CENTERS FOR MEDICARE & MEDICAID SERVICES

	EDICARE/MEDICAID CERTIFICATION RT I - TO BE COMPLETED BY THE STA		ID: 1UBM Facility ID: 00730
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245299 2.STATE VENDOR OR MEDICAID NO. (L2) 972153000	3. NAME AND ADDRESS OF FACILITY (L3) FRAZEE CARE CENTER (L4) 219 WEST MAPLE AVENUE, PO BC (L5) FRAZEE, MN		4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 11/01/2004 6. DATE OF SURVEY 12/17/2018 (L3) 	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD 4) 02 SNF/NF/Dual 06 PRTF 10 NF	<u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF	7. On-Site Visit 9. Other 8. Full Survey After Complaint
8. ACCREDITATION STATUS:(L10 0 Unaccredited 1 TJC 2 AOA 3 Other)) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/III 04 SNF 08 OPT/SP 12 RHC	D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION From (a): To (b):	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds 60 (L18 13.Total Certified Beds 60 (L17)		4. 7-Day RN (Rural SNF) 5. Life Safety Code) 8. Patient Room Size 9. Beds/Room (L12)
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 5 60	SNF ICF IID	* Code: A 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L12) (L15)
(L37) (L38) (L 16. STATE SURVEY AGENCY REMARKS (IF APPLI	39) (L42) (L43) CABLE SHOW LTC CANCELLATION DATE):		
17. SURVEYOR SIGNATURE	Date:	18. STATE SURVEY AGENCY A	APPROVAL Date:
Gail Anderson, Unit Supervi	sor 11/21/2018 (L19)		, Enforcement Specialist _{/03/2018}
PART II - T	O BE COMPLETED BY HCFA REGIONA	L OFFICE OR SINGLE STA	(L20) ATE AGENCY
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L	20. COMPLIANCE WITH CIVIL RIGHTS ACT: 21)	 Statement of Finance Ownership/Control Both of the Above : 	Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AG	REEMENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEGIN 11/01/1985	NING DATE ENDING DATE	VOLUNTARY 00 01-Merger, Closure 00	05-Fail to Meet Health/Safety
A. Susp	(L25) NATIVE SANCTIONS eension of Admissions: (L44)	02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	nt 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active
(L27) B. Resci	nd Suspension Date: (L45)		
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS	
(L28)	03001 (L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE		
(L32)	(L33)	DETERMINATION APPRO	OVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 18, 2018

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

RE: Project Numbers S5299032, H5299010

Dear Administrator:

On November 7, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on October 19, 2018 that included an investigation of complaint number H5299010. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 17, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 17, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 19, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 28, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 19, 2018, effective November 28, 2018 and therefore remedies outlined in our letter to you dated November 7, 2018, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kumalu Fiske Downing

Kamala Fiske-Downing Licensing and Certification Program Minnesota Department of Health Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

An equal opportunity employer.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245299

December 18, 2018

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 28, 2018 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Licensing and Certification Program Minnesota Department of Health Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

