DEPARTMENT OF HEALTH

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

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.

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

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 06/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/22/21, to 6/24/21, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. 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 complaint was found to be SUBSTANTIATED: H5299037C (MN00073959 and MN00073763), with deficiencies cited at F689 and F690. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are 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 that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		7/27/21

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

Electronically Signed | 07/19/2021

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F 689	Continued From page 1 Based on observation, interview, and document review the facility failed to ensure safe transfers were completed in accordance with physical therapy recommendations for 1 of 1 resident (R1) reviewed who used a mechanical stand lift for transfers. Findings include: R1's quarterly Minimum Data Set (MDS) dated 5/28/21, identified R1 had moderately impaired cognition and required extensive physical assistance of two for transfers and toileting. R1's face sheet dated 6/23/21, identified R1 had diagnoses which included a left femur fracture, syncope (fainting), muscle weakness, and difficulty walking. R1's care plan dated 5/10/21, identified R1 was at risk for falls and had an activities of daily living (ADL) self care performance deficit related to (r/t) left femur fracture. R1's care plan identified R1 required the use of a standing lift (PAL) and two staff , physical therapy (PT) and occupational therapy (TO) evaluations and treatments per 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 did not work with therapy safely to do so. The	F 689	1. It is the policy of Frazee Care Center to develop and implement written policies and procedures that prevent accidents, promote safety and provide adequate supervision. 2. Nursing staff were educated at time of original incident (6/23/21) on proper use of the safety straps on the sit-to-stand lift. R1 was re-evaluated by Physical Therapy regarding transfer status. R1's Care Plan was reviewed and updated per PT recommendations on 6/24/21. 3. All current residents of Frazee Care Center were reviewed to ensure appropriate modality for resident transfers are in place. All care plans and Kardexs' were reviewed and updated. 4. Nursing staff were educated on 7/15/21 on following the safety precautions of resident transfers, establishing the transfer status, and following the resident care plan. 5. Audits will be completed on toileting cares, toileting care plans, Kardex/Care sheets to ensure safety precautions are being followed and care plans are being updated on all units x5 time a week for 2 weeks, 3x a week for 4 weeks, 2x a week for 2 weeks. Audits will be conducted by DON or her designee. Audits will be reviewed by the QAPI committee for compliance, and will evaluate the need for continued audits.	

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F 689	Continued From page 2	F 689		

plan of care identified R1 would continue to transfer with a sit to stand lift and two staff for safety. The precautions listed on the plan of care identified R1 was at high risk for falls and experienced a cognitive decline.

Occupational therapy (OT) progress and updated plan of care dated 5/31/21, identified R1 continued to require a sit to stand lift for all functional ADL transfers. The plan of care identified R1 had decreased strength, decreased activity tolerance and concerns regarding executive functioning skills. The plan of care identified R1 waxed and waned within her functional status as her mood/behavior fluctuated.

During an observation on 6/23/21, at 10:00 a.m. nursing assistant (NA)-A pushed the PAL lift into R1's room. NA-A assisted R1 to a sitting position on the edge of the bed and placed R1's shoes on her feet. NA-A placed the lift harness around R1's waist and fastened it. NA-A attached the loops from the waist harness to the hooks on the PAL lift. R1 sat on the edge of the bed while attached to the PAL lift and NA-A placed R1's feet on the foot plate. NA-A exited the room for approximately two minutes to obtain a piece of material for R1's wheel chair to prevent her from sliding around. NA-A returned to R1's room, cued R1 to grab a hold of the handles and raised her off the bed with the PAL lift to a standing position. NA-A did not attach the safety harness around R1's lower legs prior to the transfer. R1 stood fairly straight with her knees slightly bent. NA-A pushed the PAL lift with R1 attached to it in front of the wheel chair and lowered R1 down. NA-A removed the harness straps from the PAL lift, unfastened the lift harness from around R1's

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F 689	Continued From page 3	F 689		

waist and placed her feet on the wheel chair foot rests.

