Electronically delivered
June 29, 2023

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

RE: CCN: 245299
Cycle Start Date: June 16, 2023

Dear Administrator:

On June 16, 2023, a survey was completed at your facility by the Minnesota Department(s) of Health 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 immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On June 12, 2023, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office forimposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty, (42 CFR 488.430 through 488.444).

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency

evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effectiveJune 16, 2023. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Frazee Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 16, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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

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

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,

Sarah Lane

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 06/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/15/23 through 6/16/23, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaints were reviewed: H52992854C (MN94396, MN94426) and a deficiency was issued at F689 at PAST NON-COMPLIANCE. H52992865C (MN91547) Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000	Past noncompliance: no plan of correction required.	
F 689 SS=J	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: Based on observation, interview and document review, the facility failed to ensure 3 of 6 residents (R1, R2, R3) were appropriately re-assessed to safely smoke independently at the facility and failed to ensure implementation of smoking	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 07/07/2023

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

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 06/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 1 interventions. This resulted in an Immediate Jeopardy when R1 sustained fourth degree burns to the left side of face, left side of neck, left shoulder, left arm, left chest, left abdomen, and left upper leg when she was left outside to smoke with out a smoking apron on, dropped a spark from her cigarette on her left side which set fire to her clothing. The immediate jeopardy began on 6/10/23, at approximately 7:55 p.m. when R1 was found by staff outside the facility, under a covered patio, on fire resulting in hospitalization and fourth degree burns. The immediate jeopardy was identified on 6/15/23, and the administrator was notified of the immediate jeopardy on 6/15/23, at 4:10 p.m. The immediate jeopardy was removed on 6/12/23, and the deficient practice was corrected prior to the start of the survey and was therefore issued at past noncompliance. Findings include: R1's Admission Record indicated she admitted to the facility on 8/6/19. The Admission Record identified diagnosis that included hemiplegia (one-sided paralysis), hemiparesis (partial weakness or inability to move on one side of the body) and nicotine dependence. R1's quarterly Minimum Data Set (MDS) dated 5/26/23, identified intact cognition and indicated she required limited assistance from staff for locomotion on and off the unit. R1's MDS indicated she had impairments of her upper and lower extremities on one side. R1's Smoking Evaluation Tool dated 2/24/23, identified the following question: Resident	F 689		

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 06/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2 smokes safely (Does not allow ashes or lit material to fall while smoking, inhaling or holding smoking item. Remains alert and aware while smoking. Does not forget he/she is smoking or falls asleep holding item. Does not endanger self or others while smoking. Does not burn furniture, clothing, skin, self or others. Turns oxygen off prior to lighting cigarette. Smokes only in designated areas). The question was answered no, however the assessment indicated R1 was a safe smoker who could smoke independently and unsupervised and required a smoking apron. R1's Smoking Evaluation Tool dated 5/23/23, identified a question: Resident smokes safely (Does not allow ashes or lit material to fall while smoking, inhaling or holding smoking item. Remains alert and aware while smoking. Does not forget he/she is smoking or falls asleep holding item. Does not endanger self or others while smoking. Does not burn furniture, clothing, skin, self or others. Turns oxygen off prior to lighting cigarette. Smokes only in designated areas). The assessment indicated R1 could smoke independently or with set-up and indicated she must wear a smoking apron at all times. R1's care plan dated 10/4/22, indicated she had a tendency to be non-compliant with the facility smoking policy and procedure. The care plan directed staff to remind R1 of the potential negative outcomes related to her choice of not smoking in the dedicated area and wearing a smoking apron. The care plan further directed staff to provide reminders to wear the smoking apron. R1's care plan was revised 6/11/23, and identified a critical injury from smoking. The care plan indicated per assessment R1 was unable to	F 689		

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 06/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3 smoke per facility policy. R1's Progress Notes identified the following: 2/13/23, Per nursing assistant (NA) on 2/11/23, R1 refused lunch so she could smoke. The NA went to follow up with R1 and noted R1 must have flicked an ash into her purse because it (purse) was smoking. The NA dumped out R1's purse and a few tissues were smoldering along with the purse. 2/15/23, Staff had a discussion with R1 about not being able to go outside to smoke until an assessment could be done. R1 voiced that she was safe to smoke and the previous incident had been an accident. Staff voiced concern that although it had been an accident, the outcome could have been much worse so for now R1 was unable to smoke. 2/24/23, Smoking evaluation was completed per R1's request so she could smoke again. The results were as follows: R1 could not bring a purse out to smoke. R1 would have smoking materials on the nurses cart at all times and could have one cigarette and lighter when she went out then had to return the lighter after. R1 was to dress warmly and could put phone for emergency in her right coat pocket. R1 must wear smoking apron. Will wear doorbell to alert staff when she needed assistance getting over the threshold outside and would not bring smoked cigarettes or butts back into the facility. R1 was directed to put the cigarettes out in the snow on the ledge and throw onto the snowy ground. 4/19/23, NA reported R1 was asking staff and	F 689		

