

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered August 31, 2021

Administrator
Frazee Care Center
219 West Maple Avenue, Po Box 96
Frazee, MN 56544

RE: CCN: 245299

Cycle Start Date: June 24, 2021

Dear Administrator:

On August 24, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered July 9, 2021

Administrator
Frazee Care Center
219 West Maple Avenue, PO Box 96
Frazee, MN 56544

RE: CCN: 245299 Cycle Start Date:

Dear Administrator:

On June 24, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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.

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.

Frazee Care Center July 9, 2021 Page 2

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" 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 the 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

Frazee Care Center July 9, 2021 Page 3

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

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

If substantial compliance with the regulations is not verified by September 24, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by December 24, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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 electronic 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.

Frazee Care Center July 9, 2021 Page 4

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fishe Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 07/21/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245299	B. WING _			C 24/2021
	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544	<u>, </u>	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	TS .	F 00	0		
	survey was comple complaint investiga be NOT in compliar 42 CFR 483, Subpa Term Care Facilities	1/21, a standard abbreviated ted at your facility to conduct a tion. Your facility was found to note with the requirements of art B, Requirements for Long s.				
	SUBSTANTIATED: H5299037C (MN00	073959 and MN00073763), ed at F689 and F690.				
	as your allegation on Departments accept enrolled in ePOC, year the bottom of the	f correction (POC) will serve if compliance upon the otance. Because you are your signature is not required if first page of the CMS-2567 ic submission of the POC will ion of compliance.				
F 680	onsite revisit of you validate that substa regulations has been	acceptable electronic POC, an r facility may be conducted to ntial compliance with the en attained. azards/Supervision/Devices	F 68	Q		7/27/21
	CFR(s): 483.25(d)(§483.25(d) Acciden The facility must en §483.25(d)(1) The I	1)(2) its.	1 30			.,,_
	supervision and assaccidents.	resident receives adequate sistance devices to prevent				
ABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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

