Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 12, 2023

Administrator
Frazee Care Center
219 West Maple Avenue
Frazee, MN 56544

RE: CCN: 245299
Cycle Start Date: March 2, 2023

Dear Administrator:

On March 15, 2023, we notified you a remedy was imposed. On April 4, 2023 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 31, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 30, 2023 be discontinued as of March 31, 2023. (42 CFR 488.417 (b))

However, as we notified you in our letter of March 15, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 30, 2023. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
March 15, 2023

Administrator
Frazee Care Center
219 West Maple Avenue
Frazee, MN 56544

RE: CCN: 245299
Cycle Start Date: March 2, 2023

Dear Administrator:

On March 2, 2023, a survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On March 1, 2023, the situation of immediate jeopardy to potential health and safety cited at F578 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 30, 2023.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 30, 2023, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 30, 2023, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 30, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Frazee Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 30, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

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 September 2, 2023 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with

which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900

St. Paul, Minnesota 55164-0900

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

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

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 03/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 2/27//23, to 3/2//23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/27/23, to 3/2/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H52998816C (MN90688). The survey resulted in an Immediate Jeopardy (IJ) at F578 when the facility failed to follow the facility's policies and procedures and failed to ensure resident advance directives were accurately documented in the residents paper and electronic health record to reflect the residents current wishes, which affected 1 of 17 residents. The IJ began on 2/28/23, and the immediacy was removed on 3/1/23. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are	F 000		

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

Electronically Signed | 03/25/2023

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

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F 000	Continued From page 1 enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550		3/31/23

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F 550	Continued From page 2 or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to communicate in a dignified manner to 1 of 1 residents (R17) reviewed for medication administration. Finding include: R17's quarterly Minimum Data Set (MDS) dated 12/15/22, identified R17 was severely cognitively impaired and had diagnoses which included traumatic brain injury, quadriplegia and seizure disorder. Indicated R17 was totally dependent on staff for all activities of daily living and required nutritional feedings via feeding tube. R17's care plan revised on 2/21/23, indicated R17 preferred to be called by her family name and staff were to reinforce personal connection by using preferred name with each interaction. During observation of medication administration on 2/27/23, at 4:01 p.m. R17 laid in bed covered with a blanket and the head of her bed was elevated. Licensed practical nurse (LPN)-A	F 550	Corrective Action: LPN-A received reeducation regarding addressing residents by their preferred name, and refraining from using nicknames or terms of endearment unless indicated on the resident's plan of care. Corrective Action as it Applies to Others: Other residents will be interviewed to establish individual preferences for their preferred name. Care plans will be updated and include resident approved terms of endearment, or nicknames based on the resident's personal choice. Prevent Recurrence: The policy for Dignity was reviewed and remains current. Staff meetings to educate staff on the policy was on 3/22/23. Date of Compliance: 03/31/2023 Ongoing Monitoring: Random audits will be conducted to ensure staff address	

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F 550	Continued From page 3 knocked on the door, entered R17's room with medications in hand and said "hello sweet heart, how ya doing today baby". LPN-A proceeded to raise the bed to a working level, sanitized her hands, gloved her hands and administered eye drops into R17's eyes. LPN-A removed her gloves, donned a new pair of gloves and administered R17's other medications while saying "ok baby girl." R17 began to cough and LPN-A said "you ok baby, ok" and continued to administer R17's medications while saying "almost done sweet heart." LPN-A continued to administer R17's medication and asked R17, "are you having a good day baby." LPN-A finished administering R17's medications, cleaned up her supplies, removed her gloves, sanitized her hands while saying "thank you baby" and immediately left R17's room On 3/1/23, at 2:16 p.m. nurse manager (NM)-A confirmed the above finding and indicated R17 preferred to be called by her name or nickname. NM-A indicated she would expect staff to follow R17's care plan and it was not acceptable to be using other nicknames or to be talking to residents in a different tone of voice. NM-A stated it was not respectful or dignified to talk to a resident in that manner. On 3/1/23, at 2:37 p.m. the director of nursing (DON) confirmed the above finding and indicated she would expect staff to follow R17's care plan and the facility policy. The DON indicated R17 preferred to be called by her nickname and verifed staff should not be changing their tone of voice or using other nicknames. The DON stated talking to R17 in that manner was not dignified or respectful.	F 550	residents in a manner that promotes each person's individual preferences by refraining from using terms of endearment or nicknames unless care planned otherwise. Three random audits will be conducted as follows: • 5x for 2 weeks • 3x weekly for 2 weeks • 2x for 2 weeks • weekly x4 weeks. A summary of audit results will be reviewed by the IDT during the monthly QAPI meeting for further auditing recommendations. Monitored By: Don/Designee will monitor the corrective action for ongoing compliance.	