	DADT I	- TO BE COMP	LETED BV TL	IF STAT	E SURVEY AGENCY		Facility ID: 00730
I. MEDICARE/MEDICAID PROVIDE (L1) 245299 2.STATE VENDOR OR MEDICAID NO (L2) 972153000	R NO.	 3. NAME AND AD (L3) FRAZEE CA (L4) 219 WEST N (L5) FRAZEE, M 	DDRESS OF FACILI ARE CENTER IAPLE AVENUE	TY		 TYPE OF ACTI Initial Termination Validation 	•
5. EFFECTIVE DATE CHANGE OF O	WNEDCHID		PPLIER CATEGOR	v	<u>02</u> (L7)	7. On-Site Visit	9. Other
(L9) 11/01/2004	9/2018 (L34)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	1 09 ESRD 10 NF 11 ICF/IID 12 RHC	13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	8. Full Survey After FISCAL YEAR END 09/30	•
11LTC PERIOD OF CERTIFICATION From (a) : To (b) : 12.Total Facility Beds	60 (L18)	Compliant			And/Or Approved Waivers Of TI 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNI 5. Life Safety Code	6. Scope of 7. Medical I	Services Limit Director oom Size
13.Total Certified Beds	60 (L17)		mpliance with Progra and/or Applied Waiv		* Code: B *	(L12)	
 14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 60 (L37) (L38) 16. STATE SURVEY AGENCY REMANDING 	19 SNF (L39)	ICF (L42) E SHOW LTC CANCE	IID (L43) ELLATION DATE):		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
7. SURVEYOR SIGNATURE		Date:			18. STATE SURVEY AGENCY	APPROVAL	Date:
Denise Erickson, HF	E NE II	1	11/21/2018	(L19)	Douglas Larson, Enf	orcement Spec	ialist 12/03/2018
I	PART II - TO BE	COMPLETED	BY HCFA RE	GIONAL	OFFICE OR SINGLE ST	ATE AGENCY	
 DETERMINATION OF ELIGIBILI 1. Facility is Eligible to 1 2. Facility is not Eligible 	Participate		APLIANCE WITH C GHTS ACT:	IVIL		ncial Solvency (HCFA-25 ol Interest Disclosure Stmt : :	
22. ORIGINAL DATE	23. LTC AGREEM	ENT 24	4. LTC AGREEME	INT	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION 11/01/1985	BEGINNING	DATE	ENDING DATE		<u>VOLUNTARY</u> <u>0</u> 01-Merger, Closure	05-Fail t	JNTARY o Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination		o Meet Agreement
5. LTC EXTENSION DATE: (L27)	 ALTERNATIV A. Suspension B. Rescind Sus 	of Admissions:	(L44)		04-Other Reason for Withdrawal	OTHER	ider Status Change
. ,	D. Reseniu Sus	pension Date.	(L45)				
8. TERMINATION DATE:	29	. INTERMEDIARY/C			30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	DETERMINATION (OF APPROVAL DA	TE			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 7, 2018

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

RE: Project Number S5299032, H5299010, H5299011, and H5299012

Dear Administrator:

On October 19, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the October 19, 2018 standard survey the Minnesota Department of Health, completed an investigation of complaint number H5299010.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the October 19, 2018 standard survey, the Minnesota Department of Health, completed an investigation of complaint number H5299011, and H5299012 that was found to be unsubstantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is November 28, 2018.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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.

Frazee Care Center November 7, 2018 Page 2

- 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 a 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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the 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) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota 56537-3858 Email: gail.anderson@state.mn.us Phone: (218) 332-5140 Fax: (218) 332-5196

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

Frazee Care Center November 7, 2018 Page 3 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 January 19, 2019 (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 April 19, 2019 (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

Frazee Care Center November 7, 2018 Page 4

deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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

Minnesc	ta Department of He	ealth			1 OT WI	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A BOILDING.			5
		00730	B. WING			9/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FRAZEE	CARE CENTER		MAPLE AV	ENUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre- pursuant to a surver found that the defice herein are not corre- not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When 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.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	o participate in the electronic insure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR		ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
Electron	ically Signed					11/14/18

If continuation sheet 1 of 75

	NT OF DEFICIENCIES	2011h (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED
		00730	B. WING		10/19/201	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
FRAZEE	CARE CENTER		T MAPLE AVE MN 56544	NUE, PO BOX 96		
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2 000	Department of Heal you electronically. is necessary for Sta enter the word "corr text. You must then State licensure proo completion date, the corrected prior to el Minnesota Departm On October 15th, 1 2018, surveyors of the above provider orders are issued. I unvestigations were the licensing survey complaints H52990 H5299012, were co substantiated along Statute) is as follow H5299010. MN Rul Subp. 3. Please indicate in correction that you and identify the date completed. Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 6th, 17th, 18th, and 19th this Department's staff, visited and the following correction n addition complaint e also completed at the time of y. An investigsation of 10, H5299011, and omplated. The complaint g with the (MNRule#/MN /s: e/MN Statute #4658.0525 your electronic plan of have reviewed these orders,				