Electronically Signed

07/19/2021

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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		245299	B. WING			24/2021
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F 689	· •	age 1 ition, interview, and document	F 689) 1. It is the policy of Frazee (Care Center to	
	review the facility f were completed in therapy recommen	ailed to ensure safe transfers accordance with physical adations for 1 of 1 resident (R1) d a mechanical stand lift for		develop and implement writt and procedures that prevent promote safety and provide supervision.	en policies i accidents, adequate	
	5/28/21, identified cognition and requ	mum Data Set (MDS) dated R1 had moderately impaired ired extensive physical or transfers and toileting.		2. Nursing staff were educat original incident (6/23/21) on of the safety straps on the si R1 was re-evaluated by Phy regarding transfer status. R1 was reviewed and updated precommendations on 6/24/2	n proper use it-to-stand lift. sical Therapy 1's Care Plan per PT	
	diagnoses which ir syncope (fainting), difficulty walking.	ted 6/23/21, identified R1 had included a left femur fracture, muscle weakness, and ed 5/10/21, identified R1 was at		3. All current residents of Fra Center were reviewed to ens appropriate modality for resi are in place. All care plans a were reviewed and updated.	sure dent transfers and Kardexs'	
	risk for falls and ha (ADL) self care per left femur fracture. required the use of staff, physical ther therapy (TO) evalu	ad an activities of daily living rformance deficit related to (r/t) R1's care plan identified R1 f a standing lift (PAL) and two rapy (PT) and occupational lations and treatments per		 Nursing staff were educat on following the safety preca resident transfers, establishi transfer status, and following care plan. 	autions of ing the	
	medical doctor (MD) orders. The nursing assistant kardex report dated 6/15/21, identified R1 required the use of a PAL lift and two staff to transfer. PT progress and updated plan of care dated 5/31/21, identified R1 was able to safely transfer from the bed to wheel chair requiring dependent (100 percent) assistance. The plan of care identified R1 was capable of performing squat pivot transfers at times, but would not agree to or			5. Audits will be completed of cares, toileting care plans, K sheets to ensure safety pred being followed and care plan updated on all units x5 time weeks, 3x a week for 4 weel for 2 weeks. Audits will be conditionally be reviewed by the committee for compliance, a evaluate the need for continuous.	Cardex/Care cautions are ns are being a week for 2 ks, 2x a week conducted by e QAPI and will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		245299	B. WING _		06	5/24/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 219 WEST MAPLE AVENUE, PO BOX FRAZEE, MN 56544	DE	
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F 689	plan of care identifitransfer with a sit it safety. The precaudentified R1 was a experienced a cogo Occupational theraplan of care dated continued to requifunctional ADL traitidentified R1 had activity tolerance a executive functional status affunctional status affu	fied R1 would continue to to stand lift and two staff for utions listed on the plan of care at high risk for falls and unitive decline. apy (OT) progress and updated 5/31/21, identified R1 are a sit to stand lift for all nefers. The plan of care decreased strength, decreased and concerns regarding ing skills. The plan of care and waned within her sher mood/behavior ation on 6/23/21, at 10:00 a.m. (NA)-A pushed the PAL lift into assisted R1 to a sitting position bed and placed R1's shoes on ced the lift harness around R1's dit. NA-A attached the loops ness to the hooks on the PAL edge of the bed while attached NA-A placed R1's feet on the		9		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
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	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 219 WEST MAPLE AVENUE, PO BOX FRAZEE, MN 56544	DE		
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F 689	waist and placed herests. During an observator occupational thera around R1's upper wheel chair up to the chair and instructed edge of the wheel complete that task lifted R1 off of the grabbed the railing able to stand for all bent knees and he explained to R1 the her legs to support her need to hold he informed R1 all tracompleted with the strength improved. During an interview NA-A stated the lower used on each that did not move that di	age 3 ler feet on the wheel chair foot tion on 6/23/21, at 11:15 a.m. pist (OT) placed a gait belt waist area and pushed R1's he railing. OT locked the wheel d R1 to scoot her bottom to the chair. R1 was unable to . OT held onto the gait belt, wheel chair seat and R1 li bar with her hands. R1 was exproximately 20 seconds with lid herself up with her arms. OT eximportance of straightening ther body better and lessen exister up with her arms. OT nsfers would need to be exister PAL lift for now until R1's and she started to walk. If you on 6/23/21, at 10:30 a.m. wer leg belt with the PAL lift very resident; especially those their legs. NA-A verified she did exister legs. NA-A verified she did exister legs. NA-A stated with PAL lift transfers should with all residents in the facility to extransfer. NA-A stated she was equirement until now. If you on 6/23/21, at 11:50 a.m. AL lift should have always been to belt and the lower leg belt revent falls. NA-B indicated all	F 689				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
