DEPARTMENT OF H						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL FE SURVEY AGENCY	ID: SQMJ Facility ID: 00730
1. MEDICARE/MEDICAID I		3. NAME AND AI			IE SURVEI AGENCI	4. TYPE OF ACTION: 7 (L8)
(L1) <b>245299</b>	FROVIDER NO.	(L3) FRAZEE C.				
2.STATE VENDOR OR MED	DICAID NO.	(L4) 219 WEST	MAPLE AVEN	UE, PO B	OX 96	1. Initial2. Recertification3. Termination4. CHOW
(L2) <b>972153000</b>		(L5) FRAZEE, N	1N		(L6) <b>56544</b>	5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHAN	NGE OF OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEG	GORY	<u>02</u> (L7)	
(L9) 11/01/2004		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY	01/30/2015 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
<ol> <li>ACCREDITATION STATU 0 Unaccredited</li> </ol>	US:(L10) 1 TJC	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/III 12 RHC	D 15 ASC 16 HOSPICE	09/30
	3 Other	04 5141	00 01 1/51	12 KIIC	IT HOST ICE	
11. LTC PERIOD OF CERTIF	FICATION	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		X A. In Complia				The Following Requirements:
To (b) :			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12. Total Facility Beds	74 (L18)		cceptable POC		4. 7-Day RN (Rural SN	
					5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	<b>74</b> (L17)	B. Not in Con Requirem	npliance with Prog ents and/or Appli	gram ied Waivers:	* Code: A	(L12)
14. LTC CERTIFIED BED BE	REAKDOWN				15. FACILITY MEETS	
18 SNF 18/	/19 SNF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
	74					
(L37) (	(L38) (L39)	(L42)	(L43)			
16. STATE SURVEY AGEN	CY REMARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):		
17. SURVEYOR SIGNATUR	RE	Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Gail Anderson	Unit Supervisor	(	02/12/2015		mail meath	, Enforcement Specialist 02/17/2015
Guil I macroon,				(L19)		(L20)
	PART II - TO BE	COMPLETED	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF H	ELIGIBILITY		IPLIANCE WITI HTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
<b>X</b> 1. Facility is Eli	igible to Participate	KIOI	IIISACI.		3. Both of the Above	· · · · · · · · · · · · · · · · · · ·
2. Facility is no	ot Eligible (L21)					
	()					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	<u>VOLUNTARY</u> <u>00</u>	
11/01/1985					01-Merger, Closure 02-Dissatisfaction W/ Reimburse	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		03-Risk of Involuntary Terminatio	m
25. LTC EXTENSION DAT		IVE SANCTIONS n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
		n of / Kunissions.	(L44)			00-Active
(	L27) B. Rescind S	uspension Date:				
			(L45)			
28. TERMINATION DATE:	29	9. INTERMEDIARY	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1	530 24	2. DETERMINATION		DATE		
51. NO RECEIF I OF CMIS-1.		02/03/2015	, OF AFT KUVAL	DAIL		
	(L32)	52, 00, 2010		(L33)	DETERMINATION APPI	ROVAL



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

Minnesota Department of Health • Compliance Monitoring General Information: 651-201-5000 • Toll-free: 888-345-0823 http://www.health.state.mn.us An equal opportunity employer Reduction Project (0938-0390), Washington, D.C. 20503.

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245299	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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	(Y4)	Item		(Y5)	Date	(Y4)	ltem		Y5)	Date
			Correction					Correction					Correction
ID Prefix	50460		Completed 01/15/2015			50470		Completed 01/15/2015		ID Prefix	50005		Completed 01/15/2015
			01/15/2015		ID Prefix			01/15/2015					
Reg. # LSC	483.10(c)(6)				Reg. # LSC	483.10(i)(1)				Reg. # LSC	483.13(c)(1)(ii)-(	iii), (c)(2)	- (4)
					200					200			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0226		01/15/2015		ID Prefix	F0241		01/15/2015		ID Prefix	F0279		01/15/2015
Reg. #	483.13(c)					483.15(a)				-	483.20(d), 483.2	0(k)(1)	_
LSC					LSC					LSC			_
			<b>o</b> "					<b>a</b> "					<b>.</b>
			Correction Completed					Correction Completed					Correction Completed
ID Prefix	F0309		01/15/2015		ID Prefix	F0312		01/15/2015		ID Prefix	F0329		01/15/2015
Reg. #	483.25		-		Reg. #	483.25(a)(3)		-		Reg. #	483.25(I)		
LSC					LSC					LSC			_
									+-				
			Correction					Correction					Correction
ID Drofiv	E0224		Completed 01/15/2015			E0274		Completed 01/15/2015		ID Drofiv	50429		Completed 01/15/2015
ID Prefix			01/15/2015		ID Prefix			01/15/2015		ID Prefix			01/15/2015
Reg. # LSC	483.25(n)				Reg. # LSC	483.35(i)				Reg. # LSC	483.60(c)		_
					100					200			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			-		ID Prefix					ID Prefix			_
Reg. #			-		Reg. #					Reg. #			
LSC					LSC					LSC			_
Reviewed By	1	Reviewed I	Ву	Dat	e:	Signature o	f Surve	vor:				Date:	
State Agenc	/	GA/mr	n	02/	11/201	-		034					0/2015
Reviewed By	/	Reviewed I		Dat	e:	Signature of	f Surve	yor:				Date:	
CMS RO													
Followup to	Survey Comp	leted on:		Check for any Uncorrected Deficiencies. Was a Summary of					a Summary of				
12/12/2014						Unce	orrecte	d Deficiencies	(CMS	-2567) Sent	to the Facility?	YES	NO

DEPARTMENT OF HEALTH			-	~		DICARE & MEDICAID SERVICES			
					AND TRANSMITTAL	ID: SQMJ			
					TE SURVEY AGENCY	Facility ID: 00730			
1. MEDICARE/MEDICAID PROVIDER (L1) 245299	NO.	3. NAME AND AI (L3) FRAZEE CA				4. TYPE OF ACTION: $\underline{2}(L8)$			
2.STATE VENDOR OR MEDICAID NO.		(L4) 219 WEST N	MAPLE AVEN	IUE, PO B	OX 96	1. Initial2. Recertification3. Termination4. CHOW			
(L2) <b>972153000</b>		(L5) FRAZEE, M	1N		(L6) <b>56544</b>	5. Validation 6. Complaint			
5. EFFECTIVE DATE CHANGE OF OW	NERSHIP	7. PROVIDER/SU	JPPLIER CATEC	GORY	<u>02</u> (L7)	7. On-Site Visit 9. Other			
(L9) <b>11/01/2004</b>		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint			
6. DATE OF SURVEY 12/12/20	<b>)14</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III		09/30			
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	03/30			
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:					
From (a):		A. In Complia	ince With		And/Or Approved Waivers Of	The Following Requirements:			
To (b) :			equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit			
12. Total Facility Beds	74 (L18)	*	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	<ul> <li>7. Medical Director</li> <li>IF)8. Patient Room Size</li> </ul>			
			-		5. Life Safety Code	9. Beds/Room			
13.Total Certified Beds	<b>74</b> (L17)	X B. Not in Con Requirement	npliance with Pro- ents and/or Appli		* Code: <b>B</b> *	(L12)			
14. LTC CERTIFIED BED BREAKDOW	Ň				15. FACILITY MEETS				
18 SNF 18/19 SNF 74	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)			
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:			
Denise Erickson, HFE	NEII	0	01/21/2015	(L19)	Mark Meeth, Enforcement Specialist 01/30/2015 (L20)				
PART	II - TO BE	COMPLETED I	BY HCFA RI	EGIONA	L OFFICE OR SINGLE S	TATE AGENCY			
19. DETERMINATION OF ELIGIBILITY	Y		IPLIANCE WIT	H CIVIL		ncial Solvency (HCFA-2572)			
1. Facility is Eligible to Part	icipate	RIGE	HTS ACT:		<ol> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	ol Interest Disclosure Stmt (HCFA-1513)			
2. Facility is not Eligible	(L21)								
	~ /								
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	()			
OF PARTICIPATION 11/01/1985	BEGINNING	G DATE	ENDING DA	TE	<u>VOLUNTARY</u> <u>00</u>				
	(7.41)		(1.05)		01-Merger, Closure 02-Dissatisfaction W/ Reimburse	05-Fail to Meet Health/Safety ement 06-Fail to Meet Agreement			
(L24) 25. LTC EXTENSION DATE: 2	(L41)	VE SANCTIONS	(L25)		03-Risk of Involuntary Terminatio	m			
25. LIC EXTENSION DATE: 2		n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change			
			(L44)			00-Active			
(L27)	B. Rescind St	uspension Date:							
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/	/CARRIER NO.		30. REMARKS				
		03001							
	(L28)			(L31)	Posted 02/03/2015 0	Co.			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAL	DATE					
	(L32)			(L33)	DETERMINATION APPI	ROVAL			



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:

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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.

### Frazee Care Center December 30, 2014 Page 4 **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 Frazee Care Center December 30, 2014 Page 5

> 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

Mr. 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

		AND HUMAN SERVICES			FORM	03/05/2015 APPROVED
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CONSTRUCTION		0. 0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD			
		245299	B. WING	3		
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	12	/12/2014
FRAZEI	E CARE CENTER		1	219 WEST MAPLE AVENUE, PO BOX 96		
				FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFID TAG		LD BE	(X5) COMPLETION DATE
F 000		S	FO	000		
	as your allegation o Department's accept	f compliance upon the ptance. Your signature at the age of the CMS-2567 form will				
	revisit of your facility validate that substa	acceptable POC an on-site / may be conducted to ntial compliance with the n attained in accordance with				
	,					
				GA 1/21/15		
F 160 SS=B	FUNDS UPON DEA		F 16	60 Policies and procedures were reviewed regarding resident	1	
	deposited with the fa within 30 days the re	resident with a personal fund cility, the facility must convey sident's funds, and a final		receiving personal funds within 30 days of death.		
	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN/	ATURE	Executive Director		X6) DATE
			_	-recurive prector		

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

PRINTED: 03/05/2015

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY
					G		
	PROVIDER OR SUPPLIER	245299	B. WING			12/	12/2014
					STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96		
FRAZEE					FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETIC DATE
F 160	Continued From pa		   F1	160	SSD has been educated on the policy and procedure and	4	
		funds, to the individual or administering the resident's			timely disbursement of	4	
	estate.	auministering the resident's			personal funds, and will		
					coordinate with the Business		
	This REQUIREMEN	IT is not met as evidenced	1		Office Manager and	,	
	by: Report on interview	and decomposition de s			Administrator to ensure that		
		and document review, the ire personal funds were			all residents that have		
	conveyed within the	appropriate time frame for 4			passed away, will have timely	,	
	DR4)accounts revie	dents (DR1, DR2, DR3, and wed.			30 day refunds.	, 	
	Findings include:				DR1, DR2, DR3 and DR4's		
	<b>Trust Account Balan</b>	014. Review of the Resident ce report printed on 12/11/14, 26.67 currently in the			funds were all dispersed and paid out.		
	account, 241 days a				Administrator to audit all d/c		
	DB2 expired on 9/12	2/14. Review of the Resident			residents to assure		
	<b>Trust Account Balan</b>	ce report printed on 12/11/14.			reimbursements have been		
	revealed DH2 had \$ account, 90 days aft	197.20 currently in the er DR2 expired.			made after discharge.		
		7/14. Review of the Resident			QAA will review and monitor		
		ce report printed on 12/11/14, 21.29 currently in the			for compliance for 3		
	account, 65 days aft				months		
		/14. Review of the Resident			Responsible parties:		
		ce report printed on 12/11/14, 1170.88 currently in the			Administrator, Social Services		
	account, 32 days aft				Director, and Business Office		
		on 12/11/14, at 2:15 p.m. the			Manager.		
		cated she was the accounts The secretary stated that			Date of completion: 1-15-		
	trust account funds v	vere held until the end of the			2015		

Facility ID: 00730

If continuation sheet Page 2 of 34

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:	03/05/2015
FORM	APPROVED
OMB NO.	0938-0391

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION		(X3) DAT	TE SURVEY
		245299	B. WING	ž		12	/12/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 219 WEST MAPLE AVENUE, F FRAZEE, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD I	BE	(X5) COMPLETION DATE
	month after a resider care and drug store fund account balance resident families if the the resident was not would be sent to the be returned to the co The secretary states (SSD) sent the notice resident passed aw During an interview of the SSD verified the remaining greater the had expired. The SS protocol for resident when a resident expl a letter was sent to re deaths would be sent SSD verified DR1's t continued to be in a to 241 days after the re have been sent to DI the power of attorney would be sent to the The SSD identified a communication and f fund accounts. During an interview of SSD clarified an emain after a resident death the county do what the affidavit is sent to us. DR3, and DR4, had to with the facility that has in the 30 day time frai	ent death to be sure all hair bills had been paid. Trust bills had been paid. Trust be resident was private pay. If t private pay, an affidavit o county and the funds would bunty or to the funeral home. d social services designee tes to the county when the ay. on 12/11/2014, at 2:23 p.m. accounts with balances an 30 days after the resident D identified the usual funds had been as follows; ired Monday through Friday, notify the county, weekend t the following week. The rust account balance facility account since April, sident expired, and should R1's family member who was 7. The 3 other accounts county or funeral homes.	F 1	160			

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

Facility ID: 00730

If continuation sheet Page 3 of 34

		& MEDICAID SERVICES			<u>OMB NC</u>	D. 0938-0391
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	TE SURVEY
		245299	B. WING	i	12	2/12/2014
				STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 9 FRAZEE, MN 56544	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
SS=C	residents trust acco "send a second e-m During and interview the director of nursi was responsible for accounts following r verified she was aw conveyed within a c however, was unaw The DON indicated trust fund accounts frame. The facility policy tit Accounts, dated rev Procedure #6 Upon Dispersal of said fur days of the resident 483.10(i)(1) RIGHT SEND/RECEIVE UN The resident has the communications, inc promptly receive ma This REQUIREMEN by: Based on interview facility failed to ensu their personal mail o practice had the pote in the facility. Findings include:	unts, and stated, we do not nail." v on 12/12/14, at 4:30 p.m. ng (DON) verified the SSD conveyance of trust fund esident expiration. The DON are accounts were to be ertain amount of time; vare of the exact time frame. the SSD was in charge of the and would know the time ed Resident Personal ision 8/2005, identified in the death of a resident nds will be made within 30 s death. TO PRIVACY - IOPENED MAIL e right to privacy in written buding the right to send and	F 1			1/15/15