(EACH DEFICIENCY M REGULATORY OR LSC Continued From page findings which are in v after the statement, " evidence by." Followi are the Suggested Me Time period for Corre	219 WES FRAZEE, MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION) 2 2 violation of the state statute This Rule is not met as ng the surveyors findings ethod of Correction and	B. WING DRESS, CITY, ST T MAPLE AVE MN 56544 ID PREFIX TAG 2 000	ATE, ZIP CODE NUE, PO BOX 96 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
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PLAN OF CORRECT	ION FOR VIOLATIONS OF			
		2 302		11/28/18
DISORDER TRAININ	IG:			
Àlzheimer's disease or related dis segregated or genera care staff and their supervisors	orders, whether in a al unit, the facility's direct			
 an explanation of <i>i</i> related disorders; assistance with ac problem solving w 	Alzheimer's disease and ctivities of daily living; rith challenging behaviors;			
	"PROVIDER'S PLAN APPLIES TO FEDER THIS WILL APPEAR THERE IS NO REQU PLAN OF CORRECT MINNESOTA STATE MN State Statute 144 or related disorder tra ALZHEIMER'S DISE/ DISORDER TRAININ MN St. Statute 144.6 (a) If a nursing facility Alzheimer's disease or related dis segregated or general care staff and their supervisors dementia care. (b) Areas of required (1) an explanation of related disorders; (2) assistance with ac (3) problem solving w and (4) communication sk	 "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in 	 "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in 	 "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in

STATE FORM

ND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	COM	E SURVEY PLETED
		00730	B. WING		10/19/20	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RAZEE	CARE CENTER		「MAPLE AV MN 56544	'ENUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 302	written or electronic training program, th trained, the frequen topics covered. (d) The facility shall this section. This MN Requireme by: Based on staff inter employee records, i that all direct care s the required demen direct care and sup designee (SSD)-A a reviewed. Also, the specific training for daily living (ADL) for disease or related of Findings include: The facility provided Alzheimer's disease training program. T undated handout tit Strategies for Quali included 3 videos ti Dementia Care, par training program fai with activities of dai	e form a description of the le categories of employees acy of training, and the basic document compliance with ent is not met as evidenced view and the review of the facility failed to ensure staff and supervisors received tia care training for 2 of 5 ervisory staff (social service and registered nurse (RN)-C) facility failed to provide assistance with activities of r residents with Alzheimer's disorders.	2 302	Corrected		

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00730		CONSTRUCTION	Сом	E SURVEY PLETED C 19/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE	• • • •	
	CARE CENTER	219 WES		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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 302	completed the dem training videos. Social Service Desi 8/16/18. SSD-A ha training videos. On 10/18/18, at 11: DON) reviewed the or related disorder f surveyor. DON cor training for providin Alzheimer's disease indicated all staff re employee orientation On 10/19/18, at 10: relations and admiss handled the NEO tr DON reviewed the reviewed with surve would be able to ide completed the requi On 10/19/18, at 12: employee training r and RN-C had not o	 9/25/18. RN-C had not entia ignee (SSD)-A Was hired on id not completed the dementia 37 a.m. director of nursing (e facilities Alzheimer's disease training program with firmed the program lacked g ADLs for residents with e or related disorders. DON eceived training at time of new on (NEO). 13 AM DON indicated public ssion director (PRAD)-A raining the facility provided. training records of employees eyor. DON indicated PRAD-A entify which staff had ired training. 20 p.m. PRAD-A reviewed ecords and confirmed SSD-A completed their Alzheimer's o training, and both were 		DEFICIENCY		
	(General) revised J on-going, planned e conducted for the d of necessary skills personnel. Training	tled In-Service Programs une 2017, identified an education program was evelopment and improvement and knowledge for all facility g would be performed via ie) or in person. The policy				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		00730	B. WING		C 10/19/201	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RAZEE	CARE CENTER		T MAPLE AV MN 56544	ENUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETI DATE
2 302	Continued From pa	ige 5	2 302			
	would be complete who had not attend	ow up of employee training d monthly to identify those led the required in-services nd communicate expectation ance.				
	The Director of Nur service for all direc regarding Alzheime designee could ens completed the train and assurance con	THOD OF CORRECTION: rsing could schedule an in t care staff and supervisors er's disease. The DON or sure all required staff ing. The quality assessment mittee could audit employee o ensure compliance.				
	TIME PERIOD FOI days.	R CORRECTION: Thirty (30)				
2 510	MN Rule 4658.030	0 Subp. 2 Use of Restraints	2 510			11/28/18
	must be free from a restraints imposed	from restraints. Residents any physical or chemical for purposes of discipline or not required to treat the symptoms.				
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview and document ailed to ensure 1 of 1 free from the use of physical		Corrected		
	Findings include:					
		ted 10/19/18, indicated R5 had cluded vascular dementia with				