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F 689	residents required unless they refuse During a combined p.m. OT and physis both verified R1 re and assist of two sto R1's behaviors had not worked on OT stated R1 had times and that had strength, and the a indicated it was an safety belt around transfer to ensure was especially im who was weak and During an interview licensed practical expected to apply legs during all PAL plan indicated othe were expected to find guidelines for the legs from buckling feet and legs in plate the toilet. DON indicated to the toilet of the legs from the low transfer. DON stat resident's care pla functional needs for the legs from the low transfer.	the lower leg belt to be placed d. d interview on 6/23/21, at 12:46 cal therapy assistant (PTA) quired transfer with the PAL lift staff for safety. OT stated due and decreased strength she pivot transfers and standing. refused her therapy many affected her progress, ability to stand and walk. PTA expectation for staff to use the the lower legs during a PAL lift a safe transfer. PTA stated is portant during transfers with R1 d her tolerance was very low. In on 6/23/21, 1:32 p.m. Thurse (LPN)-B stated staff were the safety belt on the lower lift transfers unless the care exwise. LPN-B indicated staff follow the manufacturer's PAL lift to help prevent R1's, provide support to keep the ace, and to prevents falls. In on 6/23/21, at 3:10 p.m. (DON) stated R1 required and two staff for transfers to icated if the resident was able they did not require the use of er legs during a PAL lift ed that it was expected each in clearly identify the resident's	F 68			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 689	sessions and that I indicated R1 needed PAL lift was used for resident moved the the PAL lift then a I used. PT indicated was unpredictable, safety was an issued During an interview registered nurse (Fassistance of two sto wheel chair due was not able to foll care plan indicated and assist of two sconfirmed R1's car PAL lift was require the lower leg belt stransfers unless it to not use it. RN-A applied to the lower Manufacturer's ope Way Smart Stand use the shin pad stancessary to keep	sed many physical therapy nad affected her progress. PT ed assist of two staff when the or any transfer. PT stated if a eir legs during a transfer with ower leg belt should have been R1 was not strong enough yet, was distracted easily and	F 68	9		
F 690 SS=D	CFR(s): 483.25(e)(§483.25(e) Inconting §483.25(e)(1) The resident who is conadmission receives	nence. facility must ensure that national timent of bladder and bowel on second	F 69	0		7/27/21
	admission receives					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E	COMPLETED	
		245299	B. WING		06/24/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544	
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F 690	superstanding the second present that and (iii) A resident who indwelling catheter is assessed for reas possible unless demonstrates that and (iii) A resident who indwelling catheter is assessed for reas possible unless demonstrates that and (iii) A resident who receives appropriate prevent urinary tracontinence to the expension of the second present and (iii) A resident who receives appropriate prevent urinary tracontinence to the expension of the second present as a sensure that a residence in the second present as much not possible. This REQUIREMED by: Based on observations as ensure that a residence is a second present as much not possible.	omes such that continence is intain. a resident with urinary ed on the resident's sessment, the facility must enters the facility without an is not catheterized unless the condition demonstrates that is necessary; enters the facility with an ir or subsequently receives one moval of the catheter as soon the resident's clinical condition catheterization is necessary; is incontinent of bladder te treatment and services to ct infections and to restore	F 690	1. It is the policy of Frazee Care C that residents have the right to par	
		entinence care for 1 of 1 ewed for bladder incontinence.		in the development and implement resident centered plan of care arou toileting and preventing incontinent	ınd
	_	nimum Data Set (MDS) dated		2. R1 was re-assessed for bladder function on 6/24/21. R1 care plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245299	B. WING			1	24/2021
	PROVIDER OR SUPPLIER CARE CENTER			219	REET ADDRESS, CITY, STATE, ZIP CODE WEST MAPLE AVENUE, PO BOX 96 AZEE, MN 56544	<u>, </u>	
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F 690	occasionally incontialways continent of R1's face sheet dat diagnoses which confracture, syncope (fand difficulty walking R1's Care Area Ass 5/23/21, identified Fistatus, poor memor urgency and was to toileting, R1's care plan date an activity of daily liperformance deficit care plan indicated staff to transfer for identified R1 was a was needed. R1's bladder data of dated 5/10/21, and currently incontiner (night time) enures treatment consisted training program. The was alert and did to needed to use the listated she was unat the bathroom howe the first day. R1 was The assessments i scheduled toileting.	R1 was cognitively intact, was inent of bladder and was bowel. ded 6/23/21, identified R1 had possisted of a left femural fainting), muscle weakness	F 6		reviewed and updated per assession and resident preferences of care of 6/24/21. Re-education was complewith the clinical management staff updating the care plans and Kardetime of assessment completion on 7/15/21. 3. Toileting audits were completed residents identified as incontinent mixed incontinence to ensure toile needs are addressed. Resident caplans and Kardex were updated as needed with individualized toileting interventions. 4. Education was provided on the importance of toileting intervention part of developing a resident center plan of care on 7/15/21. 5. Audits will be completed on toile cares, toileting care plans, and Kardex/Care sheets on all units x5 week for 2 weeks, 3x a week for 42x a week for 2 weeks. Audits will conducted by DON or her designed Audits will be reviewed by the QAF committee for compliance, and will evaluate the need for continued audits and the service of the care of the compliance of the care of the car	on eted on ex at the on and ting re s ered eting time a weeks, be e.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
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F 690	lift and two staff to R1 was able to ale needed. The karder R1 on the commod Review of R1's uriting and a to a t	transfer. The kardex indicated ent staff when toileting was ex instructed staff to not leave de unattended. nary continence log identified: n.m., 8:17 a.m., and 9:01 p.m. of urine. n.m., 1:59 a.m., and 8:42 p.m. of urine. n.m., 8:56 a.m., and 9:50 p.m. of urine. n.m. R1 did not void and at 1:59 furine. n.m. R1 was continent of urine and 8:15 p.m. incontinent of urine of urine. n.m. R1 was continent of urine and 3:31 p.m. incontinent of urine. n.m. R1 did not void, 1:59 p.m. on tinent of urine of urine. n.m. R1 did not void, 1:59 p.m. on tinent of urine of urine. n.m. R1 did not void, 1:59 p.m. on tinent of urine of urine. n.m. R1 did not void, 1:59 p.m. on tinent of urine.	F 69	0			