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

Facility ID: 00730

If continuation sheet Page 4 of 34

PRINTED: 12/30/2014 FORM APPROVED OMB NO. 0938-0391

ATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245299	B. WING				12/12/201 11/2014	
AME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
RAZEE C	ARE CENTER				WEST MAPLE AVENUE, PO BOX 96 AZEE, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	3	F	000				
	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.				Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softwa Tag numbers have been assigned to Minnesota state statutes/rules for Nurs Homes.	sing		
					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. TH WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION F	IS		
					VIOLATIONS OF MINNESOTA STATE			
F 160 SS=B	FUNDS UPON DEA		F	160	STATUTES/RULES.			
	deposited with the fa	resident with a personal fund acility, the facility must convey esident's funds, and a final						
BORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATURE	E	1	Executive Director		(X6) DATE	
her safegua lowing the o lowing ogram partic	rds provide sufficient protec date of survey whether or n g the date these documents	tion to the patients. (See instructions.) Ex ot a plan of correction is provided. For nurs are made available to the facility. If deficie	cept for nurs sing homes, t encies are cit	sing hor the abc ted, an	excused from correcting providing it is determined mes, the findings stated above are disclosable 90 ove findings and plans of correction are disclosable approved plan of correction is requisite to continu ility ID: 00730		IVED eet Page 1 of 3- <b>2015</b>	
					U V MI	N Dept c Fergus	of Health Falls	

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					110. 0930-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONST		í íco	ATE SURVEY OMPLETED
		245299	B. WING _				2/12/14 12/11/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREETA	DDRESS, CITY, STATE, ZIP CODE		
				219 WES	T MAPLE AVENUE, PO BOX 96		
FRAZEE C	CARE CENTER			FRAZEE	, MN 56544		
(24) 10	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRE	CTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	COMPLETION DATE
F 160	Continued From page	ə 1	E.	160			
1 100							
		unds, to the individual or dministering the resident's					
	estate.	diministering the resident's					
	estate.						
	This REQUIREMENT	Γ is not met as evidenced					
	by:						
		and document review, the					
		e personal funds were					
		appropriate time frame for 4					
	DR4)accounts review	lents (DR1, DR2, DR3, and					
	DR4)accounts review	wed.					
	Findings include:						
1	DR1 expired 4/15/ 20	014. Review of the Resident					
		ce report printed on 12/11/14,					
	revealed DR1 had \$2						
	account, 241 days at	fter DR1 expired.					
	DR2 expired on 9/12	/14. Review of the Resident					
		ce report printed on 12/11/14,					
		197.20 currently in the					
	account, 90 days afte	er DR2 expired.					
	DR3 expired on 10/7	7/14. Review of the Resident					
	Trust Account Balan	ce report printed on 12/11/14,					
	revealed DR3 had \$2	21.29 currently in the					
	account, 65 days afte	er DR3 expired.					
	DR4 expired on 11/0	/14. Review of the Resident					
		ce report printed on 12/11/14,					
	revealed DR4 had \$	1170.88 currently in the					
	account, 32 days after	er DR4 expired.					
		·					
		on 12/11/14, at 2:15 p.m. the					
	facility secretary indi	cated she was the accounts					
		The secretary stated that					
1	trust account funds v	were held until the end of the					
FORM CMS-25	67(02-99) Previous Versions Ob	solete Event ID:SC	QMJ11	Facility ID:	00730	If continuation	n sheet Page 2 of 34

STATEMENT OF DEFICIENCIES (X1) PROVIDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245299	B. WING			12/12	2/14 / <b>11/2014</b>
	ROVIDER OR SUPPLIER	I	<b>I</b>	219	EET ADDRESS, CITY, STATE, ZIP CODE WEST MAPLE AVENUE, PO BOX 96 SZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 160	month after a resider care and drug store b fund account balance resident families if the the resident may not would be sent to the be returned to the co The secretary stated (SSD) sent the notice resident passed awa During an interview of the SSD verified the remaining greater tha had expired. The SS protocol for resident when a resident expiral a letter was sent to no deaths would be sen SSD verified DR1's t continued to be in a 241 days after the re have been sent to D0 the power of attorney would be sent to the The SSD identified a communication and fund accounts. During an interview of SSD clarified an ema after a resident deatt the county do what t affidavit is sent to us DR3, and DR4, had with the facility that f in the 30 day time fra	At death to be sure all hair bills had been paid. Trust as were returned to the e resident was private pay. If private pay, an affidavit county and the funds would unty or to the funeral home. social services designee as to the county when the ay. an 12/11/2014, at 2:23 p.m. accounts with balances an 30 days after the resident D identified the usual funds had been as follows; red Monday through Friday, otify the county, weekend t the following week. The rust account balance facility account since April, sident expired, and should R1's family member who was y. The 3 other accounts county or funeral homes.	F	160			

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

Facility ID: 00730

If continuation sheet Page 3 of 34

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SU COMPLET	
		245299	B. WING		12/11/	/2014
				STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 160	"send a second e-ma During and interview the director of nursin was responsible for of accounts following re- verified she was awa conveyed within a ce- however, was unaw The DON indicated t trust fund accounts a frame. The facility policy title Accounts, dated revi Procedure #6 Upon Dispersal of said fun days of the resident <sup>th</sup>	nts, and stated, we do not iil." on 12/12/14, at 4:30 p.m. g (DON) verified the SSD conveyance of trust fund esident expiration. The DON ire accounts were to be ortain amount of time; are of the exact time frame. the SSD was in charge of the ind would know the time ed Resident Personal sion 8/2005, identified in the death of a resident ds will be made within 30 is death.	F 16	Preparation, submission an implementation of this Pla Correction do not constitu admission of or agreement and conclusions set forth o report. Our Plan of Corre prepared and executed as continuously improve the o and to comply with all app and federal regulatory req	n of te an with the facts n the survey ction is a means to quality of care licable state	
F 170 SS=C	SEND/RECEIVE UN The resident has the communications, inc promptly receive ma This REQUIREMEN by: Based on interview facility failed to ensu their personal mail of	OPENED MAIL right to privacy in written Juding the right to send and	F 17	<ul> <li>Policies and procedures reviewed regarding the distribution policy, incl right of residents to hav delivered on Saturday's</li> <li>Activity Staff has been the policy and procedur distribution on 1/8/15. I included ensuring resid mail on Saturdays. The will coordinate, and dis Saturday mail.</li> </ul>	mail uding the ve their mail s. educated on re of mail Education ent's receive activity staff	

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

Facility ID: 00730

PRINTED: 12/30/2014 FORM APPROVED OMB NO. 0938-0391

			A, BUILDING	<u>,</u>	COM	LETED
		245299	B. WING		12/12 12/	2/14 11/2014
	OVIDER OR SUPPLIER	<b>.</b>		STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	the facility does not d Saturdays. During interview on 1 activity director (AD) does not deliver mail even though the post to the facility on Satu activity staff pick up t on Monday and deliv The AD confirmed the residents within 24 h delivering the mail or During interview on 1 administrator reporte the mail, and then the deliver the mail to the administrator was not delivered to the resident Saturdays and the me Monday morning the staff picks up the mai residents. The undated mail dis staff are expected to within 24 hours. 483.13(c)(1)(ii)-(iii), ( INVESTIGATE/REP	esentative (R1) reported that eliver mail to residents on 2/11/4, at 9:50 a.m. the confirmed that the facility to residents on Saturday, al service delivers the mail rday. The AD reported the he mail from the front office ers the mail to the residents. e mail is not delivered to the rs of the postal service in Saturday. 2/11/14, at 10:05 a.m. the d the front office receives e activity department staff e residents. The t certain if the mail was lents on Saturdays. 12/11/14, at 10:06 a.m. the firmed the postal service t mail to the facility on nail is kept in the office until n the activity department il and delivers it to the stribution policy, indicated deliver the mail to residents c)(2) - (4) ORT	F 17		adits for 6 idents are Saturday. reported at sident ther review 5/15	
0-0	ALLEGATIONS/IND			reviewed regarding repo injury of unknown source	orting an	

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	) <u>. 0938-039</u>
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
						12/1	2/14
		245299	B, WING			12/	11/2014
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE C	ARE CENTER				I9 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
				<u> </u>	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
F 225	mistreating residents had a finding enterer registry concerning a of residents or misar and report any know court of law against indicate unfitness fo other facility staff to or licensing authoriti The facility must ens involving mistreatme including injuries of misappropriation of immediately to the a to other officials in a through established State survey and ce The facility must hav violations are thorou prevent further pote investigation is in pr The results of all inv to the administrator representative and with State law (inclu certification agency) incident, and if the a	abusing, neglecting, or s by a court of law; or have d into the State nurse aide abuse, neglect, mistreatment opropriation of their property; rledge it has of actions by a an employee, which would r service as a nurse aide or the State nurse aide registry es. sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported idministrator of the facility and ccordance with State law procedures (including to the rtification agency). we evidence that all alleged ughly investigated, and must ntial abuse while the ogress.	F	225	<ul> <li>immediate reporting to the C Entry Point (CEP)/ State Age (SA).</li> <li>IDT team has been educated facility policy on VA 1/9/15. Education included facility Vulnerable Adult (VA) polici investigating events and repore events to the Administrator immediately.</li> <li>Any reported cases will be re daily during IDT meetings to proper reporting and investig has taken place and proper interventions are in place. A events will be kept for tracki Administrator / designee will complete Random audits x 6 of tracking logs to assure res will be reported at the QA m for further review and recommendations.</li> <li>Date of completion: 1/15/15</li> </ul>	on the y, orting eviewed assure ation log of ng. l weeks ults eetings	
	by: Based on interview	IT is not met as evidenced and document review, the ort an incident of potential					

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

#### PRINTED: 12/30/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		ATE SURVEY OMPLETED
		245299	B. WING _		12	2/12/14 12/11/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DDE	
				219 WEST MAPLE AVENUE, PO BOX	96	
FRAZEE	ARE CENTER			FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 225	abuse/neglect immed (SA) for 1 of 3 resider potential abuse/negle Findings include: R77 was admitted to diagnoses including: anxiety per the facility minimum data set (M 11/5/14 indicated R77 assistance with bed r room, dressing, eatin hygiene. The brief in (BIMS) scored 99 ind complete the assess for cognition indicate term memory probler related to cognitive s making. Review of the facility an incident dated 7/2 R77. The incident date resident sitting on flo doorway" The phy indicated: "No scrape	liately to the State agency hts (R77) reviewed for hts (R77) reviewed for hts (R77) reviewed for http://www.encodesidesidesidesidesidesidesidesidesidesi	F	225		
	further indicated ther incident. Review of t entry dated 7/27/14 a "Found resident sittir 2.55 p.m. No witnes When asked, resider further indicated the hip pain and was una side without pain. The notified and order resident	e were no witnesses to the the nurses notes revealed an at 10:45 p.m. indicating: ng outside of doorway @ (at) ses to what happened. nt stated "I fell"." The note resident had increased right able to bear weight on right he nurse practitioner was ceived to transfer R77 to the				
EORM CMS-25		R) for further evaluation. The esolete Event ID: SQM	/J11	Facility ID: 00730	If continuation	n sheet Page 7 of 34

PRINTED: 12/30/2014 FORM APPROVED

		ID HUMAN SERVICES				FORM	APPROVED	
		MEDICAID SERVICES	<u> </u>			OMB NO. 0938-039 (X3) DATE SURVEY		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					LETED	
		245299	B. WING			12/11/2014		
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				2	19 WEST MAPLE AVENUE, PO BOX 96			
FRAZEE	CARE CENTER			F	RAZEE, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 225	resident was subseque hospital with diagnos When interviewed on the director of nursing resulting in a fracture the SA. The DON st the care plan and wo to see the circumstar it was witnessed or n When interviewed at DON confirmed that witnessed by staff. T the resident had seve was able to state she though was unable to surrounding the fall. The facility's policy ti Prevention/Resident November 2011, incl facility to take approp occurrence of: Abuse Neglect Misappropriation of r It is also the policy of appropriate steps to violations of federal of mistreatment, negleo source, and misappr ("alleged violations") the administrator of the are also reported imi- accordance with exis- investigates such all reports the results of	<ul> <li>uently admitted to the to the is of left hip fracture.</li> <li>12/11/2014, at 10:02 a.m.</li> <li>g (DON) confirmed R77's fall had not been reported to the staff were following uid have to check the record notes of the fall as to whether ot.</li> <li>12/11/2014, at 5:08 p.m. the R77's fall had not been The DON stated that though are cognitive impairment she is had fallen when asked to report the circumstances</li> <li>tled, Abuse Treatment, revised uded: "It is the policy of this priate steps to prevent the</li> </ul>	F2	225				