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F 550	Continued From page 4 On 3/2/23, at 10:20 a.m. family member (FM)-A confirmed R17 would not want to be called anything other than her name or nickname and that it would bother her. Review of facility policy titled, Dignity Quality of Life revised on 10/22, indicated in full recognition of his or her individuality, the facility promoted care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect. Respecting social status by speaking and acting respectfully.	F 550		
F 578 SS=J	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		3/31/23

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F 578	Continued From page 5 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident advance directives were accurately documented in the clinical record to reflect the residents' current wishes which affected 1 of 17 residents (R20) reviewed for advanced directives. This deficient practice resulted in an immediate jeopardy (IJ) for R20 who would have received cardiopulmonary resuscitation (CPR), contrary to their wishes, in the absence of a pulse or respirations. The IJ began on 2/15/23, when R20's electronic health record (EHR) main screen and orders identified R20 was to have CPR however, R20's updated POLST signed on 2/15/23, identified R20's wishes of do not resuscitate (DNR). The administrator, assistant administrator and director of nursing (DON) were notified of the IJ on 2/28/23, at 5:39 p.m. The IJ was removed on 3/1/23, at 1:55 p.m. when the facility had	F 578	F578 Request/Refuse/Discontinue Treatment/Formulate Advance Directives (J) Corrective Action: The POLST form and electronic medical record for R20 were immediately updated to ensure the documentation accurately reflected the residents wishes for advance directives. The resident has not been adversely affected by the alleged deficient practice. Corrective Action as it applies to others: A review of all other residents was completed on 2/28/2023 to ensure that POLST forms are current, and accurately documented in the medical record based on the residents wishes. The audit revealed all other residents had accurately documented advance directives, and care planned interventions.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 6 implemented corrective action, however non-compliance remained at the lower scope and severity level of D, isolated with no actual harm but potential to cause more than minimal harm. Findings include: R20's annual Minimum Data Set (MDS) dated 11/30/22, identified R20 had mild cognitive impairment and diagnoses which included: hypertension, emphysema (lung condition that causes shortness of breath) and Alzheimer's disease. R20's care plan revised 9/6/22, identified R20's advanced directives to be followed per medical provider (MD) orders. The care plan indicated the POLST would be reviewed as needed and placed in the front of R20's paper chart. R20's POLST signed by the medical provider on 2/15/23, identified DNR, scanned into R20's EHR. R20's POLST signed by the medical provider on 4/1/20, identified CPR, which was located in R20's paper medical record and in addition was scanned into R20's EHR. The paper chart lacked the most current updated POLST from 2/15/23. Review of R20's EHR orders on 2/27/23, at 5:16 p.m. identified the order for CPR which had a revision date of 2/7/23. The EHR lacked an order for DNR. Review of R20's progress notes from 2/1/23, to 2/27/23, identified the following: -2/13/23, at 12:50 p.m. discussion with R20's guardian regarding R20's POLST and goals of care, provider felt R20 was more appropriate for	F 578	Prevent Recurrence: The policy and procedure for Advance Directives was reviewed by the Executive Director, Assistant Administrator, Director of Nursing, and Regional Director of Quality and Clinical Services on 2/28/2023. The policy for Advance Directives remains current and up to date. Education was provided to the Director of Nursing on 2/28/2023, and licensed nursing staff on 3/1/2023. Date of Compliance: 3/1/2023 Ongoing Monitoring: Documentation audits will be completed to ensure each residents records are current and accurately reflect the residents wishes for advance directives. Three random audits will be conducted as follows: • 5x for 2 weeks • 3x weekly for 2 weeks • 2x for 2 weeks • weekly x4 weeks. A summary of audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored By: Don/Designee will monitor the corrective action for ongoing compliance.	