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 06/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4 other residents to pick up cigarette butts for her to smoke. 6/2/23, Staff discussed smoking privileges at the facility and concerns from family member that R1 could only have two cigarettes at a time when she went outside. 6/10/23, Trained medication aide (TMA) went outside to administer medications to R1. As the TMA got to the outside door he noted fire under the covered patio and when he got outside realized it was R1 who was on fire and ran toward her and attempted to pat the fire out on the left side of her neck. The TMA then began removing clothing that was on fire. The TMA used R1's soda to dump on her and the clothes to extinguish the fire. The TMA called for assistance and emergency services were called. R1 was flown to Hennepin County Medical Center. Per staff, R1 was last seen at about 6:00 p.m. coming inside the facility wearing a smoking apron. 6/12/23, R1's family member reported R1 had been switched to comfort focused care with a goal to return to facility. Staff was able to get information from the hospital nurse who reported R1 sustained 4th degree burns and required dressing changes multiple times per day. During observation on 6/16/23, at 8:07 a.m. R1 was lying in bed with her eyes closed. R1 had a blanket covering the lower half of her body. R1 had no hair, had multiple bandages covering part of her face and neck and bandages covering her entire left arm and hand. R2's Admission Record indicated an admission date of 3/27/20. The Admission Record identified	F 689		

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 06/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5 diagnosis that included Hemiplegia, hemiparesis and tobacco use. R2's annual MDS dated 4/1/23, indicated he had intact cognition, required extensive assistance with transfers and supervision with locomotion. R2's MDS indicated he had impairments to both his upper and lower extremities on one side of his body. R2's Smoking Evaluation Tool dated 3/30/23, identified the following question: Resident utilizes ashtray safely and properly (Gets ashes into ashtray. Does not cause/allow sparks or lit tobacco to fall anywhere but into the ashtray). The box was checked no however, the evaluation indicated R2 was a safe smoker and could smoke unsupervised. The use of a smoking apron was not indicated. R2's care plan dated 5/16/23, identified a risk for injury related to smoking. The care plan directed nursing to store smoking materials and indicated R2 required a smoking apron. The care plan was updated 6/11/23, and indicated all residents who smoke must be supervised. R2's Progress Notes identified the following: 4/7/23, Staff provided R2 with education about the facility smoking area and that he could not be smoking outside other residents windows. Staff reminded R2 that if he chose not to use the designated smoking area his privileges could be revoked. 5/5/23, R2 was seen outside tipped over in his wheel chair. R2 said his wheel went off the sidewalk onto the grass and caused his chair to	F 689		

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 06/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6 tip over backwards. 5/15/23, NA reported R2 had gone out to smoke without a smoking apron which resulted in burn holes in the the mechanical lift sling and R2's pants. Staff had an in-depth conversation with R2 who stated, "I am too lazy to put it on, but I will wear it if someone helps me put it on." Decision made to have R2's smoking materials placed in the medication cart so he would have to have a smoking apron put on. R3's Admission Record indicated she admitted to the facility on 1/21/22, with diagnosis that included muscle weakness. R3's significant change MDS dated 5/19/23, identified intact cognition. The MDS indicated R3 required supervision with locomotion on and off the unit and indicated she had lower extremity impairment on one side. R3's Smoking Evaluation Tool dated 5/15/23, indicated she could safely smoke independently but must request smoking materials from staff. R3's care plan dated 3/16/22, identified a risk for injuries related to smoking. The care plan directed staff to assess for safe smoking practices on admission, quarterly and as needed. R3's care plan was revised 6/12/23, to include all residents required to be supervised and have dedicated smoking times. R3's Progress Notes identified the following: 3/8/23, Staff found cigarette ashes in R3's bed, cigarettes on the floor in her room and it appeared R3 had put a cigarette out on the	F 689		