		ition on 6/23/21, at 9:45 a.m. NA)-A entered R1's room with					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 219 WEST MAPLE AVENUE, PO BOX 9 FRAZEE, MN 56544	E	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 690	a PAL lift. R1 state and she needed to requested a basin clothes to wash up the front of the brid from front to back onto her right side, and cleansed her with a wipe. NA-A a dark colored yell sheets underneath with urine from R1 above her knees. I NA-A positioned a attached the tabs the assisted R1 up to her upper body are then transferred he PAL lift. NA-A wash hair up in a pony talinens located on the During an interview stated the last time around 10:00 p.m. indicated the days NA-A entered the relight around 9:45 the needed a brief challight on otherwises brief all night until indicated her dauglike urine at times R1 stated she was she used to so she urine odor smell likindicated she laid in morning, believed	d her brief was wet with urine get cleaned up for the day. R1 of warm water and wash and cleansed R1's peri area with a wipe. NA-A turned R1 removed the saturated brief rectal area from front to back stated the urine in the brief was ow. The NA-A indicated the the resident were saturated by supper back area down to just R1 laid on the wet sheets while clean brief underneath her and to fasten the brief. NA-A as sitting position, did not wash as or change her t-shirt and the into her wheel chair with the ned her hands, placed R1's will removed and bagged all the bed and exited the room. If on 6/23/21, at 10:18 a.m. R1 as staff changed her brief was or so the previous night. R1 whift had not checked her until froom and answered her call that a.m. R1 stated when she ange, she had to put the call she would have laid in a wet the next day sometime. R1 ther informed her she smelled and stated that bothered her. The not able to smell as well as a probably did not notice the see her daughter did. R1 in urine soaked sheets that ther t-shirt she had slept in was in the back side. R1 stated she	F 690			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	PLE CONSTRUCTION G		COMPLETED	
		245299	B. WING		06	5/24/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 219 WEST MAPLE AVENUE, PO BOX 9 FRAZEE, MN 56544	DE .	-
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 690	had wanted her t-sphysical therapy a urine. R1 stated siskin on her bottom NA-A stated she dlater than planned breakfast in bed a early in the shift to toilet or have her kR1 did not use her required frequent R1 should have befor toileting needs During an interview LPN-A indicated N and change reside the resident was in frequent checks. Lexpected to toilet indicated R1 had a infections, was rechad been placed of During an interview director of nursing bladder data collections, and followed regaindicated staff wer more frequently. During an interview RN-C verified she collection tool asserved.	shirt changed prior to going to and did not want to smell like the was concerned about the a when she sat in urine or stool. W on 6/23/21, at 10:45 a.m. id not make it to R1's room until and she usually checked on her a see if she needed to go to the orief changed. NA-A identified a call light consistently and checks by staff. NA-A stated een checked every two hours throughout each shift. W on 6/23/21, at 2:20 p.m. IA's were expected to check ents every two hours and when ancontinent they required more LPN-A stated staff were R1 every two hours. LPN-A is history of urinary tract cently diagnosed with one and	F 69			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C	
		245299	B. WING		06	/24/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 219 WEST MAPLE AVENUE, PO BOX FRAZEE, MN 56544	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 690	of bladder then regincontinent during to not use the comindicated R1 had a home during the notated the recommental to check R1 of her toileting needs assessment identition toileting and the caupdated to reflect implemented. During an interview RN-A verified she collection tool asson 5/10/21. RN-A R1 had been continent of toileting schedule indicated the care	age 11 gressed and became the day. RN-C stated R1 chose amode anymore. RN-C been incontinent of bladder at ight prior to admission. RN-C been incontinent of bladder at ight prior to admission. RN-C been incontinent of bladder at ight prior to admission. RN-C been incontinent of bladder at ight prior to admission. RN-C been incontinent of bladder dave been for every two hours to make sure is were met. RN-C stated the fied the need for scheduled are plan should have been that with interventions and on 6/24/21, at 11:00 a.m. competed a bladder data essment upon R1's admission stated the assessment showed nent of bladder during the day bladder during the night and a had been recommended. RN-A plan should have been updated ing needs and to prevent	F 69			
	management revision was a system to element of bladder in appropriate treatment of normal eliming resident who was appropriate treatment of the extent possification of th	I bowel and bladder sed 11/2016, identified there insure that each resident with incontinence would receive itent and services to maintain as ination function as possible. A incontinent of bladder received itent and services to prevent itens and to restore continence ible. If deemed appropriate and to schedule on bladder training owel toileting or training it implemented. The erson-centered care plan would unde the resident's bowel and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
245299 B.V			B. WING			C 06/24/2021	
	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 219 WEST MAPLE AVENUE, PO BOX FRAZEE, MN 56544	DDE	124/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	(X5) COMPLETION DATE	
F 690		ge 12 Is, and personal preferences.	F 6	90			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			71. 501251110.		С	
		00730	B. WING		06/2	4/2021
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
FRAZEE	CARE CENTER		MAPLE AV MN 56544	ENUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surve found that the deficiency found that the deficiency found that the deficiency for the corrected shall with a schedule of the Minnesota Deputermination of worrected requires requirements of the number and MN Ruwhen a rule contain comply with any of lack of compliance, re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	conducted at your f Minnesota Departm facility was found N State Licensure. Pl plan of correction y	TS: A/21, a complaint survey was facility by surveyors from the nent of Health (MDH). Your HOT in compliance with the MN ease indicate in your electronic ou have reviewed these orders e when they will be completed.				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 07/19/21

