1979 building in 1993 include an activities addition to the west and the business/ main entrance addition to the east. These areas were determined to be Type V (111) construction and the business / main entrance addition is separated from the apartment building with a 2- hour fire barrier, so the Apartment Building was not surveyed at this time. The facility is divided into 5 smoke zones with smoke barrier walls of 30 minutes and 90 minute rated fire barriers. The facility is completely sprinkler protected in accordance with NFPA 13 Standard for the	K 000		

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

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

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K 000	Continued From page 1 Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system with smoke detection throughout the corridor system and in the common spaces installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). In the 1971 building is now fully sprinkler protected. The facility has a capacity of 74 beds and had a census of 64 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0952
December 30, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5299026

Dear Mr. Huhta:

The above facility was surveyed on December 8, 2014 through December 12, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring 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 only a suggestion 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 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.

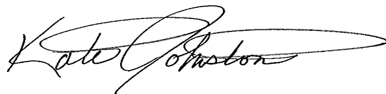
When all orders are corrected, the order form should be signed and returned to Gail Anderson at Minnesota Department of Health, 1505 Pebble Lk Rd #300, Fergus Falls, MN 56537. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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.

Please feel free to call me with any questions.

Sincerely,



Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992   Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00730	A. BUILDING: ______ B. WING ______	12/12/2014** 12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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.

INITIAL COMMENTS:
On 12/8/14, 12/9/14, 12/10/14, 12/11/14, and 12/12/14, the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of

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2 000	Continued From page 1 these orders for your records and return the original to the address below: Minnesota Department of Health 1505 Pebble Lake Road, Suite 300, Fergus Falls, MN 56537 c/o Gail Anderson, Unit Suervisor	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section.	2 302		

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2 302	Continued From page 2	2 302		

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure consumers were provided information for care of residents with Alzheimer's disease and dementia in a written or electronic form. In addition, the facility failed to identify a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered in the training.

During interview with the director of nursing (DON) on 12/12/14, at 12:24 p.m. confirmed the facility does not provide their consumers with the required information regarding Alzheimer's training. The DON stated she was not aware of the requirement.

The facility's current admission packet was reviewed with the director of social services (DSS). Facility services were identified in the brochure and the DSS confirmed information on staff training for the care of resident's with Alzheimer's and dementia was not included.

Review of the facility's list of documents given to a new resident upon admission didn't include written or electronic or access information of the facility staff training or caring for residents with Alzheimer's disease and dementia.

During interview on 12/12/14, at 12:48 p.m., the administrator confirmed the facility had not informed their consumers of the Alzheimer's training information.

SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding staff training to the resident admission packet for

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2 302	Continued From page 3 consumer information. The DON or designee could educate staff and conduct audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 500	MN Rule 4658.0275 Subp. 2 Return of Funds After Discharge or Death Subp. 2. Death of a resident. Upon the death of a resident, a nursing home must convey the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure personal funds were conveyed within the appropriate time frame for 4 of 7 discharged residents (DR1, DR2, DR3, and DR4)accounts reviewed. Findings include: DR1 expired 4/15/ 2014. Review of the Resident Trust Account Balance report printed on 12/11/14, revealed DR1 had $26.67 currently in the account, 241 days after DR1 expired. DR2 expired on 9/12/14. Review of the Resident Trust Account Balance report printed on 12/11/14, revealed DR2 had $197.20 currently in the account, 90 days after DR2 expired. DR3 expired on 10/7/14. Review of the Resident Trust Account Balance report printed on 12/11/14,	2 500		

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2 500	Continued From page 4	2 500		

revealed DR3 had $21.29 currently in the account, 65 days after DR3 expired.

DR4 expired on 11/9/14. Review of the Resident Trust Account Balance report printed on 12/11/14, revealed DR4 had $1170.88 currently in the account, 32 days after DR4 expired.

During an interview on 12/11/14, at 2:15 p.m. the facility secretary indicated she was the accounts receivable manager. The secretary stated that trust account funds were held until the end of the month after a resident death to be sure all hair care and drug store bills had been paid. Trust fund account balances were returned to the resident families if the resident was private pay. If the resident was not private pay, an affidavit would be sent to the county and the funds would be returned to the county or to the funeral home. The secretary stated social services designee (SSD) sent the notices to the county when the resident passed away.