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F 578	Continued From page 7 DNR status as R20 did not desire any further medical interventions for care and did not wish to leave the facility. R20's guardian agreed and R20's POLST was changed to DNR. During an interview on 2/28/23, at 12:07 p.m. registered nurse (RN)-B indicated in the event a resident did not have a pulse or respirations, RN-B would refer to the resident's paper chart for code status. RN-B reviewed R20's paper chart and confirmed R20's POLST identified CPR was to be administered. RN-B stated the facility had instructed staff to follow the POLST in the paper chart. During an interview on 2/28/23, at 12:19 p.m. RN-A stated in the event of a resident experiencing cardiac arrest, staff were instructed to refer to POLST in the resident's paper chart. RN-A confirmed R20's POLST identified CPR and RN-A stated she would call 911 and begin CPR on R20 in the event of cardiac arrest. During an interview on 2/28/23, at 1:38 p.m. RN-C stated in the event a resident was not breathing or unresponsive, she would review the POLST in the resident's paper chart to determine code status. RN-C indicated the facility had provided education to staff to review the residents' paper charts to determine their code status. During an interview on 2/28/23, at 1:43 p.m. DON stated residents' POLST were completed with residents and/or their representative and their provider when they were admitted to the facility. DON stated the facility process involved completing the POLST with the resident or representative upon admission, make a copy of	F 578		

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F 578	Continued From page 8 the POLST and placing in the resident's paper chart until it was reviewed and signed by the provider. Once the POLST was signed by the provider, staff were expected to place a gold copy of the form in the front of the resident's paper chart and scan it into the resident's EHR. DON identified if a resident was CPR, those wishes would also be identified in the resident's orders and would show up on their EHR. Further, if the resident's POLST identified DNR, the order would read "see POLST". DON stated the facility recently completed education to the nursing staff on advanced directives which directed the staff to always look in the front of the paper chart in the event of cardiac arrest to assure the resident's wishes were followed. During a follow-up interview at 2:01 p.m. DON reviewed R20's POLST in R20's paper chart, confirmed the POLST identified CPR and verified it was inaccurate. DON reviewed R20's EHR and confirmed R20's main screen and orders identified CPR and again verified it was inaccurate. DON reviewed R20's current POLST signed 2/15/23, located in R20's EHR scanned forms which identified DNR and verified it reflected R20's current wishes. During a follow up interview at 2:26 p.m. DON stated POLST orders were completed by nurse manager (NM)-A, MDS coordinator (MDSC)-A, RN-B, or herself. DON indicated she had completed R20's POLST signed on 2/15/23, with the guardian and had placed it in the provider's file for review and signature. DON verified she was not certain where the paper copy of the POLST was currently located. At 4:00 p.m. DON confirmed R20's current POLST signed 2/15/23, had been found in the providers folder at the	F 578		

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F 578	Continued From page 9 nurses station. DON confirmed R20's POLST orders and paper chart had not been updated after R20's provider had reviewed and signed R20's updated POLST. The facility policy titled Advanced Directives and Rights Regarding Treatment revised 10/22, identified the resident had the right to refuse treatment and to formulate an advanced directive. Identified if a resident had an advance directive or completed an advanced directive upon admission copies would be obtained and the documents would be consistently maintained in the same section of the resident's medical record and readily retrievable by any facility staff. Indicated the community would periodically review the existing care instructions and whether the resident wishes would change or continue with these instructions. Identified the resident's choices would be documented and communicated to the interdisciplinary team. The IJ was removed on 3/1/23, at 1:55 p.m. when the facility developed and implemented a systemic removal plan which was verified by interview and document review: -All residents' records were reviewed to ensure the POLST form and electronic medical record were updated to ensure resident's wishes for advance directive and care plan interventions were accurate on 3/1/23. -The Advanced Directive policy was reviewed on 2/28/23. -Nine RNs and two licensed practical nurses (LPNs) were educated on the policy for advanced directives, obtaining and documenting the POLST to reflect the resident's wishes, on 2/28/23, to 3/1/23, as evidenced by the Education Sign in Sheet.	F 578		

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F 578	Continued From page 10 -A process was implemented to assure all other nurses completed mandatory education prior the start of their next shift on 3/1/23, by notification of required mandatory education via phone/text. -During interviews on 3/1/23, RN-D, NM-A, RN-A, RN-C, and DON, verified they received education regarding policies for advance directives, obtaining and documenting the POLST to reflect the resident's wishes.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		3/31/23