STATE FORM 6899 If continuation sheet 1 of 14 PGY911

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			7 t. Boilesii (o.			С	
		00730	B. WING			24/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
FRAZEE	CARE CENTER		T MAPLE AVI MN 56544	ENUE, PO BOX 96			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
2 000	Continued From pa	nge 1	2 000				
	SUBSTANTIATED: H5299037C (MN00 with licensing order Minnesota Departmenthe State Licensing Federal software. The assigned to Minneson Nursing Homes. The appears in the far-litag." The state statisted in the "Summer column and replace the correction order the findings which a statute after the states as evidence by." For with the states are states as evidence by the states are states as evidence by the states are states as evidence by the states are states are states as evidence by the states are states.	nor3959 and MN00073763), its issued at 0830 and 0910. In ent of Health is documenting a Correction Orders using ag numbers have been sota state statutes/rules for the assigned tag number eft column entitled "ID Prefix atute/rule out of compliance is the "To Comply" portion of its includes are in violation of the state attement, "This Rule is not met collowing the surveyor's findings Method of Correction and					
	receipt of State lice the Minnesota Dep Informational Bullet https://www.health. n/infobulletins/ib14 orders are delineate Department of Hea you electronically. Although no plan of State Statutes/Rule "CORRECTED" in must then indicate licensure process, date, the date your to electronically sub	p participate in the electronic ensure orders consistent with artment of Health tin 14-01, available at state.mn.us/facilities/regulatio _1.html The State licensing ed on the attached Minnesota alth orders being submitted to f correction is necessary for es, please enter the word the box available for text. You in the electronic State under the heading completion orders will be corrected prior omitting to the Minnesota alth. The facility is enrolled in					

Minnesota Department of Health

STATE FORM PGY911 If continuation sheet 2 of 14

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			,
		00730	B. WING			4/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FRAZEE	CARE CENTER		MAPLE AV MN 56544	ENUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 000	PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	e a signature is not required at st page of state form. RD THE HEADING OF THE	2 000			
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from to	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident	2 830			7/27/21
	by: Based on observation review the facility far were completed in a therapy recommend reviewed who used transfers. Findings include:	ent is not met as evidenced on, interview, and document illed to ensure safe transfers accordance with physical dations for 1 of 1 resident (R1) a mechanical stand lift for		Corrected.		

Minnesota Department of Health

STATE FORM PGY911 If continuation sheet 3 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00730	B. WING			C 24/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
FRAZEE	CARE CENTER			ENUE, PO BOX 96		
040.15	CLIMMADY CTA	<u> </u>	MN 56544	DDOVIDEDIC DI ANI CE CO	ODDECTION	0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 3	2 830			
	cognition and requi	R1 had moderately impaired red extensive physical or transfers and toileting.				
	diagnoses which in	ed 6/23/21, identified R1 had cluded a left femur fracture, muscle weakness, and				
	risk for falls and had (ADL) self care per left femur fracture. required the use of staff, physical thera	d 5/10/21, identified R1 was at d an activities of daily living formance deficit related to (r/t) R1's care plan identified R1 a standing lift (PAL) and two apy (PT) and occupational ations and treatments per b) orders.				
		ant kardex report dated R1 required the use of a PAL transfer.				
	5/31/21, identified F from the bed to whe (100 percent) assis identified R1 was ca pivot transfers at tir did not work with th plan of care identified transfer with a sit to safety. The precaut	odated plan of care dated R1 was able to safely transfer eel chair requiring dependent tance. The plan of care apable of performing squat mes, but would not agree to or erapy safely to do so. The ed R1 would continue to a stand lift and two staff for tions listed on the plan of care thigh risk for falls and nitive decline.				
	plan of care dated s continued to require functional ADL trans	py (OT) progress and updated 5/31/21, identified R1 e a sit to stand lift for all sfers. The plan of care ecreased strength, decreased				