During an interview on 12/11/2014, at 2:23 p.m. the SSD verified the accounts with balances remaining greater than 30 days after the resident had expired. The SSD identified the usual protocol for resident funds had been as follows; when a resident expired Monday through Friday, a letter was sent to notify the county, weekend deaths would be sent the following week. The SSD verified DR1's trust account balance continued to be in a facility account since April, 241 days after the resident expired, and should have been sent to DR1's family member who was the power of attorney. The 3 other accounts would be sent to the county or funeral homes. The SSD identified a facility lack of communication and follow up with resident trust

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2 500	Continued From page 5	2 500		

fund accounts.

During an interview on 12/11/14, at 3:23 p.m. the SSD clarified an email was sent to the county after a resident death, then the "caseworker and the county do what they need to" and then the affidavit is sent to us. The SSD verified DR1,DR2, DR3, and DR4, had trust fund account balances with the facility that had not been conveyed with in the 30 day time frame. The SSD verified no further follow up is routinely done with the expired residents trust accounts, and stated, we do not "send a second e-mail."

During and interview on 12/12/14, at 4:30 p.m. the director of nursing (DON) verified the SSD was responsible for conveyance of trust fund accounts following resident expiration. The DON verified she was aware accounts were to be conveyed within a certain amount of time; however, was unaware of the exact time frame. The DON indicated the SSD was in charge of the trust fund accounts and would know the time frame.
The facility policy titled Resident Personal Accounts, dated revision 8/2005, identified in Procedure #6 Upon the death of a resident... Dispersal of said funds will be made within 30 days of the resident's death.

Suggested Method of Correction: The DON or designee could work with the business office to ensure upon death that the resident's personal funds were conveyed in a timely manner.

Time Period for Correction: Twenty one (21) days.

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2 560	Continued From page 6	2 560		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to develop a care plan to address the coordination of hospice services for 1 of 1 resident (R62) who was reviewed for hospice care. In addition, the facility failed to develop a care plan for 1 of 5 residents (R71) receiving anti-psychotropic medication. Findings include: R62 had a diagnosis from the hospice agency's initial certification form, dated 11/11/14, which included a terminal diagnosis of senile degeneration of brain with coexisting diagnoses of generalized pain and loss of weight. Review of the physician orders dated 11/11/14 included an order to admit to hospice with standing orders. The orders also included, "6. Morphine concentrate 2.5 mg buccal every 1 hour as needed for pain. 7. lorazepam concentrate .25 mg buccal every 4 hours as needed for anxiety. 8. Glycopyrrorate 1 mg buccal every 8 hours as	2 560		

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2 560	Continued From page 7	2 560		

needed for secretions. 9. #6-8 above to be initiated by HRRV (Hospice Red River Valley) only."

Review of R62's facility care plan last revised 11/13/14 indicated, "I am now receiving hospice services." The care plan did not include end of life care provided by facility staff or the hospice care givers including interventions for pain.

When interviewed on 12/11/14, at 4:45 p.m. the director of nursing (DON) confirmed that the facility care plan was not integrated with the hospice care plan, including a delineation of services and lines of communications between the two entities.

Review of R71's current care plan with revision date of 12/8/14,identified the care plan lacked identification of the use of an antipsychotic medication, the target behaviors displayed by the resident, any non-pharmacological interventions, and possible side effects of the medication.

R71 had diagnoses which included dementia with out behavioral disturbance. R71's current medication orders signed 11/18/14, identified Seroquel (an antipsychotic medication) 25 mg (milligrams) at bedtime for Psychosis, with a start date of 10/13/14.

The quarterly MDS (Minimum Data Set) dated 9/22/14, identified R71 had a diagnosis of dementia, a brief mini mental status (BIMS) identified severe cognitive impairment, and had displayed behaviors not directed towards others 1 to 3 days during the assessment period.

During an interview on 12/12/2014, at 1:40 p.m.