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

Event ID: SQMJ11

Facility ID: 00730

If continuation sheet Page 8 of 34

PHERK       Pherk <th< th=""><th>CENTER</th><th>S FOR MEDICARE &amp;</th><th>MEDICAID SERVICES</th><th></th><th></th><th></th><th>OMB NO</th><th>. 0938-039</th></th<>	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-039
24529     B. WHO     12/11/2014       STREET ACORESS. CITY, STATE, ZPP CODE       TRAZEE CARE CENTER       PRAJEE CARE CENTER     STREET ACORESS. CITY, STATE, ZPP CODE       PAUL DEFINITION     21/11/2014       PAUL DEFINITION     21/11/2014       PARACE     ELMANAY EXPLANT OF DEFIDENCES     PRETRY       PROVER     PRETRY     PRETRY       PAUL DEFIDENCY OR LSC IDENTIFYING REFORMATION     PRETRY     PRETRY       F 226     Continued From page 8     PRETRY     PRETRY       SS=D     ABUSE/NEGLECT, ETC POLICIES     The Vulnerable Adult Policy (VA)       This REQUIREMENT Is not met as evidenced     Vulnerable Adult Policy (VA)       Based on interview and document review, the facility field to follow their policies to ensure that an allegation of potential abuse/neglect.     IDT team has been educated on the Vulnerable Adult Policy and reporting aud investigating events and reporting events to the Administrator immedi	STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1			COMPI	LETED
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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 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 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 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 Misappropriation of resident property ("alleged violations") are reported immediately to state agencies in Misappropriation of the facility. Such violations are also reported immediately to state agencies in Misappropriation of resident property ("alleged violations") are reported immediately to state agencies in Misappropriation of the facility. Such violations ("alleged violations") are reported immediately to state agencies in Misappropriation of the facility. Such violations						A deministrator / designed will		
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 Date of completion: 1/15/15			esident property					
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 inof tracking logs to assure results will be reported at the QA meetings for further review and recommendations.Date of completion: 1/15/15		It is also the policy o	f this facility to take			complete Random audits x 6	weeks	
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 Date of completion: 1/15/15		appropriate steps to	ensure that all alleged					
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 infor further review and recommendations.Date of completion: 1/15/15		violations of federal	or state laws which involove			will be reported at the QA me	etings	
("alleged violations") are reported immediately to the administrator of the facility. Such violations are also reported immediately to state agencies in Date of completion: 1/15/15		mistreatment, negled	ct, abuse, injuries of unknown			for further review and		
the administrator of the facility. Such violations are also reported immediately to state agencies in Date of completion: 1/15/15		source, and misappr	opriation of resident property			recommendations.		
are also reported immediately to state agencies in Date of completion: 1/15/15		("alleged violations")	the facility Such violations					
Example 2014 March 2017 Facility (D): 00730 If continuation sheet Page 9		are also reported im	mediately to state agencies in			Date of completion: 1/15/15		
		67(02-99) Previous Versions Ob	psolete Event ID: SQN		Fa	icility ID: 00730 If cont	inuation she	et Page 9 (

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

Facility ID: 00730

PRINTED: 12/30/2014 FORM APPROVED OMB NO. 0938-0391

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

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	CONTROLION		A. BUILDIN	lG	12/12/14	
		245000	B. WING			
		245299		STREET ADDRESS, CITY, STATE, ZIP	12/11/2014	+
NAME OF PI	ROVIDER OR SUPPLIER			219 WEST MAPLE AVENUE, PO BO		
FRAZEE C	ARE CENTER				× 50	
			l	FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLE THE APPROPRIATE DAT	ETION
F 226	Continued From page	ə 9	F 2	226		
	accordance with exis investigates such alle reports the results of	ting state law. The facility ged violation thoroughly and all investigations to the l as to state agancies as				
	diagnoses including: anxiety per the facility minimum data set (M 11/5/14 indicated R7 assistance with bed r room, dressing, eatin hygiene. The brief in (BIMS) scored 99 inc complete the assess for cognition indicate term memory problem	the facility on 5/2/14 with dementia, depression, and y face sheet. The quarterly (DS) assessment dated 7 required extensive mobility, transfer, walk in the transfer that the transfer to the transfer that the transfer to the transfer that the transfer that the transfer that the transfer that the transfer that the transfer that the transfer that the transfer that the transfer that the transfer that the transfer that the transfer that the transfer that t				
	an incident dated 7/2 R77. The incident date resident sitting on flo doorway" The phy indicated: "No scrape unable to bear weigh further indicated ther incident. Review of entry dated 7/27/14 a "Found resident sittin 2.55 p.m. No witnes When asked, residen further indicated the hip pain and was una side without pain. The notified and order resident sitting	sical assessment findings es or bruising, but resident at without pain." The report re were no witnesses to the the nurses notes revealed an at 10:45 p.m. indicating: ng outside of doorway @ (at) ses to what happened. It stated "I fell"." The note resident had increased right able to bear weight on right he nurse practitioner was ceived to transfer R77 to the				
EORM CMS 25		R) for further evaluation. The	1MJ11	Facility ID: 00730	If continuation sheet Page 1	10 of 34

CENTER	S FOR MEDICARE &	VIEDICAID SERVICES			CIMB NO: 0000-0001
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED
					12/12/14
		245299	B. WING		12/11/2014
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
FRAZEE C	ARE CENTER			219 WEST MAPLE AVENUE, PO BOX 96	
				FRAZEE, MN 56544	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 226	resident was subseque hospital with diagnos When interviewed on the director of nursing resulting in a fracture the SA. The DON si the care plan and wo to see the circumstar it was witnessed or n When interviewed at DON confirmed that witnessed by staff. T the resident had seve	uently admitted to the to the is of left hip fracture. 12/11/2014, at 10:02 a.m. g (DON) confirmed R77's fall had not been reported to lated the staff were following uld have to check the record nees of the fall as to whether	F 22	6	
F 241 SS=E	though was unable to surrounding the fall. 483.15(a) DIGNITY A INDIVIDUALITY The facility must pror manner and in an en	o report the circumstances AND RESPECT OF mote care for residents in a vironment that maintains or lent's dignity and respect in	F 24	<sup>1</sup> <b>F241</b> POC for R55, R4, R59, R43, I and R9 have been reviewed an updated if needed related to re- individual meal assistance need	nd esident
	by: Based on observation review, the facility fait dining experience for	T is not met as evidenced on, interview and document iled to ensure a dignified r 6 of 6 residents (R55, R4, (20) observed during the		Staffing around meal times have reviewed and changes made a needed to assure meal service completed in a dignified many Education for nursing staff have completed on 1-06 and 1-07 to ensure that all residents are tree with dignity and have a pleasa	s is ner. s been o eated
FORM CMS-25	Finding include:	solete Event ID: SQM	J11	with dignity and have a pleasa dining experience.	

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

CENTER	SFOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					12/12/14	
		245299	B. WING		12/11/2014	4
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 219 WEST MAPLE AVENUE, PC		
FRAZEE	CARE CENTER			FRAZEE, MN 56544		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5 E ACTION SHOULD BE COMPLI TO THE APPROPRIATE DAT DIENCY)	LETIO
F 241	R55's care plan (CP) R55 had diagnoses of heart failure, cerebro depression. R55's C alteration in cognitive from staff to complet (ADL's). Further revip provide extensive as R4's CP dated 12/8/ diagnoses which inc respiratory failure and he was cognitive and staff to complete all Further review of the extensive assistance R59's CP dated 11/1 diagnoses which inc and anxiety. R59's C alteration in cognitio from staff to complet ADL's. Further revie provide extensive as R43's CP revised on diagnoses which inc disorder and macula identified she had al dementia and requir complete all activitie review of the CP dire extensive assistance R9's CP dated 10/10 diagnoses which inc and anxiety. R9's CI in cognition and requi	<ul> <li>dated 12/15/14, identified</li> <li>which included congestive</li> <li>pvascular disease and</li> <li>P identified she had</li> <li>e and required assistance</li> <li>e all activities of daily living</li> <li>ew of the CP directed staff to</li> <li>sistance with meals.</li> <li>14, identified R4 had</li> <li>luded quadriplegia, chronic</li> <li>id anxiety . R4's CP identified</li> <li>d required assistance from</li> <li>activities of daily living ADL's.</li> <li>e CP directed staff to provide</li> <li>with meals.</li> <li>11/14, identified R59 had</li> <li>luded depression, psychosis,</li> <li>CP identified she had</li> <li>n and required assistance</li> <li>te all activities of daily living</li> <li>w of the CP directed staff to</li> <li>sistance with meals.</li> <li>11/14, identified R59 had</li> <li>luded depression, psychosis,</li> <li>CP identified she had</li> <li>n and required assistance</li> <li>te all activities of daily living</li> <li>w of the CP directed staff to</li> <li>sistance with meals.</li> <li>a 6/17/14, identified R43 had</li> <li>cuded dementia, depressive</li> <li>ar degeneration. R43's CP</li> <li>teration in cognition related to</li> <li>ed assistance from staff to</li> <li>so f daily living ADL's. Further</li> <li>ected staff to provide</li> </ul>	F 2	241 DON/Designee wi weekly audits X3 : monthly X3 month residents are treated Results of audits v QA meetings for f recommendations Date to be comple	months and hs to ensure that ed with dignity will be reviewed at urther review and	

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STATEMENT OF DEFICIENCIES AND PLANE OF CORRECTION     (M) PROVERING/ICIN VANUESE:     (M) PROVERING/ICIN VANUESE:     (M) PLANE OF A DULINING     <	<u>CENTER</u>	<u>S FOR MEDICARE &amp;</u>	MEDICAID SERVICES					ONR NC	0938-0391
24529         B. WING         12/11/2014           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STREE, ZIP CODE         STREET ADDRESS, ZIP CODE				1 · ·				COMP	LETED
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       219 WEST MAPLE AVENUE, PO BOX %       FRAZEE CARE CENTER       Ord, ID PHON     BUMMARY STREMENT OF DEFICIENCIES       Ord, ID PHON     BUMMARY STREMENT OF DEFICIENCIES       IF 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 Alzhelmer, dementia, and anxiety, R20° CP identified see 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 continued lobservation 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 round the blb. In between R55 and R55, she was assisting R55 on the rangh wild bother residents in the area at the same time.       At 6:21 p.m. nurses aid (NA-E) was observed standing next to the rable, in between R4 and R20 to her left of her supper while waking around and wilking with other residents in the area at the same time.       At 6:21 p.m. nurses sitig R4 to the right of the rand R20 to her left of her by giving them bites of their food using a silver spoon to give her bites of their food using a silver spoon to give her bites and malked over to the sink in the dining area and washed her hands, then returned to the table and wakked over to the sink in the dining area and washed her hands, then returned to the table as short while later and assisted R90 to the left of her supper wills a R55 her medication and then proceeded to give R55 her medication and then proceeded to give R55 her medication and then resuper			245200	B MING					
219 WEST MAPLE AVENUE, PO BOX 98 PRAZEE CARE CENTER       249 UNEST MAPLE AVENUE, PO BOX 98 PRAZEE, NN 58644       PHATE TRAD     00000000000000000000000000000000000			245299	B. WING				12/	11/2014
FRAZEE CARE CENTER       FRAZEE, MN 56544         (M) D PHEFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (RACD EPCREVEW MUST & FRACECOED BY FULL REGULTORY OF LSC DENTIFYING INFORMATION)       D PREFIX TAG       PROVIDERS PLAN OF CORRECTION (RACD EPCREVEW MUST & FRACECOED BY FULL REGULTORY OF LSC DENTIFYING INFORMATION)       D PREFIX TAG       PROVIDERS PLAN OF CORRECTION (RACD EPCREVEW DET SE TRANSPORTANCE DEFICIENCY)       Order Deficiency Defi	NAME OF PI	ROVIDER OR SUPPLIER							
OHID PREFX IVAG     SUMMARY STREEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECREDED BY FULL RECULTORY OR LISCIDENTPYING INFORMATION)     PRECV IVAG     PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECREDED BY FULL PRECISE TO THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     Organisation       F 241     Continued From page 12 review of the CP directed staff to provide extensive assistance with meals.     F 241     F 241       R20*D CP dated 5/8/13, Identified R20 had diagnoses which included Alzheimer, dementia, and anxiety. R20*S CP identified assistance from staff to complete all activities of ally living ADL*, Further review of the CP directed staff to provide extensive assistance with meals.     F 241       During continual observation of the supper meal on 12/8/14 at 6:20 p.m. R4, R56, R20, R59 were seated at a large round table meat the entrance of the main dining room with various food litems in front of them. Licensed practical nurse (LPN-B) was observed standing next to the table, in between R59 and R56, she was sasisting R56 on her right side to eat portions of her food using a silver spoon to give her bites of her supper while salted ray and visiting with other residents in the area at the same time.       At 6:21 p.m. nurses aid (I/N-E) was observed standing next to the table, in between R4 and R20, she was assisting R4 to he right of her and R20 to her left of her big in the read at alter At 16:23 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 waked over to the skin in the dine garea and washed her hands, then returned to the table as short while later and assisted R59 to the left of her supper using a	FRAZEE C	ARE CENTER			1				
Precision     Precision     Precision       Tx0     CROSS-REFERENCED to THE APPROPRIATE DEFICIENCY     DATE   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, dementla, 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 af C20 pm. R4, R56, R20, R59 were seated at a large round table near the entrance of the main dining room with various food litems in from to fthem. Licensed practical nurse (LPN-RB) 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 supper while waking around and visiting with other residents in the area at the same time. At 6:21 pm. 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, be was assisting R4 to the right of her and R20, be was assisting R4 to the right of her and R20, be was assisting R4 to the right of her and R20, be was assisting R4 to the right of her and R20, be was assisting R4 to the right of her and R20, be was assisted R59 to the is of their food using a silver spoon on at a time. At 6:23 pm. LPN-B and NA-E continue to stand and feed R4, R56, 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 supper using a						FRAZEE, MN 56544			
<ul> <li>review of the CP directed staff to provide extensive assistance with meals.</li> <li>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.</li> <li>During continual observation of the supper meal on 12/8/14 at 6:20 p.m. R4, R56, R20, R59 were seated at a large round table near the entrance of the main dining room with various food lems in front of them. Licensed practical nurse (LPN-B) was observed standing next to the table, in between R59 and R55, she was assisting R56 on her right side to eat portions of her supper while walking around and visiting with other residents in the area at the same time.</li> <li>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 field 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.</li> <li>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 bites of their spice R58 to the right of her supper Wile R56 to the right of her supper sup</li></ul>	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	FIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE		
silver spoon, while NA-E continues to stand while	F 241	review of the CP dire extensive assistance R20's CP dated 5/8/1 diagnoses which incl and anxiety. R20's C alteration in cognition from staff to complete ADL's. Further review provide extensive ass During continual obse on 12/8/14 at 6:20 p. seated at a large rou the main dining room front of them. License was observed standi between R59 and R5 her right side to eat p silver spoon to give h walking around and w the area at the same At 6:21 p.m. nurses a standing next to the to R20, she was assisti R20 to her left of her food using a silver sp p.m. LPN-B and NA- R4, R55, R20, and R At 6:24 p.m. LPN-B I to the sink in the dini hands, then returned later and assisted R5 R59 her medication a R55 to the right of her	cted staff to provide with meals. 3, identified R20 had uded Alzheimer, dementia, P identified she had and required assistance e all activities of daily living v of the CP directed staff to sistance with meals. ervation of the supper meal m. R4, R55, R20, R59 were nd table near the entrance of a with various food items in ed practical nurse (LPN-B) ing next to the table, in 55, she was assisting R55 on portions of her food using a her bites of her supper while visiting with other residents in time. aid (NA-E) was observed table, in between R4 and ing R4 to the right of her and by giving them bites of their poon one at a time. At 6:23 E continue to stand and feed t59. eft the table and walked over ing area and washed her it to the table a short while 59 to the left of her by giving and then proceeded to give ar a bite of her supper using a	F	. 24				