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 06/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7 plastic part of her cigarette pack. R3 stated she did not remember lighting a cigarette in bed after being shown the ashes on her sheets. Staff reviewed the smoking policy with R3 and completed a smoking assessment. R3 continued to be a safe smoker but her cigarettes would be stored in the medication cart. 5/16/23, R3 fell out of her wheelchair outside while smoking . R3 stated she had been reaching down to get her cigarettes that she dropped. A NA found R3 face first on the ground. During interview on 6/15/23, at 1:45 p.m. the director of nursing (DON) stated smoking assessments were completed on admission, quarterly and if a policy change occurred. The DON said staff watched the resident while smoking to see how they did. The DON stated after R1 had the incident when she dropped the spark in her purse, she felt the interventions put in place at that time made R1 safe to continue smoking independently. The DON stated after R2 burned holes in his clothing he was assessed to need a smoking apron and felt that would make R2 safe to smoke independently also. When asked who monitored the residents to ensure the interventions were implemented the DON said she felt like the staff and the residents themselves were responsible. In regard to R3 falling out of her wheel chair while outside smoking and finding ashes in her bed along with burned plastic on her cigarette pack, The DON said staff removed R3's smoking materials and placed them in the medication cart. The DON was unable to articulate why supervision of smoking was not implemented following R1, R2 and R3's demonstrations of unsafe smoking.	F 689		

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 06/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8 On 6/15/23, at 2:09 p.m. NA-A stated she remembered bringing R1 outside to smoke about 2:30 p.m. on 6/10/23, and she put a smoking apron on her. NA-A said she saw R1 at about 4:30 p.m. before dinner but did not recall seeing her after that time. NA-A said R1 could get herself out the door and said at that time there had been no restrictions on her smoking but said R1 needed to wear a smoking apron because she was one of the two residents that would burn themselves. On 6/15/23, at 2:14 p.m. NA-B stated she did not know how R1 had gotten outside and said R1 usually sat outside most of the day. NA-B said when she saw R1 just before 6:00 p.m. she had a smoking apron on and said when R1 went back outside she was not wearing one. NA-B said R1 had trouble getting over the threshold to get outside. NA-B said the only person staff worried about when smoking was R2 because he had burned a couple holes in the mechanical lift sling. NA-B said R1 and R2 were the only residents that needed a smoking apron. NA-B stated the incident with R1's purse was the reason she got the smoking apron. During interview on 6/15/23, at 2:22 p.m. TMA-A stated on the evening of 6/10/23, he went outside to bring R1 her medications. TMA-A stated when he got outside he saw a fire and initially thought it was the picnic table. He said when he got closer he realized R1 was on fire. TMA-A stated he tried to put the fire out and ended up ripping off R1's clothing, dumped her pop on her and radioed for help. TMA-A said he thought R1 had been outside for about an hour and had not been wearing a smoking apron when the fire started. TMA-A said R1 had been wearing a shirt,	F 689		

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 06/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9 sweatshirt and a blue nylon scarf. Facility policy Frazee Care Center Complex Resident Smoking Policy dated 5/5/21, indicated all residents who want to smoke or use tobacco products at the facility will be assessed by a nurse for safety and appropriateness upon admission to the facility, quarterly and as needed. Each resident will be assessed for physical, cognitive, mood and behavior factors that may affect a resident's ability to independently and safely smoke while at the facility. The policy identified the designated smoking area and indicated from 6:00 a.m. to 10:00 p.m. was "open smoking." The past noncompliance immediate jeopardy began on 6/10/23. The immediate jeopardy was removed, and the deficient practice corrected on 6/12/23, after the facility implemented a systemic plan that included the following actions: - All residents in the facility who smoked were re-assessed for safety. - The facility implemented designated smoking times with staff supervision for all residents and implemented smoking audits. - The door leading out to the smoking area was equipped with a fire extinguisher, a fire blanket and additional smoking aprons. - The facility's smoking policy was updated to include: All residents will be supervised while smoking and taken outside at the designated times. - Staff education was implemented and ongoing and was verified through observation, interview and document review.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 29, 2023

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

Re: Event ID: NQDQ11

Dear Administrator:

The above facility survey was completed on June 16, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00730	A. BUILDING: _____ B. WING _____	C 06/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 6/15/23 through 6/16/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. The following complaints were reviewed during	2 000		

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 06/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 the survey. H52992854C (MN94396, MN94426) H52992865C (MN91547) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		