During an observation on 6/23/21, at 11:15 a.m. occupational therapist (OT) placed a gait belt around R1's upper waist area and pushed R1's wheel chair up to the railing. OT locked the wheel chair and instructed R1 to scoot her bottom to the edge of the wheel chair. R1 was unable to complete that task. OT held onto the gait belt, lifted R1 off of the wheel chair seat and R1 grabbed the railing bar with her hands. R1 was able to stand for approximately 20 seconds with bent knees and held herself up with her arms. OT explained to R1 the importance of straightening her legs to support her body better and lessen her need to hold herself up with her arms. OT informed R1 all transfers would need to be completed with the PAL lift for now until R1's strength improved and she started to walk.

During an interview on 6/23/21, at 10:30 a.m. NA-A stated the lower leg belt with the PAL lift was not used on every resident; especially those that did not move their legs. NA-A verified she did not use the lower leg belt during the PAL lift transfers with R1.

During a follow up interview on 6/23/21, 11:00 a.m. NA-A approached the surveyor and stated the lower leg strap with PAL lift transfers should have been used with all residents in the facility to help ensure a safe transfer. NA-A stated she was unaware of that requirement until now.

During an interview on 6/23/21, at 11:50 a.m. NA-B stated the PAL lift should have always been used with the waist belt and the lower leg belt attached to help prevent falls. NA-B indicated all

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F 689	Continued From page 4	F 689		

residents required the lower leg belt to be placed unless they refused.

During a combined interview on 6/23/21, at 12:46 p.m. OT and physical therapy assistant (PTA) both verified R1 required transfer with the PAL lift and assist of two staff for safety. OT stated due to R1's behaviors and decreased strength she had not worked on pivot transfers and standing. OT stated R1 had refused her therapy many times and that had affected her progress, strength, and the ability to stand and walk. PTA indicated it was an expectation for staff to use the safety belt around the lower legs during a PAL lift transfer to ensure a safe transfer. PTA stated is was especially important during transfers with R1 who was weak and her tolerance was very low.

During an interview on 6/23/21, 1:32 p.m. licensed practical nurse (LPN)-B stated staff were expected to apply the safety belt on the lower legs during all PAL lift transfers unless the care plan indicated otherwise. LPN-B indicated staff were expected to follow the manufacturer's guidelines for the PAL lift to help prevent R1's legs from buckling, provide support to keep the feet and legs in place, and to prevents falls.

During an interview on 6/23/21, at 3:10 p.m. director of nursing (DON) stated R1 required assist of a PAL lift and two staff for transfers to the toilet. DON indicated if the resident was able to fully weight bear they did not require the use of the belt on the lower legs during a PAL lift transfer. DON stated that it was expected each resident's care plan clearly identify the resident's functional needs for transfers.

During an interview on 6/24/21, at 9:24 a.m. PT

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F 689	Continued From page 5 stated R1 had refused many physical therapy sessions and that had affected her progress. PT indicated R1 needed assist of two staff when the PAL lift was used for any transfer. PT stated if a resident moved their legs during a transfer with the PAL lift then a lower leg belt should have been used. PT indicated R1 was not strong enough yet, was unpredictable, was distracted easily and safety was an issue. During an interview on 6/24/21, at 11:20 a.m. with registered nurse (RN)-A stated R1 required assistance of two staff and the PAL lift from bed to wheel chair due to stability reasons and she was not able to follow cues. RN-A verified R1's care plan indicated R1 transferred with a PAL lift and assist of two staff for toileting. RN-A confirmed R1's care plan should have indicated a PAL lift was required for all transfers. RN-A stated the lower leg belt should always be used with PAL transfers unless it was indicated in the care plan to not use it. RN-A identified the transfer belt applied to the lower legs assured a safe transfer. Manufacturer's operator instructions titled EZ Way Smart Stand revised 7/30/18, identified to use the shin pad strap if a caregiver deemed it necessary to keep a patient's shins or feet on the foot plate and to secure the shin strap around the patients's legs.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		7/27/21

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F 690	Continued From page 6 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This 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. Findings include: R1's admission Minimum Data Set (MDS) dated	F 690	1. It is the policy of Frazee Care Center that residents have the right to participate in the development and implementation of resident centered plan of care around toileting and preventing incontinence. 2. R1 was re-assessed for bladder function on 6/24/21. R1 care plan was	