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2 560	Continued From page 8 registered nurse (RN)-A verified R71's current care plan and the lack of focus, goals and interventions regarding resident behaviors and Seroquel use. RN-A verified the facility's usual practice for antipsychotic use would include a care plan which identified target behaviors of the resident and possible side effects of the medication. During an interview on 12/12/2014, at 12:38 p.m. the director of nursing (DON) verified R71's current care plan did not address R71's use of Seroquel. The requested facility policy was not provided. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the facility develop care plans according to the residents individualized needs. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures.The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on	2 830		

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2 830	Continued From page 9 individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain comfortable wheelchair positioning for 1 of 1 resident (R62) reviewed for positioning. In addition, the facility failed to provide licensed staff education regarding peritoneal dialysis for 1 of 1 resident (R18). Findings include: On 12/08/2014, at 5:22 p.m. R62 was observed seated in a Broda wheelchair (w/c) in her bedroom. R62 was positioned with the back of the chair upright and the legrest positioned straight downward which offered no support to R62's legs or feet; the chair did not have an actual footrest attached to it. R62's feet were observed to be dangling approximately 10 inches from the floor. On 12/08/2014, at 5:50 p.m. until approximately 6:30 p.m. R62 was continually observed in the dining room during the supper meal. R62 was seated in a Broda w/c positioned with the back of the chair upright and the legrest positioned straight downward. R62's heels were observed	2 830		

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2 830	Continued From page 10	2 830		

resting in between the webbing on the legrest of the wheelchair. R62 required total assistance from staff with eating and was not observed to be repositioned throughout the entire observation.

On 12/08/2014, at 7:52 p.m. and 12/9/14 at 9:34 a.m. R62 was observed in her bedroom seated in a Broda w/c with the backrest positioned upright, legrest positioned straight downward, and residents feet observed to be dangling approximately 10 inches from the floor without support to legs or feet.

On 12/9/14, at 11:30 a.m. R62 was observed seated in a Broda w/c in her bedroom with the back of the chair positioned upright and the legrest positioned straight downward. R62 was observed with her knees bent and feet curled beside her on the seat of the chair

On 12/09/2014, at 1:18 p.m. R62 was observed seated in a Broda w/c in her bedroom with the back of the chair positioned upright and the legrest positioned straight downward. R62's left foot was dangling and right knee was bent with the right foot resting on the upper legrest webbing towards the seat of the chair.

On 12/10/2014 at 8:19 a.m. and 11:00 a.m. R62 was observed seated in a Broda w/c in her bedroom with the back of the chair positioned upright and the legrest positioned straight downward. During the 8:19 a.m. observation R62's feet were observed dangling approximately 10 inches from the floor with no support. During the 11:00 a.m. observation R62's heels were observed to be resting slightly on the webbing of the chair offering minimal support.

On 12/11/2014, at 8:15 a.m. R62 was observed

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2 830	Continued From page 11	2 830		

seated in a Broda w/c in the dining room being assisted by staff with eating breakfast. R62 was positioned with her back slightly reclined and the legrest positioned straight downward with R62's feet dangling approximately 10 inches from the floor.

Review of R62's significant change minimum data set (MDS) dated 11/17/14 indicated R62 was totally dependent on staff with transfer, dressing, toilet use, locomotion on unit, and eating and required extensive assistance with bed mobility and personal hygiene. The MDS further indicated R62 had severe cognitive impairment and received hospice services.

On 12/11/2014, at 11:35 a.m. R62 was observed with the director of nursing (DON), registered nurse (RN)-A and RN-B. R62 was seated in a Broda w/c in her room with the back of the chair reclined slightly and the legrest raised supporting R62's legs/feet. The DON confirmed that this was proper positioning for R62 and also commented that this was the most comfortable R62 had looked in a long time. The DON confirmed that the legrest should by elevated on R62's w/c to support the legs/feet to prevent them from dangling. The DON stated that when R62 is eating in the dining room the w/c is not able to get under/up to the table when the footrest is elevated so during meals the footrest is put down and staff may forget to raise it again once the meal is over. The DON showed surveyor a laminated sheet with instructions of how the w/c should be positioned that was attached to the back of R62's w/c. The laminated sheet included a picture of the w/c when positioned properly and indicated, "Place chair in tilt not just the recline. Tilt is the lower handle. Also, elevate the legs." The picture also included a foot rest which was

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not included on R62's w/c. Below the picture of the w/c indicated, "38 degrees of seat tilt". The DON confirmed that the footrest had been removed from R62's w/c as her feet didn't reach it which would not give any support.