Minnesota Department of Health

STATE FORM PGY911 If continuation sheet 4 of 14

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00730	B. WING		l l	C 24/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
FRAZEE	CARE CENTER			NUE, PO BOX 96		
		FRAZEE,	MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 4	2 830			
	executive functionir identified R1 waxed functional status as fluctuated.	nd concerns regarding and skills. The plan of care and waned within her her mood/behavior at 10:00 a.m.				
	nursing assistant (NR1's room. NA-A as on the edge of the Nether feet. NA-A place waist and fastened from the waist harn lift. R1 sat on the eto the PAL lift and Nether foot plate. NA-A exi approximately two material for R1's where sliding around. NA-R1 to grab a hold of the bed with the NA-A did not attach R1's lower legs price fairly straight with houshed the PAL lift of the wheel chair aremoved the harnes unfastened the lift has not the straight with houshed the paragraph of the wheel chair aremoved the lift has not the straight with houshed the paragraph.	NA)-A pushed the PAL lift into sisted R1 to a sitting position ped and placed R1's shoes on ed the lift harness around R1's it. NA-A attached the loops ess to the hooks on the PAL dge of the bed while attached IA-A placed R1's feet on the				
	occupational therap around R1's upper wheel chair up to the chair and instructed edge of the wheel of complete that task. lifted R1 off of the w	ion on 6/23/21, at 11:15 a.m. bist (OT) placed a gait belt waist area and pushed R1's be railing. OT locked the wheel R1 to scoot her bottom to the chair. R1 was unable to OT held onto the gait belt, wheel chair seat and R1 bar with her hands. R1 was				

Minnesota Department of Health

STATE FORM PGY911 If continuation sheet 5 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00730	B. WING			C 24/2021
NAME O	F PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
FRAZE	E CARE CENTER			NUE, PO BOX 96		
			MN 56544			
(X4) ID PREFI) TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
2 83	able to stand for appent knees and helexplained to R1 the her legs to support her need to hold he informed R1 all transformed R1. During an interview NA-A stated the lower leg strap have been used with help ensure a safe unaware of that recommended Particles R1 all transformed R1 all transformed R1 all transformed R1 recommended R	proximately 20 seconds with d herself up with her arms. OT importance of straightening her body better and lessen erself up with her arms. OT insfers would need to be PAL lift for now until R1's and she started to walk. You on 6/23/21, at 10:30 a.m. wer leg belt with the PAL lift very resident; especially those heir legs. NA-A verified she did be belt during the PAL lift interview on 6/23/21, 11:00 hed the surveyor and stated with PAL lift transfers should the all residents in the facility to transfer. NA-A stated she was quirement until now. You on 6/23/21, at 11:50 a.m. AL lift should have always been belt and the lower leg belt event falls. NA-B indicated all the lower leg belt to be placed				

Minnesota Department of Health

STATE FORM PGY911 If continuation sheet 6 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00730	B. WING		l l	C 24/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
FRAZEE	CARE CENTER		Γ MAPLE AVE MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	safety belt around to transfer to ensure a was especially imp who was weak and During an interview licensed practical nexpected to apply the legs during all PAL plan indicated other were expected to forguidelines for the Plegs from buckling, feet and legs in place During an interview director of nursing (assist of a PAL lift at the toilet. DON indicated to fully weight bear the belt on the lower transfer. DON states resident's care plan functional needs for During an interview stated R1 had refus sessions and that hindicated R1 neede PAL lift was used for resident moved the the PAL lift then a loused. PT indicated was unpredictable, safety was an issue stated was unsuppredictable, safety was an issue stated was unpredictable, safety was an issue stated was unpredictable.	he lower legs during a PAL lift a safe transfer. PTA stated is cortant during transfers with R1 her tolerance was very low. on 6/23/21, 1:32 p.m. urse (LPN)-B stated staff were the safety belt on the lower lift transfers unless the care rwise. LPN-B indicated staff follow the manufacturer's AL lift to help prevent R1's provide support to keep the ce, and to prevents falls. on 6/23/21, at 3:10 p.m. (DON) stated R1 required and two staff for transfers to cated if the resident was able they did not require the use of a legs during a PAL lift at that it was expected each a clearly identify the resident's ransfers. on 6/24/21, at 9:24 a.m. PT and assist of two staff when the or any transfer. PT stated if a ir legs during a transfer with ower leg belt should have been R1 was not strong enough yet, was distracted easily and	2 830			
	registered nurse (R assistance of two s	N)-A stated R1 required taff and the PAL lift from bed to stability reasons and she				