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F 584	Continued From page 11 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure housekeeping services for a clean environment was provided for 1 of 1 resident (R2) who had a soiled wheelchair. Findings Include: R2's quarterly Minimum Data Set (MDS) dated 2/2/23, identified R2 was cognitively intact and had diagnoses which included: multiple sclerosis (disease of the central nervous system that affected the flow of information between brain and body) paraplegia (paralysis of lower part of body) and depression. Identified R2 required extensive assistance with activities of daily living (ADL) and limited assistance for eating. R2's care plan revised 2/27/23, identified R2 had potential for complications with deficits with ADLs related to dependence on staff for cares and transfers and had diagnoses of multiple sclerosis and paraplegia. R2's interventions identified staff assistance in all areas of ADLs with set up assistance for eating.	F 584	Corrective Action: The wheelchair for R2 was cleaned. Corrective action as it applies to others: An audit will be completed to ensure other wheelchairs are clean and free from visible soiling. Prevent Recurrence: The policy for environment/equipment cleaning was reviewed and remains current. A wheelchair cleaning schedule will be developed to ensure wheelchairs are cleaned on a routine basis, and spot cleaned as needed when soiled. Staff will be educated on the policy and cleaning schedule by 03/22/2023. Date of Compliance: 03/31/2023 Ongoing Monitoring: Visual audits will be completed to ensure resident equipment is clean and in good repair. Three random audits will be conducted as follows: • 5x for 2 weeks	

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F 584	Continued From page 12 On 2/28/23, at 12:08 p.m. nursing assistant (NA)-C transported R2 in his wheelchair to the dining room. R2's wheelchair cushion on the left side was visibly soiled with multiple white, tan and brown spots varying in size from pin point to one quarter inch in size. On 3/1/23, at 11:26 a.m. R2's wheelchair cushion was visibly soiled on the left side, from the front of the cushion to a few inches from the back. The cushion had white, tan and brown spots varying in size from pin point to 1/4 inch, covering the area. Additionally, the metal areas of his wheelchair and the wheel on the left side had multiple light colored spots, spills, and dust. R2's cushioned foot pedals had multiple crumbs, food and a few spots as well. Registered nurse (RN)-A confirmed R2's wheelchair was visibly soiled, began to wipe R2's wheelchair cushion with a moistened paper towel and picked crumbs and food out of the foot pedals. During an interview on 3/1/23, at 11:36 a.m. RN-A indicated she would expect the nursing assistants to clean R2's wheelchair when it was soiled. RN-A stated R2's wheelchair cushion should have been removed and sent to laundry for cleaning. Additionally, R2's wheelchair should have been cleaned in the facility wheelchair washer. During an interview on 3/1/23, at 12:00 p.m. nurse manager (NM)-A indicated the facility was working on a schedule to assure resident's wheelchairs were cleaned regularly and stated she expected the nursing assistants to wipe off wheelchairs when soiled. During an interview on 3/1/23, at 2:16 p.m.	F 584	• 3x weekly for 2 weeks • 2x for 2 weeks • weekly x4 weeks. A summary of audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored By: Don/Designee will monitor the corrective action for ongoing compliance.	

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F 584	Continued From page 13 director of nursing (DON) stated she expected staff to keep all residents' wheelchairs clean. DON indicated it was important to keep the wheelchairs clean to maintain a resident' s dignity and for infection prevention purposes. DON stated dependent on the size, the wheelchairs could either be cleaned by the facility wheelchair washer or wiped down by staff. DON indicated wheelchair cushion covers should be removed and laundered, or the cushion replaced when soiled. The facility policy titled Environment-Cleaning Of Equipment revised 10/22, identified the community provided a clean, safe, comfortable, and homelike environment. The policy identified all unit equipment, including wheelchairs, were cleaned on a routine basis. The facility policy titled Wheelchair Cleaning And Routine Maintenance revised 3/22, identified wheelchairs would be maintained in a clean, sanitary and functional condition. The policy identified wheelchairs would be spot cleaned, as needed, to remove any food particles, spilled liquids, or soiling as soon as reasonably possible. The policy identified routine washing of wheelchairs would be completed weekly or more often as needed to remove heavily soiled debris and removable wheelchair cushions would be cleaned and disinfected with an EPA approved disinfectant weekly or as needed.	F 584		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		3/31/23