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

Facility ID: 00730

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PRINTED	: 12/30/2014
FORM	APPROVED
OMP NO	0038-0301

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		12/12/14	
		245299	B. WING		12/11/2014	4
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		·
			219	9 WEST MAPLE AVENUE, PO BOX 96		
FRAZEE	CARE CENTER		FR	AZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLE	ETION
F 241	Continued From page	e 13	F 241			
	to the kitchen and as another resident sittir LPN-B continues to c residents in the dining is done eating and le staff continue to stan in the dining room. A back over to R59 to s continued to give R59 using a silver spoon, out of the dining room while NA-E continue with eating until 6:34	eft the table again and went ked for some toast for ng at the table. At 6:27 p.m. feliver food and assist other g room area. At 6:28 p.m. R4 ft the dining room area while d and assist other residents t 6:29 p.m. LPN-B came see if she is done eating and 5 more bites of her food then proceeded to take R59 n and back to her room, d to stand and assist R20 p.m. when she took R20 out hile R55 remained at the				
	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.					
	go home and R9 said to take R9 back to he R43 continued to sit room with their food					
FORM CMS-25	67(02-99) Previous Versions Ob	t director of nursing (ADON)	 ViJ11 Faci	ility ID: 00730 If	continuation sheet Page 1	4 of 34

	S FUR MEDICARE &							. 0000-0001
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE SURVEY COMPLETED		
							12/12	2/14
		245299	B, WING				12/*	11/2014
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE			
FRAZEE (	CARE CENTER				EST MAPLE AVENUE, PO BOX 96			
				FRAZ	ZEE, MN 56544		·····	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
F 241	LPN-B and NA-E cor time while assisting F R43 from 6:20 p.m. to During interview on 1 confirmed that she st assisting residents to stated, "Its wrong ar while you are feeding that she does bounce because there is not residents eat. During interview on 2 confirmed that she st assisting residents to stated, "I do not feel food and then come that they do not have room to help feed the During interview on 2 of nursing (DON) con standing while they a verified staff should I residents at a time a forth between reside do not feel this is dig several residents." Review of facility pol Life dated 4/1/2008, for residents in a ma	d table and started to h her supper. ervation of the supper meal attinued to stand the entire R4, R55, R20, R59, R9, and o 6:39 p.m. 2/11/14 at 2:25 p.m. NA-E tood the entire time while o eat in the dining room and id its not dignified to stand g people". NA-e also verified e around to feed people enough staff to help all the 12/11/14 at 2:35 p.m. LPN-B tood the entire time while o eat in the dining room and it is dignified to give them back". LPN-B also verified e enough help in the dining e residents. 12/11/14 at 2:59 p.m. director nfirmed staff should not be are feeding residents and be feeding one or two nd not be going back and nts. The DON also stated "I unified to stand and feed	F	241				
	that maintains or enl	nances each residents dignity						
							allen ahaa	+ Dage 15 of 3

Facility ID: 00730

If continuation sheet Page 15 of 34

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMP	(X3) DATE SURVEY COMPLETED		
					12/1	2/14		
		245299	B. WING		12/	11/2014		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE			
FRAZEE (	ARE CENTER			219 WEST MAPLE AVENUE, PO BOX 9 FRAZEE, MN 56544	96			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 241 F 279 SS=D	and respect by assist independence in eati 483.20(d), 483.20(k)( COMPREHENSIVE of A facility must use the to develop, review ar comprehensive plan The facility must deve plan for each residen objectives and timeta medical, nursing, and needs that are identifi assessment. The care plan must of to be furnished to atth highest practicable p psychosocial well-be §483.25; and any se be required under §4 due to the resident's §483.10, including th under §483.10(b)(4). This REQUIREMEN' by: Based on interview facility failed to deve the coordination of h	ting and promoting ng and dining. (1) DEVELOP CARE PLANS e results of the assessment nd revise the resident's of care. elop a comprehensive care at that includes measurable ables to meet a resident's d mental and psychosocial fied in the comprehensive describe the services that are ain or maintain the resident's hysical, mental, and ing as required under rvices that would otherwise 183.25 but are not provided exercise of rights under the right to refuse treatment T is not met as evidenced and document review the lop a care plan to address ospice services for 1 of 1	F 24	<ul> <li><sup>9</sup> F279 Plan of Care (POC) fo R71 has been reviewed</li> <li>POC for residents on I residents on anti-psych medications have been and updated as needed</li> <li>Education for nursing completed on 1-06 and ensure those residents services and who are of psychotropic medicati</li> <li>DON/Designee will conduct Audits weekly X3 and to ensure that resident Hospice services POC areas of concern</li> <li>SW will complete Audit X3 and monthly X3 to</li> </ul>	d and updated Hospice and hotropic reviewed staff has been d 1-07 to on Hospice on Anti- ons omplete I monthly X3 s receiving addresses dits weekly o ensure that			
	resident (R62) who v care. In addition, the	vas reviewed for hospice e facility failed to develop a esidents (R71) receiving		residents receiving Ar psychotropic medicati addresses areas of con	ons POC			

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

Event ID: SQMJ11

		IDENTIFICATION NUMBER		TIPLE	(X3) DATE SURVEY COMPLETED			
		IDENTIFICATION NUMBER:	A. BUILDI	NG		12/12/14		
		245299	B. WING			12/	2/11/2014	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
FRAZEE C	ARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 279	Continued From pa R62 had a diagnosi initial certification fo	F	279	Results of Audits will be repo QA meetings for further revie recommendations				
	included a terminal degeneration of bra of generalized pain			Date of completion: 1-15-15				
	Review of the physi included an order to standing orders. Th Morphine concentra as needed for pain. mg buccal every 4 8. Glycopyrrorate 1 needed for secretio initiated by HRRV ( only."							
	11/13/14 indicated, services." The care	cility care plan last revised "I am now receiving hospice e plan did not include end of y facility staff or the hospice ng interventions for pain.			Ÿ			
	director of nursing facility care plan wa hospice care plan,	on 12/11/14, at 4:45 p.m. the (DON) confirmed that the as not integrated with the including a delineation of of communications between						
	date of 12/8/14,ide identification of the medication, the tar resident, any non-r	irrent care plan with revision ntified the care plan lacked use of an antipsychotic get behaviors displayed by the sharmacological interventions, effects of the medication.						
	D71 had diagnoso	s which included dementia with						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT		(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBE		IDENTIFICATION NUMBER:		IG	COMPLETED 12/12/14			
		245299	B. WING _		1:	2/11/2014		
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO		CODE			
				219 WEST MAPLE AVENUE, PO B	DX 96			
FRAZEE	ARE CENTER			FRAZEE, MN 56544				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE	(X5) COMPLETIO DATE		
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		F 2	279				
	to 3 days during the a During an interview of registered nurse (RN care plan and the lac interventions regarding Seroquel use. RN-A practice for antipsych care plan which iden resident and possible medication.	on 12/12/2014, at 1:40 p.m. )-A verified R71's current k of focus, goals and ng resident behaviors and verified the facility's usual notic use would include a tified target behaviors of the e side effects of the						
	the director of nursin current care plan did Seroquel.	on 12/12/2014, at 12:38 p.m. g ( DON) verified R71's not address R71's use of		7				
F 309 SS=D			F	<sup>309</sup> <b>F309</b> Resident # 62 has be therapy for proper c	•			
				Resident # 18 has be RN with no negative not receiving annua dialysis.	een assessed by e effects for LN			

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

Facility ID: 00730

PRINTED: 12/30/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING		COMPLETED 12/12/14 12/11/2014	
	ROVIDER OR SUPPLIER	240200	S 2	TREET ADDRESS, CITY, STATE, ZIP CODE 19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 309	This REQUIREMENT by: Based on observatio review, the facility fail wheelchair positioning reviewed for positioning reviewed for positioning reviewed for positioning reviewed for positioning regarding peritoneal of (R18). Findings include: On 12/08/2014, at 5: seated in a Broda while bedroom. R62 was p the chair upright and straight downward wit R62's legs or feet; the actual footrest attach observed to be dangle from the floor. On 12/08/2014, at 5: 6:30 p.m. R62 was condining room during the seated in a Broda w/ the chair upright and straight downward. F resting in between the the wheelchair. R62 from staff with eating repositioned through On 12/08/2014, at 7: a.m. R62 was observed.	is not met as evidenced n, interview, and document led to maintain comfortable g for 1 of 1 resident (R62) ng. In addition, the facility sed staff education dialysis for 1 of 1 resident	F 309	All residents not sitting prop w/c may be affected by this practice. The facility only ha dialysis patient in the facility Education for nursing staff h completed on 1-06 and 1-07 dialysis care to assure that st provide cares to promote hig well-being. Staff received education to r a resident is not sitting prop w/c to have a therapy screen completed DON/Designee will complet weekly audits for X3 month the monthly X3 to assure hig well being is being met in al residents Results of audits will be rev QA Meetings for further rev recommendations Date to be completed 1-15-1	as one y. has been on taff ghest report if erly in te s and ghest l iewed at iew and taff y. te te te te te te te te te te

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UENTER	S FOR MEDICARE &	MEDICAID SERVICES					. 0800-0081	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
						12/12		
		245299	B. WING			12/	11/2014	
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				21	9 WEST MAPLE AVENUE, PO BOX 96			
FRAZEE C	ARE CENTER			FF	RAZEE, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
TAG F 309	Continued From page legrest positioned stra residents feet observ approximately 10 incl support to legs or fee On 12/9/14, at 11:30 seated in a Broda w/d back of the chair posi legrest positioned str observed with her kn beside her on the sea On 12/09/2014, at 1: seated in a Broda w/d back of the chair posi legrest positioned str foot was dangling an the right foot resting of towards the seat of th On 12/10/2014 at 8:1 was observed seated bedroom with the bac upright and the legre downward. During th R62's feet were obse 10 inches from the fid the 11:00 a.m. obser	<ul> <li>a 19</li> <li>aight downward, and</li> <li>ed to be dangling</li> <li>hes from the floor without</li> <li>t.</li> <li>a.m. R62 was observed</li> <li>c in her bedroom with the</li> <li>itioned upright and the</li> <li>aight downward. R62 was</li> <li>ees bent and feet curled</li> <li>at of the chair</li> <li>18 p.m. R62 was observed</li> <li>c in her bedroom with the</li> <li>itioned upright and the</li> <li>aight downward. R62's left</li> <li>d right knee was bent with</li> <li>on the upper legrest webbing</li> <li>he chair.</li> <li>9 a.m. and 11:00 a.m. R62</li> <li>d in a Broda w/c in her</li> <li>ck of the chair positioned</li> <li>st positioned straight</li> <li>he 8:19 a.m. observation</li> <li>arved dangling approximately</li> <li>por with no support. During</li> <li>vation R62's heels were</li> <li>ng slightly on the webbing of</li> </ul>		309				
	seated in a Broda w/ assisted by staff with positioned with her b legrest positioned str	15 a.m. R62 was observed c in the dining room being eating breakfast. R62 was ack slightly reclined and the raight downward with R62's imately 10 inches from the						

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

Facility ID: 00730

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				ONR NO	<u>. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						12/12	2/14
		245299	B. WING			12/	11/2014
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				21	9 WEST MAPLE AVENUE, PO BOX 96		
FRAZEE	ARE CENTER			FF	RAZEE, MN 56544		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	416	Ditte
F 309	Continued From page	ə 20	F	309			
	Review of R62's sign	ificant change minimum data					
	set (MDS) dated 11/1	7/14 indicated R62 was					
	totally dependent on	staff with transfer, dressing,					
	toilet use, locomotion	on unit, and eating and					
	required extensive as	ssistance with bed mobility					
	and personal hygiene	e. The MDS further indicated					
	R62 had severe cogr	nitive impairment and		i			
	received hospice ser	vices.					
	On 12/11/2014, at 11	:35 a.m. R62 was observed					
	with the director of nu	ursing (DON), registered					
	nurse (RN)-A and RN	I-B. R62 was seated in a					
	Broda w/c in her roor	n with the back of the chair					
	reclined slightly and t	the legrest raised supporting					
		DON confirmed that this		İ			
	was proper positionir	ng for R62 and also					
		was the most comfortable					
	R62 had looked in a	long time. The DON					
	confirmed that the le	grest should by elevated on					
		the legs/feet to prevent them					
		ON stated that when R62 is					
	eating in the dining re	oom the w/c is not able to get					
	under/up to the table	when the footrest is					
		eals the footrest is put down					
		to raise it again once the					
		ON showed surveyor a					
		instructions of how the w/c					
		that was attached to the					
		The laminated sheet included					
		when positioned properly and					
		air in tilt not just the recline.					
		le. Also, elevate the legs."					
		uded a foot rest which was					
	not included on R62'	s w/c. Below the picture of					
		8 degrees of seat tilt". The					
		the footrest had been					
		w/c as her feet didn't reach it					
	which would not give	e any support.					
FORM CMS-25	67(02-99) Previous Versions Ob	solete Event ID: SQN	AJ11	Fa	cility ID: 00730 If contin	uation shee	t Page 21 of 34