STATE FORM

1UBM11

If continuation sheet 6 of 75

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00730		CONSTRUCTION	COM	E SURVEY PLETED C	
	PROVIDER OR SUPPLIER		DRESS, CITY, ST		10/19/201		
				NUE, PO BOX 96			
FRAZEE	CARE CENTER		MN 56544	-,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 510	Continued From pa behavioral disturba cerebrovascular dis	nce, anxiety disorder and	2 510				
	7/18/18, indicated F impairment and rec two staff for bed mo also required exten for transfers, dressi hygiene, and walkir R5 utilized a chair r	mum Data Set (MDS) dated R5 had severe cognitive quired extensive assistance of obility. The MDS indicated R5 sive assistance of one staff ing, eating, toileting, personal ng. The MDS further indicated restraint daily to prevent rising us used while in bed and in the					
	(CAA) dated 1/30/1 tray on her wheel c transfer attempts as falls due to self tran of dementia and dis impairment with ori- term memory issue safety awareness a	raint Care Area Assessment 8, indicated R5 utilized a lap hair to prevent rising and self s R5 has history of frequent asferring. R5 had a diagnosis splayed severe cognitive entation, short term and long s. R5 also had very poor and decision making which her past falls and the lap tray.					
	used an external de self or to others cha injury/falls, impaired related to cognitive agitation. The care interventions which device every two he Stand, reposition, w Off during meals. T physician ordered r and reposition ever	sed on 2/8/18, indicated R5 evice for prevention of injury to aracterized by high risk for d mobility, physical aggression impairment and motor plan listed various included: lap tray restraint ours while in wheel chair. valk in hallways and reapply. The care plan also indicated restraint of lap tray, release y two hours and off at meals. er indicated to try alternative					

STATEMEN	ota Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	Сом	E SURVEY PLETED C
		00730	B. WING		10/	19/2018
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
FRAZEE	CARE CENTER		T 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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE	(X5) COMPLET DATE
IAG			IAG	DEFICIENCY		
2 510	Continued From pa	ge 7	2 510			
	If restraint still requ restraint-reduction					
	required extensive eating and directed two hours, stand up device and off at m included the followi times, release and off at meals. During observations main dining room o was seated in her v tray attached to the attempting to pedal with her feet. - at 5:55 p.m. dietar food which consiste carrots, pineapple of glass of thickened v sitting on the table. black lap tray attach she tried to propel h kitchen area. -at 6:02 p.m. nursin R5 back to the dinin with attached lap tray begin eating her foo of milk. - at 6:07 p.m. R5 re wheelchair with the room while NA-E en her what she had o - at 6:14 a.m. R5 w with the attached lap	oup A undated, indicated R5 assistance of one staff for staff to release lap tray every o/walk, reposition, replace eals. Miscellaneous directions ng in bold type: lap tray at all off load every two hours and s of the supper meal in the n 10/17/18 at 5:30 p.m. R5 wheelchair with a black lap wheelchair arms. R5 was herself into the kitchen area ry staff brought R5 a plate of ed of pureed mixed fruit, chicken and rice. R5 had a water, milk and cranberry juice R5 continued to have the ned to her wheelchair while nerself backwards into the g assistant (NA)-E assisted ng room table via wheelchair ay and encouraged R5 to od while she gave R5 a drink emained seated in her attached lap tray in the dining ncouraged her to eat by telling n her plate. as seated in her wheelchair up tray in the dining room the table, when the director				