When interviewed on 12/11/2014, at 3:02 p.m. the occupational therapist-registered (OTR) confirmed that R62 should not be positioned sitting upright with her feet dangling. OTR further stated she had observed the resident positioned this way at times and addressed it with nursing staff. OTR stated nursing staff indicated sometimes not having enough help to take the time to reposition the resident. OTR further stated she had provided a diagram to nursing as to how the chair should be positioned which was laminated and hanging on the back of R62's w/c. OTR stated feeling that the footrest should still be attached to the w/c even though the resident's feet don't reach it as a reminder to staff on proper positioning.

R18's peritoneal dialysis exchanges were completed by staff who were not trained by the dialysis provider (Davita).

R18's quarterly Minimum Data Set (MDS) dated 10/16/14, identified diagnoses which included diabetes mellitus type 2, and received specialized treatments including dialysis. R18's current care plan included peritoneal dialysis care related to end stage renal disease. The facility form titled Dialysis Policy and Procedure identified R18 began in house peritoneal dialysis at the facility on 4/15/14.

Review of the dialysis in-service training logs identified the most recent training had been

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completed 7/18/13. The DON stated licensed practical nurse (LPN)-C and RN-C had performed dialysis exchanges for R18 and provided their orientation checklists. LPN-C was oriented to dialysis on 12/4/13, by a facility employee but not from a Davita Dialysis employee. RN-C had not received training from a Davita Dialysis employee, completed orientation on 4/7/14, and had been orientated to dialysis according to the check list, by a facility employee.

During an interview on 12/10/2014, at 1:36 p.m. registered nurse (RN)-A stated dialysis training for licensed staff was completed by the Davita Dialysis company when a new resident came to the facility; however, if a new nurse started, training would be completed by the nurse working that shift.

During and interview on 12/11/2014, at 10:17 a.m. licensed practical nurse (LPN)-A verified an inservice was provided by Davita Dialysis from Moorhead for a previous resident who had the same dialysis cycler (machine used for dialysis treatment), but had not specifically trained staff for R18. LPN-A verified new nurses had been orientated by the current nurse working the shift the dialysis exchange was performed.

During an interview on 12/11/2014, at 1:27 p.m. the director of nursing (DON) verified new staff training for dialysis procedure had been completed during orientation by the nurse on the shift when the exchange was performed. The DON verified she was in charge of the education regarding dialysis, and at this time the hands on training of the dialysis procedure was done with the nurse working the floor that day.

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2 830	Continued From page 14 During a phone interview on 12/12/14, at 3:43 p.m. the primary dialysis nurse stated that Davita staff were expected to train new staff for resident's peritoneal dialysis exchanges. The undated facility policy titled Frazee Care Center Dialysis Policy and Procedure directed staff training to be provided by Davita staff. SUGGESTED METHOD OF CORRECTION: The DON or designee could review any policies, procedures or facility processes for resident dialysis procedures, and wheel chair possitioning and make any necessary revisions to facility paperwork. Appropriate staff could be educated regarding any changes. The DON or designee could develop a system to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility to provide routine personal	2 920		

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2 920	Continued From page 15 grooming for 1 of 3 residents (R87) reviewed for activities of daily living (ADL's) who was dependent on staff for grooming. Findings include: On 12/8/14, at 5:23 p.m. R87 was observed with 2 long hairs approximately 1 centimeter (cm) in length and multiple shorter hairs visible on her chin. R87's chin hair continued to be present and observed all days of the survey. R87 was admitted to the facility on 12/5/14 with diagnoses including right hip fracture, dementia, and glaucoma per the facility face sheet. R87's temporary care plan dated 12/5/14 indicated the resident required assistance of 1-2 staff with showering, assist of one staff with dressing, and set-up assistance with verbal cues with grooming. The care plan further identified a diagnosis of dementia exhibiting forgetfulness and intermittent confusion. On 12/12/2014, at 1:01 p.m. R87 was observed seated in her wheelchair in her room receiving assistance with her television from nursing assistant (NA)-A. R87 continued to have facial hair present on her chin. Surveyor interviewed NA-A who confirmed that R87 had a shower that morning and that NA-A had been the staff who assisted her. NA-A confirmed that residents were usually offered to be shaved on their bath day and acknowledged that R87 had visible facial hair present. NA-A stated she had noticed it that morning when giving R87 the shower and stated, "Guess I just forgot". NA-A then asked R87 if she would like her to shave the facial hair and R87 agreed. When interviewed on 12/12/2014 at 1:14 p.m.	2 920		