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

PRINTED: 12/30/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(	(X3) DATE SURVEY COMPLETED 12/12/14	
		245299	B. WING	· · ·			12/	11/2014
NAME OF PROVIDER OR SUPPLIER				219	REET ADDRESS, CITY, STATE, ZIP CODE WEST MAPLE AVENUE, PO BOX 96 AZEE, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULI. SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE		(X5) COMPLETION DATE
F 309	When interviewed on occupational therapis confirmed that R62 sl sitting upright with he stated she had obser this way at times and staff. OTR stated nur sometimes not having time to reposition the stated she had provid to how the chair shou laminated and hangir OTR stated feeling th attached to the w/c er feet don't reach it as positioning. R18's peritoneal dialy completed by staff wh dialysis provider (Dav R18's quarterly Minin 10/16/14, identified d diabetes mellitus type treatments including plan included periton end stage renal disea	12/11/2014, at 3:02 p.m. the t-registered (OTR) nould not be positioned r feet dangling. OTR further ved the resident positioned addressed it with nursing rsing staff indicated g enough help to take the resident. OTR further led a diagram to nursing as ald be positioned which was ag on the back of R62's w/c. at the footrest should still be ven though the resident's a reminder to staff on proper vsis exchanges were no were not trained by the <i>i</i> ta).	F	309				
	began in house perito on 4/15/14, Review of the dialysis identified the most re completed 7/18/13. T practical nurse (LPN)	rocedure identified R18 oneal dialysis at the facility s in-service training logs cent training had been he DON stated licensed o-C and RN-C had performed or R18 and provided their						
		. LPN-C was oriented to						

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

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES OFNITERO FOR MERIOARE & MERIOARD OFRICA

CENTER	S FOR MEDICARE &					0.0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		CON	e survey IPLETED 2/14
		245299	B. WING		1:	2/11/2014
		L	219	EET ADDRESS, CITY, STATE, ZIP CODE WEST MAPLE AVENUE, PO BOX 96 \ZEE, MN 56544	-	
			I			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	from a Davita Dialysis received training from employee, completed had been orientated check list, by a facility During an interview for licensed staff was Dialysis company wh the facility; however, training would be co working that shift. During and interview a.m. licensed practic inservice was provide Moorhead for a prevision same dialysis cycler treatment), but had r for R18. LPN-A verifi orientated by the cur the dialysis exchange During an interview of the director of nursin training for dialysis p completed during ori shift when the excha DON verified she wa	y a facility employee but not s employee. RN-C had not a Davita Dialysis d orientation on 4/7/14, and to dialysis according to the y employee. on 12/10/2014, at 1:36 p.m. )-A stated dialysis training completed by the Davita en a new resident came to if a new nurse started, mpleted by the nurse o on 12/11/2014, at 10:17 al nurse (LPN)-A verified an ed by Davita Dialysis from ious resident who had the (machine used for dialysis not specifically trained staff ed new nurses had been rent nurse working the shift e was performed. on 12/11/2014, at 1:27 p.m. g (DON) verified new staff rocedure had been entation by the nurse on the nge was performed. The s in charge of the education	F 309			
	training of the dialysi the nurse working the During a phone inte	rview on 12/12/14, at 3:43 ysis nurse stated that Davita				
FORM CMS-25	67(02-99) Previous Versions Ob		MJ11 Facili	ty ID: 00730	If continuation sh	eet Page 23 of 34

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0930-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY LETED 2/14
		245299	B. WING				<i>2/</i> 1 1 11/2014
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		1112011
FRAZEE C	CARE CENTER				I9 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION			(X5) COMPLETION DATE
F 309 F 312 SS=D	Center Dialysis Policy staff training to be pro 483.25(a)(3) ADL CA DEPENDENT RESID A resident who is una daily living receives the maintain good nutritice and oral hygiene. This REQUIREMENT by: Based on observation review, the facility to grooming for 1 of 3 re activities of daily livin dependent on staff for Findings include: On 12/8/14, at 5:23 p 2 long hairs approxim length and multiple sinchin. R87's chin hair observed all days of the R87 was admitted to diagnoses including to and glaucoma per the temporary care plan	dialysis exchanges. olicy titled Frazee Care y and Procedure directed ovided by Davita staff. RE PROVIDED FOR ENTS ble to carry out activities of ne necessary services to on, grooming, and personal ' is not met as evidenced n, interview, and document provide routine personal seidents (R87) reviewed for g (ADL's) who was r grooming. m. R87 was observed with hately 1 centimeter (cm) in horter hairs visible on her continued to be present and		309	F312 POC for R87 has been reviewed POC for other residents will be reviewed on an ongoing basis to assure that their desired groom cares are met. Education for nursing staff has completed on 1-06 and 1-07 to ensure that all residents require assistance with grooming are not DON/Designee will complete weekly audits X3 months and the every month X3 to assure that grooming needs are met Results of Audits will be report The QA meetings for further re- and recommendations. Date to be completed by: 1-15	to ing been ng net. then ted at	
	showering, assist of a set-up assistance wit	one staff with dressing, and h verbal cues with grooming.					

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	245299	B. WING		12/12/14 12/11/2014
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
dementia exhibiting fo confusion. On 12/12/2014, at 1:0 seated in her wheelch assistance with her tel assistant (NA)-A. R87 hair present on her ch NA-A who confirmed t morning and that NA-/ assisted her. NA-A cor usually offered to be s and acknowledged tha present. NA-A stated morning when giving I "Guess I just forgot". would like her to shav agreed. When interviewed on registered nurse (RN) residents to be offered as needed. RN-A cor been offered to be shav 483.25(I) DRUG REG SS=D Each resident's drug I unnecessary drugs. / drug when used in ex duplicate therapy); or without adequate mon indications for its use;	dentified a diagnosis of rgetfulness and intermittent 1 p.m. R87 was observed air in her room receiving levision from nursing 7 continued to have facial in. Surveyor interviewed hat R87 had a shower that A had been the staff who onfirmed that residents were shaved on their bath day at R87 had visible facial hair she had noticed it that R87 the shower and stated, NA-A then asked R87 if she the facial hair and R87 12/12/2014 at 1:14 p.m. -A stated she would expect d shaving on bath day and nfirmed R87 should have aved when bathed. IMEN IS FREE FROM UGS regimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or nitoring; or without adequate cor in the presence of the which indicate the dose discontinued; or any	F3	<ul> <li>F329</li> <li>F329</li> <li>POC for R71 has been review updated</li> <li>All residents who receive ant psychotropic medications hav reviewed to assure they have behavior monitoring sheets in to address target behaviors ar pharmacological intervention</li> </ul>	i- ve been n place nd non

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

Facility ID: 00730

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

STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		survey leted 2/14
		245299	B. WING			12/11/2014	
	ROVIDER OR SUPPLIER	L	1	21	IREET ADDRESS, CITY, STATE, ZIP CODE 19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page Based on a compreh resident, the facility n who have not used a given these drugs un therapy is necessary as diagnosed and do record; and residents drugs receive gradua behavioral interventio contraindicated, in an drugs. This REQUIREMENT by: Based on interview facility failed to ident the continued use of for 1 of 5 resident (R Findings include: R71 received Seroqu 25 milligrams at bed indications for the us addition, the facility of	<ul> <li>25</li> <li>ensive assessment of a nust ensure that residents ntipsychotic drugs are not less antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic and dose reductions, and ons, unless clinically n effort to discontinue these</li> <li>T is not met as evidenced and document review, the fig the clinical indications for a anti-psychotic medication 71 ) reviewed.</li> <li>Let (antipsychotic medication) time without adequate to fit the medication. In did not establish appropriate toring and care planning for</li> </ul>	F	329		nsure tic s in eekly hat ogical ed anti-	
	date of 12/8/14, lack an antipsychotic me displayed by the res	interventions, or possible					

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

Facility ID: 00730

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SU	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLE 12/12/	
		245299	B. WING			/2014
	ROVIDER OR SUPPLIER	243233		STREET ADDRESS, CITY, STATE, ZIP COD		12014
				219 WEST MAPLE AVENUE, PO BOX 96		
			<u> </u>	FRAZEE, MN 56544	PREATION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE
F 329	Continued From pag	e 26	F 3:	29		
	R71 had diagnoses v out behavioral distur medication orders sig	which included dementia with bance. R71's current gned 11/18/14, identified edtime for Psychosis, with a				
	9/22/14, identified R dementia, a brief mir identified severe cog	Minimum Data Set) dated 71 had a diagnosis of ni mental status (BIMS) Initive impairment, and had a ed towards others 1 to 3 days ent period.				
	registered nurse (RN lacked behavior mor	on 12/12/14, at 1:40 p.m. I)-A verified R71's record hitoring of target behaviors. hormally would have a log for someone on				
	the director of nursin of documented targe non-pharmacologica stated the behavior	on 12/12/2014, at 12:38 p.m. g (DON) confirmed the lack at behaviors or identified l interventions. The DON monitoring records were potential dosage reductions.		9		
F 334 SS=D	483.25(n) INFLUEN	y policy was not provided. ZAAND PNEUMOCOCCAL	F 3	Resident #34 records for		
	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			immunization requeste and offer of immunizat provided.		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	····				. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/12/14	
		245299	B. WING			12/*	11/2014
	ROVIDER OR SUPPLIER		I	21	REET ADDRESS, CITY, STATE, ZIP CODE 9 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 334	immunization; (ii) Each resident is of immunization Octobe annually, unless the contraindicated or th immunized during th (iii) The resident or t representative has th immunization; and (iv) The resident's m documentation that if following: (A) That the reside representative was p the benefits and pote immunization; and (B) That the reside influenza immunizat influenza immunizat immunization; (ii) Each resident is immunization; unles medically contraindi already been immur (iii) The resident of representative has t immunization; and (iv) The resident's m	offered an influenza er 1 through March 31 immunization is medically e resident has already been is time period; he resident's legal ne opportunity to refuse edical record includes indicates, at a minimum, the ent or resident's legal provided education regarding ential side effects of influenza int either received the ion or did not receive the ion due to medical refusal. velop policies and procedures e pneumococcal resident, or the resident's receives education regarding ential side effects of the offered a pneumococcal s the immunization is cated or the resident has nized;	F	334	Any resident admitted to Fra Care Center is at risk for this practice. Education provided to LN to facility policy of obtaining re upon admission and offering influenza (October- February Pnuemovax if no records are available. NM will review all new adm within 7 days of admission to records have been obtained of has offered vaccinated as our above. DON/ Designee will audit th practice for 3 months. Results of audits will be report the QA meetings for further and recommendations. Date of correction is 1/15/15	follow ecords /) and issions or assure or staff tlined is orted at review	

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

Facility ID: 00730

If continuation sheet Page 28 of 34

## DEPARTMENT OF HEALTH AND HUMAN SERVICES.

CENTER	S FOR MEDICARE &	VIEDICAID SERVICES					0. 0930-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	CON	TE SURVEY MPLETED 12/14
		245299	B. WING			1	2/11/2014
	ROVIDER OR SUPPLIER			219	EET ADDRESS, CITY, STATE, ZIP CODE WEST MAPLE AVENUE, PO BOX 96 AZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	<ul> <li>(A) That the resident representative was p the benefits and pote pneumococcal immu</li> <li>(B) That the resident pneumococcal immu the pneumococcal immu the pneumococcal immu the pneumococcal immu practitioner record pneumococcal immu years following the fill immunization, unless</li> </ul>	t or resident's legal rovided education regarding ntial side effects of nization; and t either received the nization or did not receive munization due to medical fusal. based on an assessment mmendation, a second nization may be given after 5 rst pneumococcal medically contraindicated or sident's legal representative	F	334			
	by: Based on interview of facility failed to ensur- were offered and/or of pneumovax vaccinate Findings include: R23 was admitted to remained in the facili- provided to indicate influenza and pneum During interview on of registered nurse (RN immunizations were record as being admit	the facility on 10/23/14, and ty. No documentation was R23 was offered the novax vaccination. 12/12/14, at 4:21 p.m. I)-A confirmed no recorded in R23's medical inistered or offered. On n. RN-A asked R23 if she					

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Facility ID: 00730

If continuation sheet Page 29 of 34

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
			, DOILDIN	·		12/14
		245299	B. WING _		12	/11/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY	, STATE, ZIP CODE	
FRAZEE	CARE CENTER			219 WEST MAPLE AVE FRAZEE, MN 56544	NUE, PO BOX 96	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COF	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 371	potential to effect 63 the facility. Finding include: During the initial kito p.m., dietary aid (D/ freezer in the back of During the observat large cardboard box the metal shelves of freezer. One of the contained three and packages of ground box sitting next to g and contained four On 12/8/14 at 1:08 DA-A verified the ro beef roast were on and stated, "It is no On 12/8/14 at 1:08 DA-B verified the ro beef roast were on and stated, "Nothir floor." On 12/10/14 at 1:27 confirmed that no m on the floor of the w "The meat could pot this is unsanitary." Review of facility pot dated January 2013 served to residents	in freezer. This had the 3 of 64 residents residing in chen tour on 12/8/14 at 1:08 A-A) opened the large walk in room of the kitchen area. ion it was noted there was two ces sitting on the floor under in the left hand side of the boxes was opened and a half rolls of 10 pound beef and the other cardboard round beef was still sealed 14 pound beef roasts. p.m. during the initial tour lls of ground beef and the the floor of the walk in freezer	F3	will complete Audits week ensure sanita food. Results of au dietary staff meetings, an QA meetings recommenda	Manager or designee e Proper Food Storage ly for 3 months to ry storage of resident adits will be shared with at monthly dietary staff d also reported at the s for further review and tions. completed by: 1/15/15	et Page 31 c

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		and the second	OMB NO	. 0938-039	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
		245299	B. WING		12/12/14 12/11/2014		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE		
FRAZEE	CARE CENTER			219 WEST MAPLE AVENUE, PO BOX FRAZEE, MN 56544	96 ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
	Continued From page 31 above the floor, not exposed to floor moisture and stored properly as soon as they are delivered. 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.		F 37 F 42		l for GDS cility is at risk tion		
	This REQUIREMENt by: Based on interview a facility failed to ensu- reported medication physician and the dir resident (R71)who's Findings include: R71 had diagnoses a out behavioral distur medication orders sis Seroquel (antipsycho (milligrams) at bedtir date of 10/13/14. The quarterly MDS ( 9/22/14, identified R dementia, a brief mir	T is not met as evidenced and document review, the re the consultant pharmacist irregularities to the attending rector of nursing for 1 of 5 medications were reviewed. which included dementia with bance. R71's current gned 11/18/14, identified otic medication) 25 mg ne for Psychosis with a start Minimum Data Set) dated 71 had a diagnosis of ni mental status (BIMS) gnitive impairment, and had		DON contacted consu pharmacist to provide reviewing R71 medica importance of followin medications irregulari and SW were educated to have targeted behave place for any residents anti-psychotics. SW/Designee will cor audits for 3 months to residents have non phi interventions as well a behaviors if they are r psychotic medications	ltant d education on ation and ng up on ties. The LN d on the need vior sheets in s requiring nplete weekly ensure that armacological as targeted ecciving anti-		

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Facility ID: 00730

If continuation sheet Page 32 of 34

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \_ 12/12/14 B. WING 12/11/2014 245299 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE CARE CENTER FRAZEE, MN 56544 PROVIDER'S PLAN OF CORRECTION (X5) Completion Date SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX CROSS-REFERENCED TO THE APPROPRIATE **REGULATORY OR LSC IDENTIFYING INFORMATION)** TAG TAG DEFICIENCY) F 428 Continued From page 32 F 428 DON/Designee will audit pharmacy behaviors not directed towards others 1 to 3 days reviews monthly to assure resident during the assessment period. med irregularities are being The facility form titled Pharmacist's Drug reviewed. Regimen Review indicated the consulting pharmacist reviewed R71's medications on Results of audits will be reported at 10/30/14, 17 days after the start date of the Seroquel and then again on 11/24/14, without the QA meetings for further review identifying the lack of monitoring, target and recommendations. behaviors, or identified interventions for the Seroquel use. Date of completion: 1/15/15 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.