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F 677	Continued From page 14 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide shaving assistance and personal care for 1 of 3 residents (R33) who was dependent on staff to provide personal hygiene. Findings include: R33's quarterly Minimum Data Set (MDS) dated 12/14/22, indicated R33 was cognitively intact and had diagnoses which included spinal stenosis, muscle weakness and difficulty walking. R33 required limited assistance from staff with bed mobility and transfers Identified R33 required extensive assistance with dressing, toileting, bathing and personal hygiene. R33's care plan revised on 3/1/23, indicated R33 had complications with deficits with activities of daily living (ADL's) related to closed compound fracture of L4 vertebrae to L5, spinal stonosis, weakness and repeated falls. Staff were to assist R33 with personal hygiene. R33's Visual/Bedside Kardex Report dated 3/1/23, indicated R33 required staff assistance with personal hygiene. During observations on 2/27/23, at 1:08 p.m. R33 was seated in his wheel chair in his room and was watching TV. R33's white hair was uncombed, unkept and had white, thick, facial hair all over his entire facial area that was approximately 1/4 of an inch or longer. R33 indicated staff assisted him with dressing and getting ready for the day.	F 677	Corrective Action: R33 was shaved, and his hair was combed. Corrective Action as it Applies to Others: Other residents were evaluated to ensure ADL care including shaving and hair care was provided per individual care planned interventions. Prevent Recurrence: The policy for Activities of Daily Living was reviewed and remains current. Staff will be reeducated on the policy by 03/22/2023. Date of Compliance: 03/31/2023 Ongoing Monitoring: Visual audits will be completed to ensure dependent residents are clean shaven, and hair care is provided in accordance with individualized care planned interventions. Three random audits will be conducted as follows: • 5x for 2 weeks • 3x weekly for 2 weeks • 2x for 2 weeks • weekly x4 weeks. A summary of audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored By: Don/Designee will monitor the corrective action for ongoing compliance.	

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F 677	Continued From page 15 - at 2:14 p.m. R33's hair and facial hair remained the same. R33 indicated he wanted the staff to assist him with shaving, while he took his right hand and rubbed his facial area and under his neck area and stated I would like it if they would do it for me. - at 5:01 p.m. R33's hair and facial hair remained the same while he ate supper in his room. During observations on 2/28/23, at 9:51 a.m. R33 was wheeling himself down the hallway in his wheel chair independently using his feet. R33's white hair was uncombed, with roosters sticking up on both sides of his head and his hair was pasted to the back of his head. R33 also had white, thick, facial hair all over his entire facial area that was approximately 1/4 of an inch or longer. - at 9:53 a.m. R33's call light was on and nursing assistant (NA)-C entered his room and R33 was seated on the toilet. NA-C told R33 to turn his call light on when he was done and she left the room shortly after. R33's hair and facial hair remained the same. At 10:01 a.m. R33 put his call light on, NA-C knocked, entered the room and asked R33 if he was going to go to therapy today. NA-C had R33 choose a clean pair of pants, gloved her hands, changed R33's incontinent brief, assisted R33 to a standing position, provided peri cares and pulled up his brief and pants. NA-C assisted R33 to transfer/sit down in his wheel chair, collected the garbage/linen and immediately left R33's room while he thanked her. NA-C did not assist or offer to combed or shave R33's hair. - at 10:43 a.m. R33 was seated in his wheel chair in the therapy room doing exercises with other residents. R33 had white, thick, facial hair all over his entire facial area that were	F 677		

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F 677	Continued From page 16	F 677		

approximately 1/4 of an inch or longer.
- at 12:11 p.m. R33's hair and facial hair remained the same while he ate his lunch independently in his room.

During observations on 3/1/23, at 8:01 a.m. R33 was seated on the edge of his bed eating his breakfast independently. R33's white hair was uncombed and had roosters sticking up on his head. R33 also had white, thick, facial hair all over his entire facial area that was approximately 1/4 of an inch or longer. R33 indicated he gets a bath every Friday.
- at 10:33 a.m. R33's hair and facial hair remained the same while he talked on the phone in his room.

During an interview on 3/1/23, at 10:39 a.m. NA-A confirmed R33 needed assistance with personal hygiene, grooming, and shaving. NA-A indicated she had not offered to shave R33 and indicated he usually gets shaved on his bath days. NA-A indicated staff were to make sure R33 personal hygiene was getting done and to assist his as needed. NA-A indicated R33 has never refused cares for her.

During an interview on 3/1/23, at 12:06 p.m. NA-B verified R33 receives a bath every Friday and staff shave him on his bath days. NA-C indicated she thought R33 shaved himself everyday by himself. NA-C verified R33 care plan and indicated R33 needed staff assistance for personal hygiene and shaving. NA-C confirmed she had not offered to shave R33 and stated we should be following his care plan.