TATEMENT OF D ND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	`´СОМ	E SURVEY PLETED
		00730	B. WING		C 10/19/20	
AME OF PROVID	ER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
RAZEE CARE	CENTER		T MAPLE AVE MN 56544	NUE, PO BOX 96		
(X4) ID			ID	PROVIDER'S PLAN OF C		(X5) COMPLET
		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	DATE
2 510 Cont	inued From pa	age 8	2 510			
DON juice - at 6 table down chick - at 6 table while mea supp Durin 10/1 whee room and R5 w NA-E - at 8 cere mea - at 9 cere mea - at 9 cloth whee peda into 1	I tried to give F and R5 refuse 3:16 p.m. the D with her lap tr n next to R5 ar (en with rice. 3:25 p.m. R5 w in her wheelch the DON cont I. R5's lap tray ber meal to releven of observation 9/18 at 8:52 a. I. R5's tip toes provide to a ssisted R5 to 3 assisted R5 to 3:58 a.m. NA-B al and continue 1. 0:00 a.m. NA-B al and continue (kfast. R5 rema attached lap ta sed against the elchair while Na kfast. 0:01 a.m. NA-B ing protector, u elchair, placed als and wheeleven the hallway. R5 ed and the lap preakfast meal	t, R5 refused to respond. The R5 a drink of her cranberry ed. DON pushed R5 back up to the ray in place, got a chair, sat and gave R5 a bite of her ras seated at the dining room hair with the attached lap tray tinued to feed R5 her supper was not removed during the ease the restraint. s of the breakfast meal on m. R5 was seated in her attached lap tray, at the dining heelchair brakes were locked ressed up against the floor. move in her wheelchair while to eat her breakfast. gave R5 bite of her hot ed to feed R5 her breakfast asked R5 if she was done cated she was done eating ined seated in the wheelchair able, brakes engaged, tip toes e floor, unable to move in her A-B assisted her to finish a removed R5's multi-colored unlocked the brakes on R5's her feet on the wheelchair d her out of the dining room 5's wheelchair brakes were tray was not removed during to release the restraints.				

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00730	(X2) MULTIPLE A. BUILDING: _ B. WING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/19/2018	
	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
				NUE, PO BOX 96		
FRAZEE	CARE CENTER		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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 510	at 12:29 p.m. R5 wa with an attached lap R5 had both brakes while her tip toes pr R5 was not able to NA-G assisted R5 t - at 12:32 p.m. NA her lunch while her her wheelchair and attached to the whe - at 12:36 p.m. licer confirmed R5's whe and a lap tray was a while NA-G fed her locked the brakes of fidgeting. She verif R5's lap tray neede meals. On 10/18/18 at 2:15 needed staff assista of daily living (ADL' lap tray restraint at removed every two On 10/18/18 at 2:45 needed staff assista to f daily living (ADL' lap tray restraint at removed every two On 10/18/18 at 2:45 needed staff assista LPN-B verified R5 to all times and it was hours and off to the On 10/19/18 at 11:0 care plan and indica assistance with me verified R5 utilized a as a restraint due to family request. The was to be removed	as seated in her wheelchair o tray at the dining room table. Is locked on her wheelchair, ressed up against the floor. move in her wheelchair while o eat her lunch. G continued to assist R5 eat braked remained locked on her lap tray remained eelchair. Ised practical nurse (LPN)-B belchair brakes were locked attached to R5's wheelchair lunch. NA-G indicated they on R5 wheelchair due to her ied she was not aware that d to be removed during 5 p.m. NA-F confirmed R5 ance for eating and activities s). NA-F verified R5 utilized a all times and it was to be hours and during meals. D p.m. LPN-B confirmed R5 ance for eating and all ADL's. utilized a lap tray restraint at to be removed every two	2 510			