Facility ID: 00730

If continuation sheet Page 33 of 34

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

Event ID: SQMJ11

IEDICAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245299 EMENT OF DEFICIENCIES			(X3) D. CC	NO: 0938-0391 ATE SURVEY DMPLETED	
EMENT OF DEFICIENCIES				10/10/14	
				12/12/14 12/11/2014	
		STREET ADDRESS, CITY, STATE, ZIP CO			
		219 WEST MAPLE AVENUE, PO BOX FRAZEE, MN 56544	98		
MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO TH	on Should Be He appropriate	(X5) COMPLETION DATE	
33 bolicy was not provided.	F 4	428			
	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) 33 policy was not provided.	MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) 33 33 policy was not provided. F 428	MUST BE PRECEDED BY FULL PREFIX C IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 33 F 428	

PRINTED: 12/30/2014

DEPART	MENT OF HEALTH	AND HUMAN SERV & MEDICAID SERV	ices F	52	99024		FORM	12/12/2014 APPROVED 0.0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE			IPLE CONSTRUCTION IG 01 - MAIN BUILDING		(X3) DATE S COMPLE	
		245299		B. WING			12/1	0/2014
	ROVIDER OR SUPPLIER				STATE, ZIP CODE	_		
FRAZEE	CARE CENTER			EST MAPL E, MN 56	.E AVENUE. PO BOX 99 544	6		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIE	S	ID	PROVIDER'S PLAN	OF CORRECT		(X5)
PREFIX	(EACH DEFICIENCY MUST			PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED T	CTION SHOL	JLD BE	COMPLETION DATE
IAG	ON LOO IDE			IAG	DEFICIE		OTRAL	
K 000	INITIAL COMMENT	S		K 000				
	FIRE SAFETY							
	A Life Safety Code Survey was conducted by the							
		ent of Public Safety,						
	Fire Marshal Divisio	on. At the time of this	s survey					
		r 01 Main Building w						
		liance with the requin /ledicare/Medicaid at						
		Life Safety from Fire						
	2000 edition of Nati							
		Standard 101, Life s er 19 Existing Health						
	Code (LSC), Chapte		i Care.					
	The facility was incr	pected as one buildir						
		was constructed at						
	different times. The	original building was	3					
		, is 1-story without a						
		determined to be of In 1979 the north 20						
	addition was built. It		Jo wing					
	basement, was dete	ermined to be of a Ty						
	(000) construction, a							
	fire barriers from the the 1979 building in							
	addition to the west							
	entrance addition to							
	determined to be Ty		ion and					
	the business / main separated from the		/ith a 2-					
	hour fire barrier, so							
	not surveyed at this				£			
	The facility is divide	d into 5 smoke zono	s with					
	smoke barrier walls				÷			
	rated fire barriers.							
	The facility is served	otoly oprinklas sector	tod in					
	The facility is compl accordance with NF							
LABORATOR	RY DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESE	NTATIVE'S SIGI	NATURE	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.

	MENT OF HEALTH					FORI	l: 12/12/2014 M APPROVED D. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE			PLE CONSTRUCTION	(X3) DATE S COMPL	
		245299		B. WING		12/ <sup>-</sup>	10/2014
	PROVIDER OR SUPPLIER		219 WE		TATE, ZIP CODE E AVENUE. PO BOX 96 44		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE F BE PRECEDED BY FULL I ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 000	The facility has a fir detection throughou the common space NFPA 72 "The Natio edition). The fire ala automatic fire depa areas have automa are on the fire alarm the Minnesota State the 1971 building is The facility has a ca census of 64 at the	kler Systems (1999 of re alarm system with ut the corridor system s installed in accorda onal Fire Alarm Code arm system is monitor rtment notification. H tic fire smoke detect n system in accordan e Fire Code (2007 ec now fully sprinkler p apacity of 74 beds ar	smoke n and in ance with " (1999 ored for lazardous ion that nce with dition). In rotected. nd had a	K 000			
	2567(02-99) Previous Ver	rsions Obsolete			SQMJ21	If continuation	sheet Page 2 of 2



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

Frazee Care Center December 30, 2014 Page 2 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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		12/12/2014*	
		00730	B. WING		12/12/2014	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	ZIP CODE		
RAZEE (	ARE CENTER	219 WE	ST MAPLE AVENUE	, PO BOX 96		
		FRAZEE	, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET	
2 000	Initial Comments		2 000			
	*****ATTENTION******					
	NH LICENSING CORRECTION ORDER					
	144A.10, this correcting pursuant to a survey. found that the deficience herein are not correction not corrected shall be with a schedule of finithe Minnesota Depart Determination of whe corrected requires correquirements of the minnes requirements of the minnes of the minnes of the minnes When a rule contains comply with any of the lack of compliance. If re-inspection with any result in the assessmit	ther a violation has been				
	that may result from r orders provided that a	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a for non-compliance.				
	12/12/14, the above p licensing orders were are completed, pleas bottom of the first pag "Laboratory Director's	12/10/14, 12/11/14, and provider and the following issued. When corrections e sign and date on the ge in the line marked with				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00730	B. WING		12	12/11/2014	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
RAZEE	CARE CENTER		ST MAPLE AVENUE E, MN 56544	E, PO BOX 96			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE	
2 000	Continued From pag	e 1	2 000				
	these orders for your original to the addres	records and return the s below:					
	Minnesota Departme 1505 Pebble Lake Ro MN 56537 c/o Gail Anderson, U	oad, Suite 300, Fergus Falls,					
2 302	MN State Statute 144 or related disorder tra	4.6503 Alzheimer's disease ain	2 302				
	ALZHEIMER'S DISE DISORDER TRAININ MN St. Statute 144.6	NG:					
	Alzheimer's disease or related dis segregated or genera care staff	y serves persons with sorders, whether in a al unit, the facility's direct must be trained in dementia					
	related disorders; (2) assistance with a (3) problem solving v and (4) communication sl (c) The facility shall p written or electronic f training program, the trained, the frequenc topics covered.	Alzheimer's disease and ctivities of daily living; vith challenging behaviors;					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
			B. WING				
	ROVIDER OR SUPPLIER	00730	DDRESS, CITY, STATE		12/11/201		
			ST MAPLE AVENUE				
RAZEE (	CARE CENTER		, MN 56544	.,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE	
2 302	Continued From page	2	2 302				
	by: Based on interview at facility failed to ensur- information for care of disease and dementia form. In addition, the description of the train of employees trained, and the basic topics of During interview with (DON) on 12/12/14, at facility does not provi- required information r training. The DON st the requirement. The facility's current at reviewed with the direc (DSS). Facility service brochure and the DSS staff training for the c Alzheimer's and dement Review of the facility's a new resident upon at written or electronic of facility staff training of Alzheimer's disease at During interview on 1 administrator confirm informed their consur- training information. SUGGESTED METH DON or designee cou	ated she was not aware of admission packet was ector of social services ses were identified in the S confirmed information on are of resident's with entia was not included. s list of documents given to admission didn't include or access information of the r caring for residents with					

STATEMENT	a Department of Healt FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00730	B. WING		1:	2/11/2014
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
FRAZEE C	CARE CENTER		ST MAPLE AVENUE , MN 56544	E, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 302	Continued From page	e 3	2 302			
		n. The DON or designee nd conduct audits to ensure				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
2 500	MN Rule 4658.0275 After Discharge or De	Subp. 2 Return of Funds eath	2 500			
	a resident, a nursing resident's funds, and	resident. Upon the death of home must convey the a final accounting of those al or probate jurisdiction ident's estate.				
	by: Based on interview a facility failed to ensur conveyed within the	nt is not met as evidenced and document review, the re personal funds were appropriate time frame for 4 lents (DR1, DR2, DR3, and wed.				
	Findings include:					
	Trust Account Balance	/14. Review of the Resident ce report printed on 12/11/14, 197.20 currently in the er DR2 expired.				
	-	/14. Review of the Resident ce report printed on 12/11/14,				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		SURVEY PLETED		
	ROVIDER OR SUPPLIER	00730	T ADDRESS, CITY, STATE, ZIP CODE		12/11/201		12/1	
			ST MAPLE AVENUE					
-RAZEE (	CARE CENTER	FRAZEE	E, MN 56544					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE		
2 500	Continued From pag	je 4	2 500					
	revealed DR3 had \$21.29 currently in the account, 65 days after DR3 expired.							
	Trust Account Balan	9/14. Review of the Resident ce report printed on 12/11/14, 1170.88 currently in the er DR4 expired.						
	facility secretary indi receivable manager. trust account funds we month after a resider care and drug store fund account balance resident families if the the resident was not would be sent to the be returned to the co The secretary stated	on 12/11/14, at 2:15 p.m. the cated she was the accounts . The secretary stated that were held until the end of the nt death to be sure all hair bills had been paid. Trust es were returned to the he resident was private pay. If private pay, an affidavit county and the funds would bunty or to the funeral home. I social services designee es to the county when the ay.						
	the SSD verified the remaining greater th had expired. The SS protocol for resident when a resident exp a letter was sent to r deaths would be ser	on 12/11/2014, at 2:23 p.m. accounts with balances an 30 days after the resident 5D identified the usual funds had been as follows; ired Monday through Friday, notify the county, weekend at the following week. The trust account balance						
	241 days after the re have been sent to D the power of attorne would be sent to the The SSD identified a	facility account since April, esident expired, and should R1's family member who was y. The 3 other accounts county or funeral homes. a facility lack of follow up with resident trust						

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00730	B. WING		1:	2/11/2014
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
RAZEE	CARE CENTER		ST MAPLE AVENUE E, MN 56544	E, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 500	Continued From page	e 5	2 500			
	SSD clarified an ema after a resident death the county do what th affidavit is sent to us. DR3, and DR4, had t with the facility that h in the 30 day time fra further follow up is ro residents trust accou "send a second e-ma During and interview the director of nursing was responsible for c accounts following re verified she was awa conveyed within a ce however, was unawa The DON indicated th trust fund accounts a frame. The facility policy title Accounts, dated revis Procedure #6 Upon t	on 12/12/14, at 4:30 p.m. g (DON) verified the SSD conveyance of trust fund sident expiration. The DON re accounts were to be rtain amount of time; are of the exact time frame. he SSD was in charge of the nd would know the time ed Resident Personal sion 8/2005, identified in he death of a resident ds will be made within 30				
	designee could work ensure upon death th funds were conveyed	f Correction: The DON or with the business office to hat the resident's personal if in a timely manner. ection: Twenty one (21)				

STATE FORM

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00730	B. WING		12	2/11/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	·	
FRAZEE C	CARE CENTER		ST MAPLE AVENUE 5, MN 56544	E, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From page	e 6	2 560			
2 560	MN Rule 4658.0405 Plan of Care; Conten	Subp. 2 Comprehensive ts	2 560			
	objectives and timetal long- and short-term and mental and psyci identified in the comp assessment. The co- must include the indir required by Minnesof subdivision 14, parage This MN Requirement by: Based on interview a facility failed to devel the coordination of he resident (R62) who we care. In addition, the care plan for 1 of 5 re anti-psychotropic me Findings include:	of care must list measurable ables to meet the resident's goals for medical, nursing, hosocial needs that are prehensive resident mprehensive plan of care vidual abuse prevention plan ta Statutes, section 626.557, graph (b). In t is not met as evidenced and document review the op a care plan to address ospice services for 1 of 1 vas reviewed for hospice e facility failed to develop a esidents (R71) receiving dication.				
	initial certification for included a terminal d	with coexisting diagnoses				
	included an order to standing orders. The Morphine concentrat as needed for pain. mg buccal every 4 ho	ian orders dated 11/11/14 admit to hospice with orders also included, "6. e 2.5 mg buccal every 1 hour 7. lorazepam concentrate .25 burs as needed for anxiety. ng buccal every 8 hours as				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00730	B. WING		12/11/2014	
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
RAZEE C	CARE CENTER		ST MAPLE AVENUE	, PO BOX 96		
			E, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE <sup>-</sup> DATE
2 560	Continued From page	e 7	2 560			
		s. 9. #6-8 above to be ospice Red River Valley)				
	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.					
	director of nursing (E facility care plan was hospice care plan, inc	12/11/14, at 4:45 p.m. the DON) confirmed that the not integrated with the cluding a delineation of communications between				
	date of 12/8/14,identi identification of the us medication, the targe resident, any non-pha	ent care plan with revision fied the care plan lacked se of an antipsychotic t behaviors displayed by the armacological interventions, ects of the medication.				
	out behavioral disturt medication orders sig Seroquel (an antipsy	which included dementia with bance. R71's current gned 11/18/14, identified chotic medication) 25 mg ne for Psychosis, with a start				
	9/22/14, identified R7 dementia, a brief min identified severe cog	i mental status (BIMS) nitive impairment, and had not directed towards others 1				
	During an interview o	n 12/12/2014, at 1:40 p.m.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00730	B. WING		12	2/11/2014
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
RAZEE C	CARE CENTER		ST MAPLE AVENUE 5, MN 56544	a, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From page	e 8	2 560			
	care plan and the lac interventions regardin Seroquel use. RN-A practice for antipsych care plan which ident resident and possible medication.	ng resident behaviors and verified the facility's usual notic use would include a tified target behaviors of the				
	current care plan did Seroquel.	y policy was not provided.				
	SUGGESTED METH	IODS OF CORRECTION:				
	develop, review, and procedures to ensure plans according to th needs. The director of could educate all app and procedures. The	ng (DON) or designee could /or revise policies and e the facility develop care e residents individualized of nursing (DON) or designee propriate staff on the policies director of nursing (DON) or lop monitoring systems to poliance.				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Care	Subp. 1 Adequate and ; General	2 830			
		eneral. A resident must and treatment, personal and upervision based on				

STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00730	B. WING		12/11/2014	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
RAZEE C	CARE CENTER		ST MAPLE AVENUE , MN 56544	2, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page	e 9	2 830			
	the comprehensive replan of care as desc 4658.0405. A nursing of bed as much as po written order from the	preferences as identified in esident assessment and ribed in parts 4658.0400 and g home resident must be out ossible unless there is a e attending physician that the in bed or the resident oed.				
	by: Based on observation review, the facility fail wheelchair positionin reviewed for positionin failed to provide licen	nt is not met as evidenced n, interview, and document led to maintain comfortable g for 1 of 1 resident (R62) ing. In addition, the facility ised staff education dialysis for 1 of 1 resident				
	Findings include:					
	seated in a Broda wh bedroom. R62 was p the chair upright and straight downward wh R62's legs or feet; the actual footrest attach	22 p.m. R62 was observed neelchair (w/c) in her positioned with the back of the legrest positioned hich offered no support to e chair did not have an ed to it. R62's feet were ling approximately 10 inches				
	6:30 p.m. R62 was co dining room during th seated in a Broda w/o the chair upright and	50 p.m. until approximately ontinually observed in the supper meal. R62 was c positioned with the back of the legrest positioned R62's heels were observed				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00730			10	2/11/2014
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		12	./11/2014
			ST MAPLE AVENUE			
-RAZEE (	CARE CENTER	FRAZEE	, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page	e 10	2 830			
	the wheelchair. R62 from staff with eating	n between the webbing on the legrest of elchair. R62 required total assistance ff with eating and was not observed to be oned 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.					
	seated in a Broda w/o back of the chair pos legrest positioned str	a.m. R62 was observed c in her bedroom with the itioned upright and the aight downward. R62 was ees bent and feet curled at of the chair				
	seated in a Broda w/ back of the chair pos legrest positioned str foot was dangling and	18 p.m. R62 was observed c in her bedroom with the itioned upright and the aight downward. R62's left d right knee was bent with on the upper legrest webbing ne chair.				
	was observed seated bedroom with the bad upright and the legres downward. During th R62's feet were obse 10 inches from the flo the 11:00 a.m. observed	ne 8:19 a.m. observation erved dangling approximately por with no support. During vation R62's heels were ng slightly on the webbing of				

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		00730	B. WING		12	2/11/2014
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
RAZEE	CARE CENTER		ST MAPLE AVENUE , MN 56544	c, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From page	2 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.					
	with the director of nu nurse (RN)-A and RN Broda w/c in her room reclined slightly and th R62's legs/feet. The was proper positionin commented that this w R62 had looked in a l confirmed that the leg R62's w/c to support the from dangling. The Dr eating in the dining ro under/up to the table elevated so during mo	was the most comfortable ong time. The DON prest should by elevated on the legs/feet to prevent them ON stated that when R62 is om the w/c is not able to get				
	meal is over. The DC laminated sheet with should be positioned back of R62's w/c. T a picture of the w/c w indicated, "Place chai Tilt is the lower handle	DN showed surveyor a instructions of how the w/c that was attached to the he laminated sheet included hen positioned properly and r in tilt not just the recline. e. Also, elevate the legs." ded a foot rest which was				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00730	B. WING		12/11/2014		
NAME OF PI	ROVIDER OR SUPPLIER			, STATE, ZIP CODE			
RAZEE	ARE CENTER		ST MAPLE AVENUE	E, PO BOX 96			
			, MN 56544				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From page	e 12	2 830				
	<ul> <li>Continued From page 12</li> <li>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.</li> <li>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.</li> </ul>						
	R18's peritoneal dialy completed by staff wh dialysis provider (Day	no were not trained by the					
	10/16/14, identified d diabetes mellitus type treatments including o plan included peritono end stage renal disea Dialysis Policy and P	num Data Set (MDS) dated iagnoses which included e 2, and received specialized dialysis. R18's current care eal dialysis care related to ase. The facility form titled rocedure identified R18 oneal dialysis at the facility					
		s in-service training logs cent training had been					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			(X3) DATE SURVEY COMPLETED	
		00730	B. WING		12	2/11/2014	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				, ZIP CODE			
RAZEE C	ARE CENTER		ST MAPLE AVENUE ., MN 56544	E, PO BOX 96			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETI DATE	
2 830	Continued From page	e 13	2 830				
	completed 7/18/13. T	he DON stated licensed					
		-C and RN-C had performed					
		or R18 and provided their					
		. LPN-C was oriented to					
	-	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	y 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						
		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					
		al nurse (LPN)-A verified an					
	-	ed by Davita Dialysis from					
		ous resident who had the					
	, ,	(machine used for dialysis					
	-	ot specifically trained staff ed new nurses had been					
		rent nurse working the shift					
	the dialysis exchange	-					
	During an interview o	on 12/11/2014, at 1:27 p.m.					
		g (DON) verified new staff					
	training for dialysis pi						
		entation by the nurse on the					
		nge was performed. The					
		s in charge of the education					
		nd at this time the hands on s procedure was done with					
	the nurse working the	-					
	and the set of the set						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER	00730	ADDRESS, CITY, STATE		12/11/2014	
			ST MAPLE AVENUE			
		FRAZEE	, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page	e 14	2 830			
	p.m. the primary dialy staff were expected to resident's peritoneal of The undated facility p Center Dialysis Policy					
	DON or designee couprocedures or facility dialysis procedures, a and make any necess paperwork. Appropri regarding any change could develop a syste compliance.	OD OF CORRECTION: The uld review any policies, processes for resident and wheel chair possitioning sary revisions to facility ate staff could be educated es. The DON or designee em to monitor staff for CORRECTION: Twenty-one				
	(21) days.	CORRECTION. Twenty-one				
2 920	MN Rule 4658.0525	Subp. 6 B Rehab - ADLs	2 920			
	comprehensive reside home must ensure th B. a resident who is activities of daily livin	s unable to carry out g receives the necessary good nutrition, grooming,				
	by:	t is not met as evidenced n, interview, and document provide routine personal				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00730	B. WING		12/11/2014		
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	12/11/2014		
RAZEE C	ARE CENTER		ST MAPLE AVENUE	E, PO BOX 96			
FRAZEE, MN 56544       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION							
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE	
2 920	Continued From pag	le 15	2 920				
	grooming for 1 of 3 residents (R87) reviewed for activities of daily living (ADL's) who was dependent on staff for grooming. Findings include:						
	2 long hairs approximilength and multiple s	p.m. R87 was observed with nately 1 centimeter (cm) in shorter hairs visible on her r continued to be present and the survey.					
	diagnoses including and glaucoma per the temporary care plan resident required as showering, assist of set-up assistance wi The care plan furthe	the facility on 12/5/14 with right hip fracture, dementia, he facility face sheet. R87's dated 12/5/14 indicated the sistance of 1-2 staff with one staff with dressing, and th verbal cues with grooming. r identified a diagnosis of forgetfulness and intermittent					
	seated in her wheeld assistance with her t assistant (NA)-A. Ra hair present on her of NA-A who confirmed morning and that NA assisted her. NA-A usually offered to be and acknowledged th present. NA-A state morning when giving "Guess I just forgot". would like her to sha	101 p.m. R87 was observed chair in her room receiving relevision from nursing 87 continued to have facial chin. Surveyor interviewed 1 that R87 had a shower that A-A had been the staff who confirmed that residents were shaved on their bath day hat R87 had visible facial hair d she had noticed it that g R87 the shower and stated, . NA-A then asked R87 if she ive the facial hair and R87					
	agreed.						
	When interviewed or	12/12/2014 at 1:14 p.m.					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					12/11/2014	
		00730	B. WING			
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
RAZEE	CARE CENTER		ST MAPLE AVENUE , MN 56544	, FO BOX 30		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From page	e 16	2 920			
	residents to be offere	)-A stated she would expect d shaving on bath day and nfirmed R87 should have aved when bathed.				
	The director of nursin on the performance of	OD OF CORRECTION: g could provide education of providing activities of daily ith audits/observation.				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
21095	MN Rule 4658.0650 Storage of Nonperish	Subp. 4 Food Supplies; able food	21095			
	a minimum of six inch manner that protects other contamination, cleaning of the storag stored on equipment pallets, provided the e and constructed to all Nonperishable food a nonperishable food m exposed or unprotect	ishable food must be stored hes above the floor in a the food from splash and and that permits easy ge area. Containers may be such as dollies, racks, or equipment is easily movable low for easy cleaning. and containers of hust not be stored under ed sewer lines or similar contamination. The storage d in toilet rooms or				
	by:	t is not met as evidenced				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED		
		00700	B. WING				
	ROVIDER OR SUPPLIER	00730	DDRESS, CITY, STATE		12	12/11/2014	
			T MAPLE AVENUE				
RAZEE C	CARE CENTER		, MN 56544				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21095	Continued From page	e 17	21095				
	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.						
	DA-A verified the rolls	m. during the initial tour s of ground beef and the e floor of the walk in freezer o be on the floor."					
	DA-B verified the rolls beef roast were on th	m. during the initial tour s of ground beef and the e floor of the walk in freezer is suppose to be on the					
	confirmed that no me on the floor of the wa	o.m. dietary manager (DM) at or any food should be left lk in freezer. The DM stated, ntially get contaminated and					
	dated January 2013,	cy titled, Food Storage, indicated all food items nd clients will be stored					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		00730	B. WING		12	/11/2014
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	12	/11/2014
RAZEE	CARE CENTER		T MAPLE AVENUE , MN 56544	E, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
21095	above the floor, not e	e 18 ions, stored six inches exposed to floor moisture and on as they are delivered.	21095			
	The dietary director of storage policies and provide education to develop a monitoring compliance.					
21426		04 Subd. 4 Tuberculosis rol	21426			
	maintain a comprehe infection control prog current tuberculosis in issued by the United Control and Prevention Tuberculosis Eliminat Morbidity and Mortali This program must in infection control plan unpaid employees, con residents, and volunt Health shall provide to regarding implementa	ram according to the most nfection control guidelines States Centers for Disease on (CDC), Division of tion, as published in CDC's ty Weekly Report (MMWR). Include a tuberculosis that covers all paid and ontractors, students, eers. The Department of rechnical assistance ation of the guidelines.				
	(b) Written complian be maintained by the	ice with this subdivision must nursing home.				

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00730	B. WING			2/11/2014
NAME OF P	AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
FRAZEE (	CARE CENTER		ST MAPLE AVENUE	E, PO BOX 96		
	1		E, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From page	e 19	21426			
	by: Based on document facility failed to provid screen and a two ste	nt is not met as evidenced review and interview the de a tuberculosis symptom p TST or chest Xray for 2 of				
	5 employees in the s Findings include:	ample.				
	facility form titled Bas Healthcare Workers i screening was compl negative results. A TI on 10/15/14 with resu on 10/17/14. A secor	leted on 10/15/14 with B skin test was administered ults documented accurately nd skin test was not /9/14, greater than 7 weeks				
	The employee file lac symptoms screening 7-Day Clinic TB Skin skin test was adminis	A)-F was hired on 11/20/14, cked evidence a baseline TB was completed. A form titled Testing Form identified a TB stered on 6/10/14, and read 14, however; a second TB npleted.				
	director of nursing (D have a 2 step TB skin policy is to perform a year since the last te been done. The DON of the reason for the however: agreed it sh	on 12/11/14, at 3:00 p.m. the PON) verified AA-A did not in test. The DON stated the 2 step if it has been over a sting or if a 2 step had never indicated she was unsure gap between the tests, hould not have been longer in skin tests. The DON				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED 12/11/2014	
		00730	B. WING			
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
FRAZEE C	ARE CENTER		ST MAPLE AVENUE E, MN 56544	e, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21426	charge of the TB test NA-F's employee file and second step skin During an interview of human resources dire had a 7 week gap be HRD stated she belie test was to be comple- with in 60 days." The employee file contain with no TB symptom The HRD indicated th had completed the so form was for a two st one skin test given an The undated facility p Screening and Testin Procedure is to aid in tuberculosis and provision screening for Frazee volunteers. Procedur Center employees wi prior to the date of hi should be completed step. SUGGESTED METH The administrator, dir review and revise po surveillance. The ad	resources director was in ting. The DON also verified lacked a baseline screen in test. on 12/11/14, at 3:12 p.m. the ector (HRD) verified AA-A tween TB skin tests. The eved the second step skin eted "two weeks after but e HRD verified NA-F's ned only a one step skin test screen or two step skin test screen or two step skin test. that she believed the clinic creening and that the clinic trep skin test rather than for nd then read.	21426			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00730	B. WING		12/11/2014	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
FRAZEE C	CARE CENTER		T MAPLE AVENUE	E, PO BOX 96		
		FRAZEE	, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From page	e 21	21426			
	(21) days.					
21530	MN Rule 4658.1310	A.B.C Drug Regimen Review	21530			
	reviewed at least mor currently licensed by This review must be Appendix N of the Sta Surveyor Procedures Requirements in Lon the Department of He Health Care Financin This standard is inco available through the system. It is not subj B. The pharmaci irregularities to the di and the attending phy must be acted upon b physician visit, or soo pharmacist. For purp upon" means the acc report and the signing of nursing services at C. If the attendin with the pharmacist's not provide adequate pharmacist believes to being adversely affect refer the matter to the if the medical director physician. If the medical justification for the or	the resident's quality of life is cted, the pharmacist must e medical director for review r is not the attending dical director determines that an does not have adequate der and if the attending				
	justification for the or physician does not cl must be referred for r assessment and ass	der and if the attending nange the order, the matter				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			00730 B. WING			
	ROVIDER OR SUPPLIER	00730	ADDRESS, CITY, STATE	12	2/11/2014	
			ST MAPLE AVENUE			
FRAZEE		FRAZEE	, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From page	e 22	21530			
	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:					
	out behavioral disturt medication orders sig Seroquel (antipsycho	which included dementia with bance. R71's current gned 11/18/14, identified btic medication) 25 mg ne for Psychosis with a start				
	9/22/14, identified R7 dementia, a brief min identified severe cog	Minimum Data Set) dated 71 had a diagnosis of 11 mental status (BIMS) 11 nitive impairment, and had 12 towards others 1 to 3 days 11 period.				
	10/30/14, 17 days aft Seroquel and then ag identifying the lack of	icated the consulting R71's medications on ter the start date of the gain on 11/24/14, without				
nonoto Da		on 12/12/2014, at 1:40 p.m. )-A verified R71's record				