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2 920	Continued From page 16 registered nurse (RN)-A stated she would expect residents to be offered shaving on bath day and as needed. RN-A confirmed R87 should have been offered to be shaved when bathed. SUGGESTED METHOD OF CORRECTION: The director of nursing could provide education on the performance of providing activities of daily living and follow up with audits/observation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21095	MN Rule 4658.0650 Subp. 4 Food Supplies; Storage of Nonperishable food Subp. 4. Storage of nonperishable food. Containers of nonperishable food must be stored a minimum of six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or vestibules is prohibited. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21095		

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review the facility failed to ensure sanitary storage of resident food related to frozen meat stored on the floor of the walk-in freezer. This had the potential to effect 63 of 64 residents residing in the facility.

Finding include:

During the initial kitchen tour on 12/8/14 at 1:08 p.m., dietary aid (DA-A) opened the large walk in freezer in the back room of the kitchen area. During the observation it was noted there was two large cardboard boxes sitting on the floor under the metal shelves on the left hand side of the freezer. One of the boxes was opened and contained three and a half rolls of 10 pound packages of ground beef and the other cardboard box sitting next to ground beef was still sealed and contained four 14 pound beef roasts.

On 12/8/14 at 1:08 p.m. during the initial tour DA-A verified the rolls of ground beef and the beef roast were on the floor of the walk in freezer and stated, "It is not to be on the floor."

On 12/8/14 at 1:08 p.m. during the initial tour DA-B verified the rolls of ground beef and the beef roast were on the floor of the walk in freezer and stated, "Nothing is suppose to be on the floor."

On 12/10/14 at 1:21 p.m. dietary manager (DM) confirmed that no meat or any food should be left on the floor of the walk in freezer. The DM stated, "The meat could potentially get contaminated and this is unsanitary."

Review of facility policy titled, Food Storage, dated January 2013, indicated all food items served to residents and clients will be stored

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21095	Continued From page 18 under sanitary conditions, stored six inches above the floor, not exposed to floor moisture and stored properly as soon as they are delivered. SUGGESTED METHOD OF CORRECTION: The dietary director could review and revise food storage policies and procedures. They could provide education to appropriate staff and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21095		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		

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This MN Requirement is not met as evidenced by:
Based on document review and interview the facility failed to provide a tuberculosis symptom screen and a two step TST or chest Xray for 2 of 5 employees in the sample.

Findings include:

Activities aid (AA)-A was hired on 10/18/14. The facility form titled Baseline TB Screening Tool for Healthcare Workers identified a base line screening was completed on 10/15/14 with negative results. A TB skin test was administered on 10/15/14 with results documented accurately on 10/17/14. A second skin test was not administered until 12/9/14, greater than 7 weeks after the first skin test was read.

Nursing assistant (NA)-F was hired on 11/20/14, The employee file lacked evidence a baseline TB symptoms screening was completed. A form titled 7-Day Clinic TB Skin Testing Form identified a TB skin test was administered on 6/10/14, and read as negative on 6/13/14, however; a second TB skin test was not completed.

During an interview on 12/11/14, at 3:00 p.m. the director of nursing (DON) verified AA-A did not have a 2 step TB skin test. The DON stated the policy is to perform a 2 step if it has been over a year since the last testing or if a 2 step had never been done. The DON indicated she was unsure of the reason for the gap between the tests, however: agreed it should not have been longer that 3 weeks between skin tests. The DON

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identified the human resources director was in charge of the TB testing. The DON also verified NA-F's employee file lacked a baseline screen and second step skin test.