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F 690	Continued From page 7 5/16/21, identified R1 was cognitively intact, was occasionally incontinent of bladder and was always continent of bowel. R1's face sheet dated 6/23/21, identified R1 had diagnoses which consisted of a left femur fracture, syncope (fainting), muscle weakness and difficulty walking. R1's Care Area Assessment (CAA) dated 5/23/21, identified R1 had an altered mental status, poor memory, restricted mobility, urinary urgency and was total dependent on staff with toileting, R1's care plan dated 5/21/21, identified R1 had an activity of daily living (ADL) self care performance deficit related to femur fracture. The care plan indicated R1 required a PAL lift and two staff to transfer for toileting. The care plan identified R1 was able to alert staff when toileting was needed. R1's bladder data collection tool assessments dated 5/10/21, and 5/27/21, identified R1 was currently incontinent of bladder, had nocturnal (night time) enuresis (bed wetting) and the treatment consisted of a scheduled toileting/habit training program. The assessments indicated R1 was alert and did turn on the call light when she needed to use the bathroom during the night. R1 stated she was unaware when she had to go to the bathroom however did void in the commode the first day. R1 was incontinent during the night. The assessments indicated R1 needed to be on scheduled toileting times during the night. Review of nursing assistant (NA) kardex dated 6/15/21, indicated R1 required the use of a PAL	F 690	reviewed and updated per assessment and resident preferences of care on 6/24/21. Re-education was completed with the clinical management staff on updating the care plans and Kardex at the time of assessment completion on 7/15/21. 3. Toileting audits were completed on residents identified as incontinent and mixed incontinence to ensure toileting needs are addressed. Resident care plans and Kardex were updated as needed with individualized toileting interventions. 4. Education was provided on the importance of toileting interventions as a part of developing a resident centered plan of care on 7/15/21. 5. Audits will be completed on toileting cares, toileting care plans,and Kardex/Care sheets on all units x5 time a week for 2 weeks, 3x a week for 4 weeks, 2x a week for 2 weeks. Audits will be conducted by DON or her designee. Audits will be reviewed by the QAPI committee for compliance, and will evaluate the need for continued audits.	

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F 690	Continued From page 8	F 690		

lift and two staff to transfer. The kardex indicated R1 was able to alert staff when toileting was needed. The kardex instructed staff to not leave R1 on the commode unattended.

Review of R1's urinary continence log identified:

-6/15/21, at 1:46 a.m., 8:17 a.m., and 9:01 p.m. R1 was incontinent of urine.

-6/16/21, at 5:27 a.m., 1:59 a.m., and 8:42 p.m. R1 was incontinent of urine.

-6/17/21, at 2:11 a.m., 8:56 a.m., and 9:50 p.m. R1 was incontinent of urine.

-6/18/21, at 3:29 p.m. R1 did not void and at 1:59 p.m. incontinent of urine.

-6/19/21, at 2:56 a.m. R1 was continent of urine and at 10:48 a.m. and 8:15 p.m. incontinent of urine.

-6/20/21, at 4:17 a.m. R1 was continent of urine and at 8:11 a.m. and 3:31 p.m. incontinent of urine.

-6/21/21, at 1:44 a.m. R1 did not void, 1:59 p.m. incontinent of urine, and 9:56 p.m. continent of urine.

-6/22/21, at 2:16 a.m. R1 did not void, 1:59 p.m. and 9:59 p.m. incontinent of urine.

-6/23/21, at 5:36 a.m. R1 continent of urine and 11:23 a.m. incontinent of urine.

During an observation on 6/23/21, at 9:45 a.m. nursing assistant (NA)-A entered R1's room with

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a PAL lift. R1 stated her brief was wet with urine and she needed to get cleaned up for the day. R1 requested a basin of warm water and wash clothes to wash up. NA-A removed the tabs from the front of the brief and cleansed R1's peri area from front to back with a wipe. NA-A turned R1 onto her right side, removed the saturated brief and cleansed her rectal area from front to back with a wipe. NA-A stated the urine in the brief was a dark colored yellow. The NA-A indicated the sheets underneath the resident were saturated with urine from R1's upper back area down to just above her knees. R1 laid on the wet sheets while NA-A positioned a clean brief underneath her and attached the tabs to fasten the brief. NA-A assisted R1 up to a sitting position, did not wash her upper body area or change her t-shirt and then transferred her into her wheel chair with the PAL lift. NA-A washed her hands, placed R1's hair up in a pony tail, removed and bagged all linens located on the bed and exited the room.