During interview on 3/1/23, at 11:40 a.m. registered nurse (RN)-A confirmed R33's hair was

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F 677	Continued From page 17 unkept and not combed and he had not been shaven. RN-A indicated R33 required staff assistance with personal hygiene and grooming and indicated the resident usually get shaved on their bath days and as needed. RN-A indicated she would expect staff to make sure the residents are being shaved and well groomed and verifed staff should be following his care plan. During interview on 3/1/23, at 2:47 p.m. the director of nursing (DON) confirmed R33 care plan and indicated R33 required staff assistance with personal hygiene. The DON indicated she would expect staff to offer shaving every day and to comb his hair and to be following R33's care plan. Review of the facility policy titled, Activities of Daily Living revised on 10/22, indicated resident's who are unable to carry out ADL's receives the necessary services to maintain goo nutrition, grooming and personal hygiene.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care and	F 684	Corrective Action: Hospice was contacted for R9 and a care plan and schedule of	3/31/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 18 services, were coordinated with an outside hospice agency for 1 of 1 resident (R9) reviewed for hospice care. Findings include: R9's significant change Minimum Data Set (MDS), dated 1/13/23, identified R9 had diagnosis which included hypertension (elevated blood pressure) diabetes mellitus (DM) and traumatic brain injury (TBI). Indicated R9 had moderately impaired cognition and required limited assistance with activities of daily living (ADL's) including of bed mobility, toileting, and transfers and received hospice care while a resident of the nursing home. R9's care plan dated 1/6/23, identified R9 had orders for hospice care for a diagnosis of senile degeneration of the brain with comorbidity of malnutrition. A goal was listed which read, (R9) will have management of comfort-physical, psychosocial, spiritual; so that life is neither hastened or prolonged but follows R9's process of concluding life. Review of R9's chart lacked an integrated hospice care plan from the hospice agency. Review of R9's progress notes dated 2/24/23, indicated on 2/22/23, hospice agency had been meeting with hospice provider to discuss pain medications for R9, however the facility had not received orders for the medication until 2/24/23. During an observation on 3/2/23, at 8:55 a.m. a hospice schedule on the inside of R9's door indicated a hospice aide was scheduled to visit twice last week, social worker was scheduled to	F 684	hospice visits was received from the hospice agency. Corrective Action as it Applies to Others: A review will be completed for other residents receiving hospice services to ensure hospice care plans and visit schedules are readily available and accessible to staff to facilitate coordination of care. Prevent Recurrence: The policy for Hospice Care was reviewed and remains current. Staff will be educated on the policy by 03/22/2023. Date of Alleged Compliance: 03/31/2023 . Ongoing Monitoring: Ongoing audits will be completed to ensure hospice services and provider visits occur in accordance with the individualized care plan and visit schedule. Three random audits will be conducted as follows: • 5x for 2 weeks • 3x weekly for 2 weeks • 2x for 2 weeks • weekly x4 weeks. A summary of audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored By: Don/Designee will monitor the corrective action for ongoing compliance.	

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	245299	A. BUILDING _____ B. WING _____	C 03/02/2023

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F 684	Continued From page 19 visit once during the week of 2/6/23, and 2/13/23. The schedule lacked evidence of when a nurse was scheduled to visit R9 in the month of 2/23. A schedule for March 2023 was not posted. During an interview on 3/2/23, at 9:00 a.m. nursing assistant (NA)-A stated she had worked with R9 in the past month, however was not aware R9 was on hospice. NA-A stated she was unsure how hospice communicated with staff to notify them when they would be on site to provide cares for R9. During an interview on 3/2/23, at 9:10 a.m. NA-B stated she had worked with R9 several times in the past month, however was unsure of what, if any services R9's hospice agency was providing for R9. NA-B stated she was not aware of any hospice schedule and only became aware they were coming when they arrived to the facility. During an interview on 3/2/23, at 9:15 a.m. nurse manager (NM)-A stated R9 had been on hospice since 1/6/23. NM-A confirmed the facility had not received R9's hospice care plan from the agency to ensure coordination of care even though the facility had requested one. NM-A stated the hospice agency had not provided a schedule of hospice visits for R9 to the facility. As a result, NM-A stated the facility created and placed a schedule in R9's room of when they anticipated hospice staff would visit. NM-A indicated when hospice staff did visit, they often left without communicating with the facility staff regarding resident status. Additionally, NM-A stated there had been a significant delay in obtaining pain medication for R9 as the hospice agency had not returned the facility's phone calls timely.	F 684		