During an interview on 12/11/14, at 3:12 p.m. the human resources director (HRD) verified AA-A had a 7 week gap between TB skin tests. The HRD stated she believed the second step skin test was to be completed "two weeks after but with in 60 days." The HRD verified NA-F's employee file contained only a one step skin test with no TB symptom screen or two step skin test. The HRD indicated that she believed the clinic had completed the screening and that the clinic form was for a two step skin test rather than for one skin test given and then read.

The undated facility policy titled Tuberculosis Screening and Testing for Employees, Purpose of Procedure is to aid in the diagnoses of tuberculosis and provide guidelines for TB screening for Frazee Care Center employees and volunteers. Procedure guidelines #1 Frazee Care Center employees will have screening completed prior to the date of hire. #3 The second step should be completed 1 to 3 weeks after the first step.

SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing, could review and revise policies and procedures for TB surveillance. The administrator or director of nursing, could monitor employee TB screening to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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21426	Continued From page 21 (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is	21530		

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the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure the consultant pharmacist reported medication irregularities to the attending physician and the director of nursing for 1 of 5 resident (R71)who's medications were reviewed.

Findings include:

R71 had diagnoses which included dementia with out behavioral disturbance. R71's current medication orders signed 11/18/14, identified Seroquel (antipsychotic medication) 25 mg (milligrams) at bedtime for Psychosis with a start date of 10/13/14.

The quarterly MDS (Minimum Data Set) dated 9/22/14, identified R71 had a diagnosis of dementia, a brief mini mental status (BIMS) identified severe cognitive impairment, and had behaviors not directed towards others 1 to 3 days during the assessment period.

The facility form titled Pharmacist's Drug Regimen Review indicated the consulting pharmacist reviewed R71's medications on 10/30/14, 17 days after the start date of the Seroquel and then again on 11/24/14, without identifying the lack of monitoring, target behaviors, or identified interventions for the Seroquel use.

During an interview on 12/12/2014, at 1:40 p.m. registered nurse (RN)-A verified R71's record

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21530	Continued From page 23 lacked behavior monitoring including identification of target behaviors and non- pharmacological interventions. RN-A stated "we normally would have a behavior monitoring log for someone on seroquel". During an interview on 12/12/2014, at 12:38 p.m. the director of nursing (DON) confirmed no documentation was found regarding target behaviors and identified non- pharmacological interventions. The DON stated the consulting pharmacist reviewed resident medications for possible reductions and stated "we look at pharmacy recommendations for (medication) reductions" and would use behavior documentation to review the behaviors. During an interview on 12/12/14, at 3:31 p.m. the consulting pharmacist verified the expectation that R71 would have behavior monitoring of target behaviors when receiving Seroquel. The consulting pharmacist indicated being unaware these were not in place. The requested facility policy was not provided. SUGGESTED METHOD OF CORRECTION: The administrator, DON and Consulting Pharmacist could review and revise policies and procedures for assuring medications had indications for use, parameters and proper monitoring of medication usage. Staff could be educated as necessary. The DON or designee could monitor medications on a regular basis to ensure compliance with state and federal regulations.	21530		

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21530	Continued From page 24 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist reported medication irregularities to the attending physician and the director of nursing for 1 of 5 resident (R71)who's medications were reviewed. Findings include:	21540		

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(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) COMPLETE DATE
21540	Continued From page 25 R71 had diagnoses which included dementia with out behavioral disturbance. R71's current medication orders signed 11/18/14, identified Seroquel (antipsychotic medication) 25 mg (milligrams) at bedtime for Psychosis with a start date of 10/13/14. The quarterly MDS (Minimum Data Set) dated 9/22/14, identified R71 had a diagnosis of dementia, a brief mini mental status (BIMS) identified severe cognitive impairment, and had behaviors not directed towards others 1 to 3 days during the assessment period. The facility form titled Pharmacist's Drug Regimen Review indicated the consulting pharmacist reviewed R71's medications on 10/30/14, 17 days after the start date of the Seroquel and then again on 11/24/14, without identifying the lack of monitoring, target behaviors, or identified interventions for the Seroquel use. During an interview on 12/12/2014, at 1:40 p.m. registered nurse (RN)-A verified R71's record lacked behavior monitoring including identification of target behaviors and non- pharmacological interventions. RN-A stated "we normally would have a behavior monitoring log for someone on seroquel". During an interview on 12/12/2014, at 12:38 p.m. the director of nursing (DON) confirmed no documentation was found regarding target behaviors and identified non- pharmacological interventions. The DON stated the consulting pharmacist reviewed resident medications for possible reductions and stated "we look at	21540		