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00730	B. WING		C 10/19/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
FRAZEE	CARE CENTER		۲ 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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 510	the lap tray being re- reviewed R5's currer indicated she would care plan as written remove the lap tray staff should not be li- brakes, which would On 10/19/18 at 12:3 needed staff assista of daily living (ADL' lap tray restraint at removed every two NA-B indicated she lap tray during the r been taken off durin R5's brakes had be and indicated staff wheelchairs. Review of facility por Care revised on 4/1 restraints were only appropriately to treas symptoms and to pi function for the resi indicated a restrain purpose of disciplin SUGGESTED MET The Director of Nur develop/review and procedures on the a restraints. All appro on the process of a restraints. The Dire	emoved during meals until she ent care plan. The DON d expect staff to follow R5's and would expect staff to during all meals and verified locking R5's wheelchair d also be a restraint. B2 p.m. NA-B confirmed R5 ance for eating and activities s). NA-B verified R5 utilized a all times and it was to be hours and during meals. had forgotten to remove the meal and stated it should have ng meals. NA-B also verified en locked during the meal were not to lock the brakes on blicy titled, Restraint Free l/2016, indicated physical v used when they were used at the residents medical romote an optimal level of dent. The policy also t may never be used for the e or staff convenience. THOD OF CORRECTION: sing or designee could or revise policies and appropriate use of physical opriate staff could be educated propriate use of physical ctor of Nursing or designee onitoring system to ensure	2 510			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/19/2018	
		00730	B. WING			
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FRAZEE	CARE CENTER	219 WEST FRAZEE, I		ENUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETI DATE
2 510	Continued From pa	ge 11	2 510			
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			11/28/18
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des and 4658.0405. A be out of bed as mu is a written order fro	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 nursing home resident must uch as possible unless there om the attending physician ust remain in bed or the remain in bed.				
	by: Based on observati review, the facility f interventions for 1 of for accidents, and f transfer requirement observed using a m facility failed to imp interventions for 1 of	ent is not met as evidenced ion, interview and document ailed to implement fall of 2 residents (R7) reviewed ailed to implement safe nts for 1 of 2 residents (R7) nechanical lift. In addition, the lement safe smoking of 3 residents (R40) who image smoking materials.		Corrected		
	Findings include:					
	Set (MDS), dated 4	nge in status Minimum Data /26/18, identified R7 had pairment and had diagnoses				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/19/2018	
		00730				
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE NUE, PO BOX 96		
FRAZEE	CARE CENTER		MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S		ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	which included herr weakness of the bo Diabetes Mellitus. T required total assist and extensive assist toilet use, and perse further indicated R7 Review of R7's qua identified R7 had m and had diagnoses (managing the sym life-limiting and chro schizophrenia, and indicated R7 require transfers with two o indicated R7 require transfers with two o indicated R7 had tw assessment. Review of R7's Car dated 5/9/18, identii judgement and safe decision making as transfer, which resu indicated R7 believe attempted to do so the wheelchair to bo R7 had a history of right sided hemipar stand, was a fall ris for transfers. Review of R7's care indicated R7 was a history of falls due to R7 believed he cou incontinence, balan hemiparesis. R7's care	•				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00730		CONSTRUCTION	COM	E SURVEY PLETED C 19/2018
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
				NUE, PO BOX 96		
FRAZEE		FRAZEE,	MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 13	2 830			
	therapy to assess f	or proper wheelchair fitting I mechanical lift to transfer				
	9/23/18, indicated F high-low bed, requi activities of daily liv	Care Guide Group B, dated R7 used a wheelchair, had a red extensive assistance with ring and transferred with total nd a mechanical lift.				