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F 684	Continued From page 20 During an interview on 3/2/23, at 9:29 a.m. director or nursing (DON) stated she was unsure of what the hospice agency's process was for ensuring the facility received a hospice care plan and when a hospice visiting schedule would have been provided to the facility to ensure coordination of care. DON indicated her expectation was the facility would have received a hospice care plan for R9 and a schedule of the hospice visits for R9 in a timely manner. During an interview on 3/2/23, at 9:57 a.m. hospice manager (HM) verified R9 was receiving care from their agency. HM stated the hospice agency usually sent out the frequency of hospice visits to the facilities. NM stated the facility should have received a copy of the hospice care plan as soon as it had been developed. HM further stated his expectation was when a hospice visit had been provided, the hospice staff would have communicated with the nurse or nurse leader at the facility to ensure coordination of care. During an interview on 3/2/23, at 10:22 a.m. hospice social worker (HSW) stated she was unsure if the facility had received a copy of R9's hospice care plan. HSW indicated her expectation was the facility would have received a copy of the hospice care plan and when a nurse made a visit they would have communicated with the nurse at the facility. A facility policy titled Hospice Care revised 3/1/14, indicated when a resident received hospice care the facility's care plan should have been integrated with the hospice agency's plan of care. The policy identified the Hospice company was to collaborate with the facility to provide a schedule of hospice visits and duties.	F 684		

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with repositioning, for 1 of 2 residents (R2) reviewed for pressure ulcers. Findings include: R2's quarterly Minimum Data Set (MDS) dated 2/2/23, identified R2 was cognitively intact and had diagnoses which included: multiple sclerosis (disease of the central nervous system that affected the flow of information between brain and body) paraplegia (paralysis of lower part of body) and depression. Indicated R2 required extensive assistance with activities of daily living (ADL) and limited assistance for eating. Identified R2 was at risk of pressure ulcers and had one stage two (partial thickness loss of dermis presenting as a shallow open ulcer) and two stage IV (full thickness tissue loss with exposed bone, tendon or muscle) unhealed pressure	F 686	Corrective Action: R2's wound was reassessed following discovery of the alleged violation. The wound remained unchanged. Corrective Action as it Applies to Others: Other residents with pressure ulcers were reviewed to ensure their care plans remained current and up to date with appropriate interventions to promote wound healing. Prevent Recurrence: The policy titled Pressure Ulcer / Skin Integrity was reviewed and remains current. Staff will be reeducated on the policy to promote wound healing and tissue integrity by 03/22/2023. Date of Alleged Compliance: 03/31/2023 Ongoing Monitoring: Visual audits will be conducted to ensure continued compliance with providing repositioning according to individualized care plans to	3/31/23

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F 686	Continued From page 22 ulcers, and one stage four pressure ulcer present on admission. Identified R2 utilized a pressure relieving device in chair. R2's MDS lacked documentation R2 was on a turning/repositioning schedule. R2's admission care area assessment (CAA) dated 11/16/22, identified R2 was totally dependent on staff for all ADLs. Identified R2 had a stage four pressure ulcer, required total dependence for bed mobility, required regular scheduled turning, and a special mattress or seat cushion to reduce or relieve pressure. Identified R2's pressure ulcer would be addressed in the care plan. R2's care plan revised 2/27/23, listed various interventions which included staff assistance with bed mobility, dressing, hygiene and transfer with Hoyer (mechanical) lift. Identified R2 currently had pressure ulcers to his right and left gluteal and coccyx areas. Interventions included: low air loss mattress on bed, wound care twice daily and as needed, and encourage repositioning every two hours and as needed while in bed and chair. During an interview on 2/27/23, at 1:05 p.m. R2 indicated he had been in his wheelchair since 8 a.m. and he should have been laid down awhile ago. R2 stated his provider had stated he needed to be repositioned every two hours. R2 indicated he had a large open wound on his buttocks from sitting. On 2/28/23, at 9:16 a.m. R2 was lying on his back in his bed with the head of his bed elevated shaving himself with an electric razor. At 9:34 a.m. R2 continued to lay in his bed in the same position. At 9:42 a.m. R2 continued in his bed in	F 686	promote wound healing and prevent alterations in tissue integrity. Three random audits will be conducted as follows: • 5x for 2 weeks • 3x weekly for 2 weeks • 2x for 2 weeks • weekly x4 weeks. A summary of audit results will be reviewed by the IDT during the monthly QAPI meeting for further recommendations. Monitored By: The Don/Designee will monitor the corrective action for ongoing compliance.	