	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00730	2.1/11/2		12	12/11/2014	
NAME OF P	ROVIDER OR SUPPLIER		 DDRESS, CITY, STATE	, ZIP CODE			
FRAZEE (	CARE CENTER		ST MAPLE AVENUE	e, PO BOX 96			
			,	PROVIDER'S PLAN OF		()(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21530	Continued From page	e 23	21530				
	of target behaviors an interventions. RN-A s	itoring including identification nd non- pharmacological stated "we normally would itoring log for someone on					
	During an interview on 12/12/2014, at 12:3 the director of nursing (DON) confirmed no documentation was found regarding target behaviors and identified non- pharmacolog interventions. The DON stated the consulti pharmacist reviewed resident medications 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 consulting pharmacist verified the expectat that R71 would have behavior monitoring of target behaviors when receiving Seroquel.	g (DON) confirmed no ound regarding target ied non- pharmacological ON stated the consulting resident medications for and stated "we look at adations for (medication) d use behavior iew the behaviors.					
	these were not in pla The requested facility	/ policy was not provided.					
	The administrator, DO Pharmacist could rev procedures for assur- indications for use, po monitoring of medica educated as necessa	iew and revise policies and ing medications had arameters and proper tion usage. Staff could be ary. The DON or designee ations on a regular basis to					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00730	00730 B. WING		12/11/2014	
NAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	1 12	
RAZEE C	ARE CENTER		ST MAPLE AVENUE , MN 56544	E, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530 Continued From pag		e 24	21530			
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty one				
21540	MN Rule 4658.1315 Usage; Monitoring	Subp. 2 Unnecessary Drug	21540			
	monitor each resident unnecessary drug us home's policies and p pharmacist must repo- resident's attending p physician does not co- home's recommenda adequate justification believes the resident adversely affected, th matter to the medical medical director is no the medical director of physician does not he the order and if the a change the order, the review to the Quality (QAA) committee reo- the attending physic the consulting pharm directly to the QAA.	age, based on the nursing procedures, and the prot any irregularity to the physician. If the attending poncur with the nursing tion, or does not provide a, and the pharmacist 's quality of life is being the pharmacist must refer the director for review if the bot the attending physician. If determines that the attending ave adequate justification for ttending physician does not the matter must be referred for Assurance and Assessment quired by part 4658.0070. If ian is the medical director, acist shall refer the matter				
	by: Based on interview a facility failed to ensur reported medication physician and the dir	nt is not met as evidenced and document review, the re the consultant pharmacist irregularities to the attending ector of nursing for 1 of 5 medications were reviewed.				
	Findings include:					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY IPLETED
		00730			1:	2/11/2014
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
FRAZEE C	ARE CENTER		ST MAPLE AVENUE , MN 56544	E, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETI DATE
21540	Continued From pag	e 25	21540			
	out behavioral disturl medication orders sig Seroquel (antipsycho (milligrams) at bedtin date of 10/13/14. The quarterly MDS (I 9/22/14, identified R7 dementia, a brief mir identified severe cog behaviors not directed during the assessme The facility form titleo Regimen Review ind pharmacist reviewed	gned 11/18/14, identified otic medication) 25 mg ne for Psychosis with a start Minimum Data Set) dated 71 had a diagnosis of ni mental status (BIMS) nitive impairment, and had ed towards others 1 to 3 days int period.				
	identifying the lack of	gain on 11/24/14, without f monitoring, target ed interventions for the				
	registered nurse (RN lacked behavior mon of target behaviors a interventions. RN-A	on 12/12/2014, at 1:40 p.m. I)-A verified R71's record itoring including identification nd non- pharmacological stated "we normally would hitoring log for someone on				
	the director of nursin documentation was f behaviors and identif interventions. The Do pharmacist reviewed	on 12/12/2014, at 12:38 p.m. g (DON) confirmed no found regarding target fied non- pharmacological ON stated the consulting resident medications for and stated "we look at				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		00730			12	2/11/2014
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
RAZEE C	CARE CENTER		ST MAPLE AVENUE ., MN 56544	, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
21540	Continued From page	26	21540			
pharmacy recommendation reductions" and would us documentation to review		d use behavior				
	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.				
	desigee could work w consultant pharmacis were reviewed for un appropriate interventi place, and then could appropriate documen interventions. The DC perform audits of resi	Correction: The DON or with the medical director and t to ensure medications necessary medications, ons and monitoring was in educate staff on tation of behaviors and DN or designee could also dent records to determine if and documentation was in				
	Time Period for Corre	ection: Twenty one (21) days.				
21710	MN Rule 4658.1415 S Housekeeping, Opera		21710			
	supplied to sinks and maintained within a te	emperature. Hot water bathing fixtures must be emperature range of 105 o115 degrees Fahrenheit at				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
	ROVIDER OR SUPPLIER	00730	ADDRESS, CITY, STATE		12	2/11/2014
			ST MAPLE AVENUE			
RAZEE C	CARE CENTER		E, MN 56544	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21710	Continued From page	e 27	21710			
	by: Based on observation review, the facility fail environment that was related to hot water te resident bathrooms (I R78, R53, R69, R52, safe water temperatu Finding include: During the environme p.m. the administrato temperatures with the following water tempe -R18's resident bathro- -R67's resident bathro- -R61's resident bathro- -R68's resident bathro- -R68's resident bathro- -R69's resident bathro- -R52's resident bathro- -R52's resident bathro- -R52's resident bathro- -R52's resident bathro- -R53's resident bathro- -R53's resident bathro- the water temperature thermometer. the follower were observed: -R53's resident bathro- -R78's resident bathro-	e free of accident hazards, emperatures in 11 of 11 R14, R61, R33, R67, R29, R18, and R68) tested for res. ental tour on 12/8/14 at 5:30 r checked the water e facility thermometer. The eratures were observed: oom was 121 degrees (F) oom was 118 degrees (F) oom was 118 degrees (F) oom was 117.6 degrees (F) oom was 117.6 degrees (F) oom was 117.7 degrees (F) oom was 119.5 degrees (F) oom was 119 degrees (F) oom was 119 degrees (F) oom was 119 degrees (F) oom was 119.5 degrees (F) oom was 116.5 degrees (F)				
unesota Der	acceptable temperatue expected them to be	ure of 115 degrees F and under 115 F. he indicated ht hot water systems in the				

STATEMENT	a Department of Healt of DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00730	B. WING		12/11/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
FRAZEE C	CARE CENTER		ST MAPLE AVENUE E, MN 56544	E, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21710	building and these ro section of the building any complaints of any verified he checks the on a rotation schedul while residents are ear Review of the facility audits, revealed that for the last 4 months, completed on 12/2/14 Review of the facility Practices revised on operations superviso water temperature m temperatures at vario SUGGESTED METH The Environmental D and/or designee coul system to review wat resident level on a wa are between 105 and	oms are located in the new g and stated, "I have not had yone being burnt." MS also e water temperature weekly e and usually in the morning ating breakfast. 's monthly water temperature the audits were completed , with the last audit 4.	21710			
21885	MN St. Statute 144.6 Residents Of HC Fac	51 Subd. 21 Patients & Bill of Rights	21885			
	and residents may as privately with persons and, except as provid Commitment Act, lea choose. Personal ma interference and rece	nication privacy. Patients sociate and communicate s of their choice and enter ded by the Minnesota ve the facility as they ail shall be sent without eived unopened unless matically contraindicated				

Minnesota Department of Health STATE FORM

6899

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMP	SURVEY LETED
		00730	B. WING		10/11/2014	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	12/	11/2014
FRAZEE C	CARE CENTER		T MAPLE AVENUE , MN 56544	E, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21885		he physician in the medical s indicated of this subdivision	21885			
	by: Based on interview a facility failed to ensur their personal mail or practice had the pote in the facility. Findings include: During interview on	It is not met as evidenced nd document review the e that residents received n Saturdays. This deficient ntial to affect all 64 residents 12/11/14, at 9:42 a.m. the esentative (R1) reported that				
	Saturdays. During interview on 1 activity director (AD) does not deliver mail even though the post to the facility on Satu activity staff pick up t on Monday and deliv The AD confirmed the	eliver mail to residents on 2/11/4, at 9:50 a.m. the confirmed that the facility to residents on Saturday, al service delivers the mail rday. The AD reported the he mail from the front office ers the mail to the residents. e mail is not delivered to the rs of the postal service a Saturday.				
	administrator reporte the mail, and then the deliver the mail to the administrator was no delivered to the resid	t certain if the mail was				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
		00730			12	2/11/2014
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE <b>ST MAPLE AVENUE</b>			
RAZEE	CARE CENTER		, MN 56544	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
21885	Continued From page	e 30	21885			
	does deliver resident Saturdays and the m Monday morning the	firmed the postal service mail to the facility on ail is kept in the office until n the activity department il and delivers it to the				
S		tribution policy, indicated deliver the mail to residents				
	staff on resident right	f Correction: The educate the business office is related to mail. The quality e could audit mail delivery to				
	Time Period for Corre	ection: Twenty one (21)days.				
21995	MN St. Statute 626.5 Maltreatment of Vuln	57 Subd. 4a Reporting - erable Adults	21995			
	(a) Each facility shall ongoing written proc applicable licensing r of suspected maltrea facility has an interna mandated reporter m requirements of this s internally. However,	the facility remains lying with the immediate				
	by: Based on interview a facility failed to report	nt is not met as evidenced nd document review, the t an incident of potential diately to the State agency				

STATE FORM

STATEMEN	a Department of Healt T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00730	B. WING			2/11/2014
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		14	2/11/2014
			ST MAPLE AVENUE			
FRAZEE	CARE CENTER	FRAZEE	E, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
21995	Continued From page	e 31	21995			
	(SA) for 1 of 3 resider potential abuse/negle	nts (R77) reviewed for ect.				
	Findings include:					
	diagnoses including: anxiety per the facility minimum data set (M 11/5/14 indicated R77 assistance with bed r room, dressing, eatin hygiene. The brief in (BIMS) scored 99 ind complete the assess for cognition indicated term memory probler related to cognitive st making.	nobility, transfer, walk in ig, toilet use, and personal terview for mental status licating R77 was unable to ment. The staff assessment d R77 had long and short ns and severe impairment kills for daily decision				
	an incident dated 7/2 R77. The incident deresident sitting on floo doorway" The physi indicated: "No scrape unable to bear weigh further indicated there incident. Review of ti entry dated 7/27/14 a "Found resident sittin 2.55 p.m. No witness When asked, resident further indicated the r hip pain and was una side without pain. Th notified and order rece emergency room (ER	as incident reports revealed 7/14 at 2:55 p.m. involving escription indicated: "I found or right outside her sical assessment findings es or bruising, but resident t without pain." The report e were no witnesses to the he nurses notes revealed an at 10:45 p.m. indicating: g outside of doorway @ (at) ses to what happened. at stated "I fell"." The note resident had increased right able to bear weight on right ne nurse practitioner was ceived to transfer R77 to the R) for further evaluation. The uently admitted to the to the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		E SURVEY PLETED	
		00730			12/11/2014	
IAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	12	/11/2014
RAZEE	CARE CENTER		ST MAPLE AVENUE 5, MN 56544	, PO BOX 96		
				PROVIDER'S PLAN OF		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From page	e 32	21995			
	the director of nursing resulting in a fracture the SA. The DON st the care plan and wo to see the circumstar it was witnessed or n When interviewed at DON confirmed that I witnessed by staff. T the resident had seve was able to state she though was unable to surrounding the fall. The facility's policy tif Prevention/Resident November 2011, inclu- facility to take approp- occurrence of: Abuse Neglect Misappropriation of re- It is also the policy of appropriate steps to o violations of federal of mistreatment, neglec source, and misappro- ("alleged violations") the administrator of the are also reported imm accordance with exis investigates such alle reports the results of	12/11/2014, at 5:08 p.m. the R77's fall had not been the DON stated that though ere cognitive impairment she had fallen when asked preport the circumstances tied, Abuse Treatment, revised uded: "It is the policy of this priate steps to prevent the				

Minnesota Department of Healt STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 12/11/2014	
		00730				
IAME OF P	ROVIDER OR SUPPLIER	1	DDRESS, CITY, STATE	, ZIP CODE		
RAZEE	CARE CENTER		ST MAPLE AVENUE	, PO BOX 96		
		FRAZEE	, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	CTION SHOULD BE COMPLETI D THE APPROPRIATE DATE	
21995	Continued From pag	le 33	21995			
	The administrator, D designee(s) could re necessary the policie the internal process process of abuse or administrator, DON, designee(s) could pr appropriate staff on t procedures. The adm services or designee all reports of abuse a investigated.	es and procedures regarding of reporting/investigating the maltreatment. The social services or ovide training for all				