During an interview on 6/23/21, at 10:18 a.m. R1 stated the last time staff changed her brief was around 10:00 p.m. or so the previous night. R1 indicated the day shift had not checked her until NA-A entered the room and answered her call light around 9:45 that a.m. R1 stated when she needed a brief change, she had to put the call light on otherwise she would have laid in a wet brief all night until the next day sometime. R1 indicated her daughter informed her she smelled like urine at times and stated that bothered her. R1 stated she was not able to smell as well as she used to so she probably did not notice the urine odor smell like her daughter did. R1 indicated she laid in urine soaked sheets that morning, believed her t-shirt she had slept in was dirty and felt wet on the back side. R1 stated she

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had wanted her t-shirt changed prior to going to physical therapy and did not want to smell like urine. R1 stated she was concerned about the skin on her bottom when she sat in urine or stool.

During an interview on 6/23/21, at 10:45 a.m. NA-A stated she did not make it to R1's room until later than planned. NA-A indicated R1 ate breakfast in bed and she usually checked on her early in the shift to see if she needed to go to the toilet or have her brief changed. NA-A identified R1 did not use her call light consistently and required frequent checks by staff. NA-A stated R1 should have been checked every two hours for toileting needs throughout each shift.

During an interview on 6/23/21, at 2:20 p.m. LPN-A indicated NA's were expected to check and change residents every two hours and when the resident was incontinent they required more 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. director of nursing (DON) stated after the two bladder data collection tool assessments were completed, a plan should have been developed and followed regarding toileting needs. DON indicated staff were expected to check on R1 more frequently.

During an interview on 6/24/21, at 10:20 a.m. RN-C verified she completed a bladder data collection tool assessment on 5/27/21, on R1. RN-C stated R1 used the bedside commode upon admission 5/10/21, and had been continent

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of bladder then regressed and became incontinent during the day. RN-C stated R1 chose to not use the commode anymore. RN-C indicated R1 had been incontinent of bladder at home during the night prior to admission. RN-C stated the recommendation would have been for staff to check R1 every two hours to make sure her toileting needs were met. RN-C stated the assessment identified the need for scheduled toileting and the care plan should have been updated to reflect that with interventions implemented.

During an interview on 6/24/21, at 11:00 a.m. RN-A verified she competed a bladder data collection tool assessment upon R1's admission on 5/10/21. RN-A stated the assessment showed R1 had been continent of bladder during the day and incontinent of bladder during the night and a toileting schedule had been recommended. RN-A indicated the care plan should have been updated to meet R1's toileting needs and to prevent incontinence.

Facility policy titled bowel and bladder management revised 11/2016, identified there was a system to ensure that each resident with bowel or bladder incontinence would receive appropriate treatment and services to maintain as much normal elimination function as possible. A resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. If deemed appropriate an individualized toilet schedule on bladder training program and/or bowel toileting or training programs would be implemented. The comprehensive person-centered care plan would be updated to include the resident's bowel and

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F 690	Continued From page 12 bladder needs, goals, and personal preferences.	F 690		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/22/21, to 6/24/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5299037C (MN00073959 and MN00073763), with licensing orders issued at 0830 and 0910. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in	2 000		

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2 000	Continued From page 2 ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure safe transfers were completed in accordance with physical therapy recommendations for 1 of 1 resident (R1) reviewed who used a mechanical stand lift for transfers. Findings include: R1's quarterly Minimum Data Set (MDS) dated	2 830	Corrected.	7/27/21

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2 830	Continued From page 3 5/28/21, identified R1 had moderately impaired cognition and required extensive physical assistance of two for transfers and toileting. R1's face sheet dated 6/23/21, identified R1 had diagnoses which included a left femur fracture, syncope (fainting), muscle weakness, and difficulty walking. R1's care plan dated 5/10/21, identified R1 was at risk for falls and had an activities of daily living (ADL) self care performance deficit related to (r/t) left femur fracture. R1's care plan identified R1 required the use of a standing lift (PAL) and two staff , physical therapy (PT) and occupational therapy (TO) evaluations and treatments per 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 did not work with therapy safely to do so. The plan of care identified R1 would continue to transfer with a sit to stand lift and two staff for safety. The precautions listed on the plan of care identified R1 was at high risk for falls and experienced a cognitive decline. Occupational therapy (OT) progress and updated plan of care dated 5/31/21, identified R1 continued to require a sit to stand lift for all functional ADL transfers. The plan of care identified R1 had decreased strength, decreased	2 830		

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activity tolerance and concerns regarding executive functioning skills. The plan of care identified R1 waxed and waned within her functional status as her mood/behavior fluctuated.