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F 686	Continued From page 23 same position while the registered nurse (RN)-A administered his medications. At 9:54 a.m. R2 continued to lay in his bed in the same position while using his IPAD. RN-B entered R2's room for a brief period of time and did not offer to reposition R2. At 11:48 a.m. R2 continued to lay in bed in the same position. R2 confirmed he had not been repositioned since after breakfast around 9:00 a.m. and stated a nursing assistant had recently informed R2 they would be in soon to get him up On 2/28/23, at 11:56 a.m. nursing assistant (NA)-C and NA-D entered R2's room with the Hoyer lift. R2 was dressed in street clothes and had the Hoyer sling beneath him. At 11:59 a.m. NA-C and NA-D transferred R2 from his bed to his wheelchair using the Hoyer lift. NA-C indicated the last time R2 had been repositioned was after breakfast when they assisted him to lay down. NA-C stated they should have repositioned R2 sooner. During continuous observation, R2 was observed in his bed from 9:16 a.m. to 10:59 a.m., two hours and forty three minutes. During a telephone interview on 2/28/23, at 5:01 p.m. NA-E stated she had assisted NA-C to transfer R2 to his wheelchair before breakfast and laid R2 down after breakfast around 9:30 a.m. NA-E indicated NA-C and NA-D had assisted R2 to his wheelchair before lunch. NA-E stated she had not offered or repositioned R2 again until after lunch that day. During an interview on 3/1/23, at 7:17 a.m. NA-D stated she had assisted R2 with repositioning once yesterday before lunch. NA-D indicated she had not offered to reposition R2 any other time yesterday as she was assigned the other area of	F 686		

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F 686	Continued From page 24 the building. During an interview on 3/1/23, at 11:36 a.m. RN-A indicated she would expect R2 to be offered to be repositioned every two hours. During an interview on 3/1/23, at 12:00 p.m. nurse manager (NM)-A confirmed R2 was to be offered turning and repositioning every two hours and stated at times R2 would refuse repositioning. NM-A stated when R2 refused to be repositioned every two hours, she would expect staff to inform her, so she could provide education to R2. Additionally, NM-A indicated she would expect staff to inform her if they were behind schedule, so she could assist them with timely repositioning of residents as needed. NM-A stated timely repositioning was important for R2 as R2's pressure ulcers could worsen or become infected if he was not repositioned every two hours. During an interview on 3/1/23, at 2:16 p.m. director of nursing (DON) confirmed R2 had multiple pressure ulcers including stage four pressure ulcers. DON indicated she would expect staff to offer R2 repositioning, and if R2 refused staff would re-approach. DON stated repositioning for R2 was important to prevent worsening of his current pressure ulcers and further skin breakdown. The facility policy titled Pressure Ulcer/Skin Integrity revised 4/22, identified a resident received care, consistent with professional standards of practice, to prevent pressure ulcers and would not develop pressure ulcers unless the individual's clinical condition demonstrated they were unavoidable and would receive necessary	F 686		

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F 686	Continued From page 25 treatment and services to promote healing, prevent infection, and prevent new ulcers from developing. The policy identified interventions would be implemented to mitigate the risk of skin breakdown, based on individual risk factors, which may include an individualized turning and repositioning schedule. The policy identified care planning would be comprehensive, resident-centered and would specify interventions to preserve and/or treat skin integrity issues.	F 686		

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	245299	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**03/01/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 03/01/2023, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Frazee Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. The facility was inspected as one building: Frazee Care Center was constructed at three different times. The original building was constructed in 1971, is 1-story without a basement, and was determined to be of Type II(111) construction. In 1979 the north 200 wing addition was built. It is 1-story without a basement, was determined to be of Type II (000) construction, and is separated with 2- hour fire barriers from the main building. Additions to the 1979 building in 1993 include activities added to the west and the business/ main entrance addition to the east. These areas were determined to be Type V (111) construction, and the business / main entrance addition is separated from the apartment building with a 2-hour fire barrier. The facility is fully fire sprinkler protected and has a fire alarm system with smoke detection throughout the corridor system and in the common spaces that is monitored for automatic	K 000		

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

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

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K 000	Continued From page 1 fire department notification. The facility has a capacity of 50 beds and had a census of 40 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are MET.	K 000		