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21540	Continued From page 26 pharmacy recommendations for (medication) reductions" and would use behavior documentation to review the behaviors. During an interview on 12/12/14, at 3:31 p.m. the consulting pharmacist verified the expectation that R71 would have behavior monitoring of target behaviors when receiving Seroquel. The consulting pharmacist indicated being unaware these were not in place. The requested facility policy was not provided. Suggested Method of Correction: The DON or desigee could work with the medical director and consultant pharmacist to ensure medications were reviewed for unnecessary medications, appropriate interventions and monitoring was in place, and then could educate staff on appropriate documentation of behaviors and interventions. The DON or designee could also perform audits of resident records to determine if adequate monitoring and documentation was in place. Time Period for Correction: Twenty one (21) days.	21540		
21710	MN Rule 4658.1415 Subp. 7 Plant Housekeeping, Operation, & Maintenance Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to 115 degrees Fahrenheit at the fixtures.	21710		

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21710	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an environment that was free of accident hazards, related to hot water temperatures in 11 of 11 resident bathrooms (R14, R61, R33, R67, R29, R78, R53, R69, R52, R18, and R68) tested for safe water temperatures. Finding include: During the environmental tour on 12/8/14 at 5:30 p.m. the administrator checked the water temperatures with the facility thermometer. The following water temperatures were observed: -R18's resident bathroom was 121 degrees (F) -R33's resident bathroom was 118 degrees (F) -R67's resident bathroom was 118 degrees (F) -R61's resident bathroom was 117.6 degrees (F) -R14's resident bathroom was 117.6 degrees (F) -R68's resident bathroom was 117.7 degrees (F) -R69's resident bathroom was 117.7 degrees (F) -R52's resident bathroom was 117.7 degrees (F) During the environmental tour on 12/8/14 at 7:04 p.m. the maintenance supervisor (MS)checked the water temperatures with the facility thermometer. the following water temperatures were observed: -R53's resident bathroom was 119 degrees (F) -R29's resident bathroom was 119 degrees (F) -R78's resident bathroom was 116.5 degrees (F) During interview on 12/8/14 at 6:57 p.m. MS confirmed the water temperature were above the acceptable temperature of 115 degrees F and expected them to be under 115 F. he indicated they have two different hot water systems in the	21710		

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building and these rooms are located in the new section of the building and stated, "I have not had any complaints of anyone being burnt." MS also verified he checks the water temperature weekly on a rotation schedule and usually in the morning while residents are eating breakfast.

Review of the facility's monthly water temperature audits, revealed that the audits were completed for the last 4 months, with the last audit completed on 12/2/14.

Review of the facility policy titled, Facility Practices revised on 2008, indicated plant operations supervisor is responsible for facility water temperature monitoring system and water temperatures at various times and locations.

SUGGESTED METHOD FOR CORRECTION: The Environmental Director, Director of Nursing and/or designee could monitor and develop a system to review water temperatures at the resident level on a weekly basis to ensure they are between 105 and 115 degrees Fahrenheit.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

21885 MN St. Statute 144.651 Subd. 21 Patients & Residents Of HC Fac.Bill of Rights — 21885

Subd. 21. Communication privacy. Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated

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and documented by the physician in the medical record. (Only portions indicated of this subdivision are subject to assessment.)

This MN Requirement is not met as evidenced by:
Based on interview and document review the facility failed to ensure that residents received their personal mail on Saturdays. This deficient practice had the potential to affect all 64 residents in the facility.

Findings include:

During interview on 12/11/14, at 9:42 a.m. the resident council representative (R1) reported that the facility does not deliver mail to residents on Saturdays.