During an observation on 6/23/21, at 10:00 a.m. nursing assistant (NA)-A pushed the PAL lift into R1's room. NA-A assisted R1 to a sitting position on the edge of the bed and placed R1's shoes on her feet. NA-A placed the lift harness around R1's waist and fastened it. NA-A attached the loops from the waist harness to the hooks on the PAL lift. R1 sat on the edge of the bed while attached to the PAL lift and NA-A placed R1's feet on the foot plate. NA-A exited the room for approximately two minutes to obtain a piece of material for R1's wheel chair to prevent her from sliding around. NA-A returned to R1's room, cued R1 to grab a hold of the handles and raised her off the bed with the PAL lift to a standing position. NA-A did not attach the safety harness around R1's lower legs prior to the transfer. R1 stood fairly straight with her knees slightly bent. NA-A pushed the PAL lift with R1 attached to it in front of the wheel chair and lowered R1 down. NA-A removed the harness straps from the PAL lift, unfastened the lift harness from around R1's waist and placed her feet on the wheel chair foot rests.

During an observation on 6/23/21, at 11:15 a.m. occupational therapist (OT) placed a gait belt around R1's upper waist area and pushed R1's wheel chair up to the railing. OT locked the wheel chair and instructed R1 to scoot her bottom to the edge of the wheel chair. R1 was unable to complete that task. OT held onto the gait belt, lifted R1 off of the wheel chair seat and R1 grabbed the railing bar with her hands. R1 was

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2 830	Continued From page 5 able to stand for approximately 20 seconds with bent knees and held herself up with her arms. OT explained to R1 the importance of straightening her legs to support her body better and lessen her need to hold herself up with her arms. OT informed R1 all transfers would need to be completed with the PAL lift for now until R1's strength improved and she started to walk. During an interview on 6/23/21, at 10:30 a.m. NA-A stated the lower leg belt with the PAL lift was not used on every resident; especially those that did not move their legs. NA-A verified she did not use the lower leg belt during the PAL lift transfers with R1. During a follow up interview on 6/23/21, 11:00 a.m. NA-A approached the surveyor and stated the lower leg strap with PAL lift transfers should have been used with all residents in the facility to help ensure a safe transfer. NA-A stated she was unaware of that requirement until now. During an interview on 6/23/21, at 11:50 a.m. NA-B stated the PAL lift should have always been used with the waist belt and the lower leg belt attached to help prevent falls. NA-B indicated all residents required the lower leg belt to be placed unless they refused. During a combined interview on 6/23/21, at 12:46 p.m. OT and physical therapy assistant (PTA) both verified R1 required transfer with the PAL lift and assist of two staff for safety. OT stated due to R1's behaviors and decreased strength she had not worked on pivot transfers and standing. OT stated R1 had refused her therapy many times and that had affected her progress, strength, and the ability to stand and walk. PTA indicated it was an expectation for staff to use the	2 830		

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safety belt around the lower legs during a PAL lift transfer to ensure a safe transfer. PTA stated is was especially important during transfers with R1 who was weak and her tolerance was very low.

During an interview on 6/23/21, 1:32 p.m. licensed practical nurse (LPN)-B stated staff were expected to apply the safety belt on the lower legs during all PAL lift transfers unless the care plan indicated otherwise. LPN-B indicated staff were expected to follow the manufacturer's guidelines for the PAL lift to help prevent R1's legs from buckling, provide support to keep the feet and legs in place, and to prevents falls.

During an interview on 6/23/21, at 3:10 p.m. director of nursing (DON) stated R1 required assist of a PAL lift and two staff for transfers to the toilet. DON indicated if the resident was able to fully weight bear they did not require the use of the belt on the lower legs during a PAL lift transfer. DON stated that it was expected each resident's care plan clearly identify the resident's functional needs for transfers.