Minnesota Department of Health

STATE FORM PGY911 If continuation sheet 7 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED	
		00730	B. WING		06/2	24/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FRAZEE	CARE CENTER		ΓMAPLE AV MN 56544	ENUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	was not able to follocare plan indicated and assist of two st confirmed R1's care PAL lift was require the lower leg belt st transfers unless it v to not use it. RN-A i applied to the lower Manufacturer's ope Way Smart Stand ruse the shin pad strucessary to keep a foot plate and to se patients's legs. Suggested Method Nursing or designed procedures and traifollowing resident cuse of mechanical I designee, could condelivery of care; to services are implemassessment and as perform random au	ow cues. RN-A verified R1's R1 transferred with a PAL lift aff for toileting. RN-A e plan should have indicated a d for all transfers. RN-A stated hould always be used with PAL was indicated in the care plan dentified the transfer belt elegs assured a safe transfer. The present of a caregiver deemed it a patient's shins or feet on the cure the shin strap around the of Correction: The Director of a could review policies and a safe transfer are plans and assure proper ifts. The director of nursing or nuclet random audits of the ensure appropriate care and nented. The quality surance committee could dits to ensure compliance. R CORRECTION: Twenty-one	2 830			
2 910	MN Rule 4658.0529 Incontinence	5 Subp. 5 A.B Rehab -	2 910			7/27/21
	have a continuous property management to recurrence unnecessary use of	nce. A nursing home must program of bowel and bladder luce incontinence and the catheters. Based on the ident assessment, a nursing				

Minnesota Department of Health

STATE FORM PGY911 If continuation sheet 8 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00730	B. WING			C 24/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
FRA7FF	CARE CENTER			ENUE, PO BOX 96			
		FRAZEE,	MN 56544				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
2 910	Continued From pa	ge 8	2 910				
	without an indwellin unless the resident' that catheterization B. a resident wh receives appropriat prevent urinary trace	that: ho enters a nursing home g catheter is not catheterized s clinical condition indicates was necessary; and no is incontinent of bladder e treatment and services to it infections and to restore as er function as possible.					
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assist residents with timely bladder incontinence care for 1 of 1 residents (R1) reviewed for bladder incontinence.			corrected.			
	Findings include:						
	5/16/21, identified F	nimum Data Set (MDS) dated R1 was cognitively intact, was inent of bladder and was bowel.					
	diagnoses which co	ed 6/23/21, identified R1 had ensisted of a left femur fainting), muscle weakness g.					
	5/23/21, identified F status, poor memor	sessment (CAA) dated R1 had an altered mental ry, restricted mobility, urinary stal dependent on staff with					
		d 5/21/21, identified R1 had ving (ADL) self care					

Minnesota Department of Health

STATE FORM PGY911 If continuation sheet 9 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
						С	
		00730	B. WING		06/	24/2021	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
FRAZEE	CARE CENTER		MAPLE AV MN 56544	ENUE, PO BOX 96			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
2 910	care plan indicated staff to transfer for identified R1 was a was needed. R1's bladder data of dated 5/10/21, and currently incontinent (night time) enuresist treatment consisted training program. To was alert and did to needed to use the bathroom howe the first day. R1 was the bathroom howe the first day. R1 was cheduled toileting. Review of nursing a 6/15/21, indicated Fift and two staff to the R1 was able to aler needed. The karder R1 on the commod Review of R1's uring 1-6/15/21, at 1:46 auring 1-6/16/21, at 5:27 auring 1-6/16/21, at 5:27 auring 1-6/17/21, at 2:11 auring 1-6/17/21, auring 1-6/17/21, auri	related to femur fracture. The R1 required a PAL lift and two toileting. The care plan ble to alert staff when toileting sollection tool assessments 5/27/21, identified R1 was at of bladder, had nocturnal is (bed wetting) and the dof a scheduled toileting/habit he assessments indicated R1 arn on the call light when she bathroom during the night. R1 aware when she had to go to over did void in the commode in sincontinent during the night. Indicated R1 needed to be on times during the night. Assistant (NA) kardex dated R1 required the use of a PAL transfer. The kardex indicated it staff when toileting was ax instructed staff to not leave the unattended. Assistant (NA) and 9:01 p.m. of urine. The man of urine. The man of urine. The man of urine. The man of urine.	2 910				
	p.m. incontinent of						

Minnesota Department of Health

STATE FORM PGY911 If continuation sheet 10 of 14

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
						c	
		00730	B. WING		1	4/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ED A 7EE	CADE CENTED	219 WES	Γ MAPLE AV	ENUE, PO BOX 96			
FRAZEE CARE CENTER FRAZEE, I			MN 56544				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 910	Continued From pa	ge 10	2 910				
		m. R1 was continent of urine and 8:15 p.m. incontinent of					
		m. R1 was continent of urine d 3:31 p.m. incontinent of					
		m. R1 did not void, 1:59 p.m. , and 9:56 p.m. continent of					
	-6/22/21, at 2:16 a.i and 9:59 p.m. incor	m. R1 did not void, 1:59 p.m. ntinent of urine.					
	-6/23/21, at 5:36 a.l 11:23 a.m. incontine	m. R1 continent of urine and ent of urine.					
	nursing assistant (Na PAL lift. R1 stated and she needed to requested a basin of clothes to wash upto the front of the brief from front to back wonto her right side, and cleansed her rewith a wipe. NA-A sa dark colored yello sheets underneath with urine from R1's above her knees. RNA-A positioned a cattached the tabs to assisted R1 up to a her upper body are then transferred he	ion on 6/23/21, at 9:45 a.m. NA)-A entered R1's room with ther brief was wet with urine get cleaned up for the day. R1 of warm water and wash NA-A removed the tabs from f and cleansed R1's peri area with a wipe. NA-A turned R1 removed the saturated brief ectal area from front to back stated the urine in the brief was www. The NA-A indicated the the resident were saturated is upper back area down to just R1 laid on the wet sheets while clean brief underneath her and of fasten the brief. NA-A sitting position, did not wash a or change her t-shirt and r into her wheel chair with the ed her hands, placed R1's					