During interview on 12/11/4, at 9:50 a.m. the activity director (AD) confirmed that the facility does not deliver mail to residents on Saturday, even though the postal service delivers the mail to the facility on Saturday. The AD reported the activity staff pick up the mail from the front office on Monday and delivers the mail to the residents. The AD confirmed the mail is not delivered to the residents within 24 hrs of the postal service delivering the mail on Saturday.

During interview on 12/11/14, at 10:05 a.m. the administrator reported the front office receives the mail, and then the activity department staff deliver the mail to the residents. The administrator was not certain if the mail was delivered to the residents on Saturdays.

During interview on 12/11/14, at 10:06 a.m. the

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front receptionist confirmed the postal service does deliver resident mail to the facility on Saturdays and the mail is kept in the office until Monday morning then the activity department staff picks up the mail and delivers it to the residents.

The undated mail distribution policy, indicated staff are expected to deliver the mail to residents within 24 hours.

Suggested Method of Correction: The Administrator could educate the business office staff on resident rights related to mail. The quality assurance committee could audit mail delivery to ensure compliance.

Time Period for Correction: Twenty one (21)days.

21995 MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults (21995)

Subd. 4a. Internal reporting of maltreatment.
(a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to report an incident of potential abuse/neglect immediately to the State agency

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(SA) for 1 of 3 residents (R77) reviewed for potential abuse/neglect.

Findings include:

R77 was admitted to the facility on 5/2/14 with diagnoses including: dementia, depression, and anxiety per the facility face sheet. The quarterly minimum data set (MDS) assessment dated 11/5/14 indicated R77 required extensive assistance with bed mobility, transfer, walk in room, dressing, eating, toilet use, and personal hygiene. The brief interview for mental status (BIMS) scored 99 indicating R77 was unable to complete the assessment. The staff assessment for cognition indicated R77 had long and short term memory problems and severe impairment related to cognitive skills for daily decision making.

Review of the facility's incident reports revealed an incident dated 7/27/14 at 2:55 p.m. involving R77. The incident description indicated: "I found resident sitting on floor right outside her doorway..." The physical assessment findings indicated: "No scrapes or bruising, but resident unable to bear weight without pain." The report further indicated there were no witnesses to the incident. Review of the nurses notes revealed an entry dated 7/27/14 at 10:45 p.m. indicating: "Found resident sitting outside of doorway @ (at) 2.55 p.m. No witnesses to what happened. When asked, resident stated "I fell"." The note further indicated the resident had increased right hip pain and was unable to bear weight on right side without pain. The nurse practitioner was notified and order received to transfer R77 to the emergency room (ER) for further evaluation. The resident was subsequently admitted to the to the hospital with diagnosis of left hip fracture.

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When interviewed on 12/11/2014, at 10:02 a.m. the director of nursing (DON) confirmed R77's fall resulting in a fracture had not been reported to the SA. The DON stated the staff were following the care plan and would have to check the record to see the circumstances of the fall as to whether it was witnessed or not.

When interviewed at 12/11/2014, at 5:08 p.m. the DON confirmed that R77's fall had not been witnessed by staff. The DON stated that though the resident had severe cognitive impairment she was able to state she had fallen when asked though was unable to report the circumstances surrounding the fall.

The facility's policy titled, Abuse Prevention/Resident Treatment, revised November 2011, included: "It is the policy of this facility to take appropriate steps to prevent the occurrence of:
Abuse
Neglect
Misappropriation of resident property
It is also the policy of this facility to take appropriate steps to ensure that all alleged violations of federal or state laws which involove mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property ("alleged violations") are reported immediately to the administrator of the facility. Such violations are also reported immediately to state agencies in accordance with existing state law. The facility investigates such alleged violation thoroughly and reports the results of all investigations to the administrator, as well as to state agancies as required by state and federal law."

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21995	Continued From page 33 SUGGESTED METHOD FOR CORRECTION: The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. The administrator, DON, social services or designee(s) could provide training for all appropriate staff on these policies and procedures. The administrator, DON, social services or designee(s) could monitor to assure all reports of abuse are being reported and investigated. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21995		