During an interview on 6/24/21, at 9:24 a.m. PT stated R1 had refused many physical therapy sessions and that had affected her progress. PT indicated R1 needed assist of two staff when the PAL lift was used for any transfer. PT stated if a resident moved their legs during a transfer with the PAL lift then a lower leg belt should have been used. PT indicated R1 was not strong enough yet, was unpredictable, was distracted easily and safety was an issue.

During an interview on 6/24/21, at 11:20 a.m. with registered nurse (RN)-A stated R1 required assistance of two staff and the PAL lift from bed to wheel chair due to stability reasons and she

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2 830	Continued From page 7 was not able to follow cues. RN-A verified R1's care plan indicated R1 transferred with a PAL lift and assist of two staff for toileting. RN-A confirmed R1's care plan should have indicated a PAL lift was required for all transfers. RN-A stated the lower leg belt should always be used with PAL transfers unless it was indicated in the care plan to not use it. RN-A identified the transfer belt applied to the lower legs assured a safe transfer. Manufacturer's operator instructions titled EZ Way Smart Stand revised 7/30/18, identified to use the shin pad strap if a caregiver deemed it necessary to keep a patient's shins or feet on the foot plate and to secure the shin strap around the patients's legs. Suggested Method of Correction: The Director of Nursing or designee could review policies and procedures and train staff to assure staff are following resident care plans and assure proper use of mechanical lifts. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing	2 910		7/27/21

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2 910	Continued From page 8 home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder 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. Findings include: R1's admission Minimum Data Set (MDS) dated 5/16/21, identified R1 was cognitively intact, was occasionally incontinent of bladder and was always continent of bowel. R1's face sheet dated 6/23/21, identified R1 had diagnoses which consisted of a left femur fracture, syncope (fainting), muscle weakness and difficulty walking. R1's Care Area Assessment (CAA) dated 5/23/21, identified R1 had an altered mental status, poor memory, restricted mobility, urinary urgency and was total dependent on staff with toileting, R1's care plan dated 5/21/21, identified R1 had an activity of daily living (ADL) self care	2 910	corrected.	

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2 910	Continued From page 9	2 910		

performance deficit related to femur fracture. The care plan indicated R1 required a PAL lift and two staff to transfer for toileting. The care plan identified R1 was able to alert staff when toileting was needed.

R1's bladder data collection tool assessments dated 5/10/21, and 5/27/21, identified R1 was currently incontinent of bladder, had nocturnal (night time) enuresis (bed wetting) and the treatment consisted of a scheduled toileting/habit training program. The assessments indicated R1 was alert and did turn on the call light when she needed to use the bathroom during the night. R1 stated she was unaware when she had to go to the bathroom however did void in the commode the first day. R1 was incontinent during the night. The assessments indicated R1 needed to be on scheduled toileting times during the night.

Review of nursing assistant (NA) kardex dated 6/15/21, indicated R1 required the use of a PAL lift and two staff to transfer. The kardex indicated R1 was able to alert staff when toileting was needed. The kardex instructed staff to not leave R1 on the commode unattended.

Review of R1's urinary continence log identified:

-6/15/21, at 1:46 a.m., 8:17 a.m., and 9:01 p.m. R1 was incontinent of urine.

-6/16/21, at 5:27 a.m., 1:59 a.m., and 8:42 p.m. R1 was incontinent of urine.

-6/17/21, at 2:11 a.m., 8:56 a.m., and 9:50 p.m. R1 was incontinent of urine.

-6/18/21, at 3:29 p.m. R1 did not void and at 1:59 p.m. incontinent of urine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00730	A. BUILDING: _____ B. WING _____	C 06/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 10 -6/19/21, at 2:56 a.m. R1 was continent of urine and at 10:48 a.m. and 8:15 p.m. incontinent of urine. -6/20/21, at 4:17 a.m. R1 was continent of urine and at 8:11 a.m. and 3:31 p.m. incontinent of urine. -6/21/21, at 1:44 a.m. R1 did not void, 1:59 p.m. incontinent of urine, and 9:56 p.m. continent of urine. -6/22/21, at 2:16 a.m. R1 did not void, 1:59 p.m. and 9:59 p.m. incontinent of urine. -6/23/21, at 5:36 a.m. R1 continent of urine and 11:23 a.m. incontinent of urine. During an observation on 6/23/21, at 9:45 a.m. nursing assistant (NA)-A entered R1's room with a PAL lift. R1 stated her brief was wet with urine and she needed to get cleaned up for the day. R1 requested a basin of warm water and wash clothes to wash up. NA-A removed the tabs from the front of the brief and cleansed R1's peri area from front to back with a wipe. NA-A turned R1 onto her right side, removed the saturated brief and cleansed her rectal area from front to back with a wipe. NA-A stated the urine in the brief was a dark colored yellow. The NA-A indicated the sheets underneath the resident were saturated with urine from R1's upper back area down to just above her knees. R1 laid on the wet sheets while NA-A positioned a clean brief underneath her and attached the tabs to fasten the brief. NA-A assisted R1 up to a sitting position, did not wash her upper body area or change her t-shirt and then transferred her into her wheel chair with the PAL lift. NA-A washed her hands, placed R1's	2 910		