Minnesota Department of Health

STATE FORM PGY911 If continuation sheet 11 of 14

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			c	
		00730	B. WING			24/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
FRAZEE CARE CENTER 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
2 910	hair up in a pony ta linens located on the During an interview stated the last time around 10:00 p.m. indicated the day sl NA-A entered the relight around 9:45 the needed a brief challight on otherwise she brief all night until the indicated her daugh like urine at times at R1 stated she was she used to so she urine odor smell like indicated she laid in morning, believed he dirty and felt wet or had wanted her t-sl physical therapy an urine. R1 stated she skin on her bottom During an interview NA-A stated she die later than planned. breakfast in bed an early in the shift to toilet or have her bit R1 did not use her required frequent of R1 should have befor toileting needs to During an interview LPN-A indicated NA and change resider	il, removed and bagged all ne bed and exited the room. on 6/23/21, at 10:18 a.m. R1 staff changed her brief was or so the previous night. R1 hift had not checked her until oom and answered her call her would have laid in a wet he next day sometime. R1 her informed her she smelled and stated that bothered her. not able to smell as well as probably did not notice the her daughter did. R1 in urine soaked sheets that her t-shirt she had slept in was in the back side. R1 stated she hirt changed prior to going to ad did not want to smell like he was concerned about the when she sat in urine or stool. on 6/23/21, at 10:45 a.m. In do not make it to R1's room until NA-A indicated R1 ate and she usually checked on her see if she needed to go to the rief changed. NA-A identified call light consistently and hecks by staff. NA-A stated en checked every two hours shroughout each shift. on 6/23/21, at 2:20 p.m. A's were expected to check his every two hours and when continent they required more	2 910				

Minnesota Department of Health

STATE FORM PGY911 If continuation sheet 12 of 14

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00730	D. WING		06/2	4/2021
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
FRAZEE	CARE CENTER		MAPLE AVI MN 56544	ENUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	σ το		2 910			
	frequent checks. LPN-A stated staff were expected to toilet R1 every two hours. LPN-A indicated R1 had a history of urinary tract infections, was recently diagnosed with one and had been placed on an antibiotic. During an interview on 6/23/21, at 4:30 p.m.					
	bladder data collect completed, a plan s and followed regard	(DON) stated after the two tion tool assessments were should have been developed ding toileting needs. DON e expected to check on R1				
	RN-C verified she of collection tool asset RN-C stated R1 use upon admission 5/1 of bladder then regincontinent during to not use the commindicated R1 had be home during the nigstated the recommens staff to check R1 exher toileting needs assessment identification to the calcupdated to reflect the implemented.	con 6/24/21, at 10:20 a.m. completed a bladder data assment on 5/27/21, on R1. ed the bedside commode 0/21, and had been continent ressed and became he day. RN-C stated R1 chose mode anymore. RN-C een incontinent of bladder at ght prior to admission. RN-C endation would have been for very two hours to make sure were met. RN-C stated the ed the need for scheduled re plan should have been nat with interventions				
	RN-A verified she collection tool asset on 5/10/21. RN-A st R1 had been continuand incontinent of but toileting schedule h	on 6/24/21, at 11:00 a.m. competed a bladder data ssment upon R1's admission tated the assessment showed lent of bladder during the day bladder during the night and a ad been recommended. RN-A blan should have been updated				

Minnesota Department of Health

STATE FORM PGY911 If continuation sheet 13 of 14

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:				
		00730	B. WING		06/2	2 4/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FRAZEE	CARE CENTER		MAPLE AVENUE, PO BOX 96			
			MN 56544	DON'INFRIO DI ANI OF CORRECTIO		
(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 SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	ACTION SHOULD BE COMP TO THE APPROPRIATE DA	
2 910	Continued From page 13		2 910			
	to meet R1's toileting needs and to prevent incontinence.					
	to meet R1's toileting needs and to prevent					

6899

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