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2 910	Continued From page 11	2 910		

hair up in a pony tail, removed and bagged all linens located on the bed and exited the room.

During an interview on 6/23/21, at 10:18 a.m. R1 stated the last time staff changed her brief was around 10:00 p.m. or so the previous night. R1 indicated the day shift had not checked her until NA-A entered the room and answered her call light around 9:45 that a.m. R1 stated when she needed a brief change, she had to put the call light on otherwise she would have laid in a wet brief all night until the next day sometime. R1 indicated her daughter informed her she smelled like urine at times and stated that bothered her. R1 stated she was not able to smell as well as she used to so she probably did not notice the urine odor smell like her daughter did. R1 indicated she laid in urine soaked sheets that morning, believed her t-shirt she had slept in was dirty and felt wet on the back side. R1 stated she had wanted her t-shirt changed prior to going to physical therapy and did not want to smell like urine. R1 stated she was concerned about the skin on her bottom when she sat in urine or stool.

During an interview on 6/23/21, at 10:45 a.m. NA-A stated she did not make it to R1's room until later than planned. NA-A indicated R1 ate breakfast in bed and she usually checked on her early in the shift to see if she needed to go to the toilet or have her brief changed. NA-A identified R1 did not use her call light consistently and required frequent checks by staff. NA-A stated R1 should have been checked every two hours for toileting needs throughout each shift.

During an interview on 6/23/21, at 2:20 p.m. LPN-A indicated NA's were expected to check and change residents every two hours and when the resident was incontinent they required more

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2 910	Continued From page 12	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. director of nursing (DON) stated after the two bladder data collection tool assessments were completed, a plan should have been developed and followed regarding toileting needs. DON indicated staff were expected to check on R1 more frequently.

During an interview on 6/24/21, at 10:20 a.m. RN-C verified she completed a bladder data collection tool assessment on 5/27/21, on R1. RN-C stated R1 used the bedside commode upon admission 5/10/21, and had been continent of bladder then regressed and became incontinent during the day. RN-C stated R1 chose to not use the commode anymore. RN-C indicated R1 had been incontinent of bladder at home during the night prior to admission. RN-C stated the recommendation would have been for staff to check R1 every two hours to make sure her toileting needs were met. RN-C stated the assessment identified the need for scheduled toileting and the care plan should have been updated to reflect that with interventions implemented.

During an interview on 6/24/21, at 11:00 a.m. RN-A verified she competed a bladder data collection tool assessment upon R1's admission on 5/10/21. RN-A stated the assessment showed R1 had been continent of bladder during the day and incontinent of bladder during the night and a toileting schedule had been recommended. RN-A indicated the care plan should have been updated

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2 910	Continued From page 13 to meet R1's toileting needs and to prevent incontinence. Facility policy titled bowel and bladder management revised 11/2016, identified there was a system to ensure that each resident with bowel or bladder incontinence would receive appropriate treatment and services to maintain as much normal elimination function as possible. A resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. If deemed appropriate an individualized toilet schedule on bladder training program and/or bowel toileting or training programs would be implemented. The comprehensive person-centered care plan would be updated to include the resident's bowel and bladder needs, goals, and personal preferences. SUGGESTED METHOD OF CORRECTION: The facility could review the state requirements, review their policies/procedures and revise them to include individualized toileting schedules/plan/program, the facility could then develop assessments and tools and educate staff on how to assess, implement, and maintain an individualized toileting plan for all residents. The facility could then develop and implement an auditing system as part of the quality assure process to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		