	was lying in a low b positioned next to t wheelchair brakes was able to get him without help from s bathroom independ had fallen a couple	on 10/17/18. at 1:43 p.m. R7 bed with his wheelchair he bed near the bed rail. R7's were not locked. R7 stated he iself up and to the wheelchair taff, and was able to use the dently as well. R7 stated he weeks ago and hit his head. to the hospital and received wound.				
	Review of R7's pro 10/19/18, revealed:	gress notes from 10/1/18, to				
	roommate came to pressure to laceration	ound on the floor after get the nurse. Staff applied ion above right eye until Is services (EMS) arrived and oit Lakes.				
	review R7's fall. R7 wheelchair to bed a his forehead. R7 ha increased fall risk, a transfers. Discusse noted R7 does not wheelchair and was	blinary team (IDT) met to attempted a self transfer from and fell to the floor, lacerating ad right sided weakness that and used a full body lift for with nursing staff and was frequently apply brakes to the s unable to bear weight on his o add auto[matic] brakes				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/19/2018	
		00730	B. WING			
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
FRAZEE	CARE CENTER		T MAPLE AVE MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa (device that automa whenever the perso	atically locked the wheels	2 830			
	wheelchair for impr -10/3/18, R7's auto yet at facility. Physi for proper wheelcha was noted to slide i propels. Staff will a arrive at facility. On 10/17/18, at 6:4 wheelchair and was nursing assistant (N (DON) followed the mechanical lift. At 6 to bed by NA-H and were completed. A lowered to the floor NA-H placed the wi NA-H and the DON	oved safety. brakes are on order and not cal therapy (PT) will assess air use and positioning, as R7 n wheelchair as he self dd auto brakes when they 3 p.m. R7 was seated in the s pushed to his room by NA)-H. The director of nursing m into the room with a 5:47 p.m. R7 was transferred d the DON, and bedtime cares t 6:55 p.m. R7's bed was , he was given a call light, and heelchair next to R7's bed. left the room. R7's were not locked and the				
	required two staff for once in bed one sta as R7 could assist understood instruct him in a low bed du attempts and risk for					
	required extensive was a fall risk. NA-I something, like go	7 p.m. NA-I stated R7 assistance with cares and stated when R7 wanted to do to bed, you have to be quick to things on his own.				
	On 10/18/18, at 9:2	6 a.m. licensed practical				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C		
		00730	B. WING			10/19/2018	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST				
FRAZEE	CARE CENTER		T MAPLE AVE MN 56544	NUE, PO BOX 96			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	ge 15	2 830				
	assist with two staft mechanical lift and	ed R7 required extensive f for cares, and required a two staff for all transfers. 7 was at risk for falls due to ts.					
		0 a.m. PT-A indicated R7 had valuated by therapy.					
	with eyes closed. T elevated approxima R7's wheelchair po wheelchair's locks wheelchair lacked a R7's room and stat laid R7 in bed after fall risk and should occupied. NA-A low	8 p.m. R7 was lying in bed he bed frame remained ately two feet off the floor, with sitioned near the bed. The were not applied and the auto brakes. NA-A entered ed the day shift would have lunch. NA-A stated R7 was a be in a low bed when vered R7's bed to the floor and 's wheelchair remained					
	(CM)-A stated R7 m with all activities of transferred with two times. CM-A stated her expectation for care plan and the of had a fall on 10/1/1 the emergency dep implemented whee intervention to prev indicated she was n	14 a.m. clinical manager equired maximum assistance daily living and was o staff and mechanical lift at all R7 was at risk for falls and staff would be to follow R7's are guides. CM-A stated R7 8, which required sutures at partment. After the fall, staff lichair auto brakes as an tent future falls. CM-A not aware the wheelchair en placed on R7's wheelchair.					
	required assistance	42 a.m. the DON stated R7 with activities of daily living, and injuries, and required two					

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
	00730		B. WING		10/	19/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
FRAZEE	CARE CENTER		T MAPLE AVE MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 830	staff and mechanica DON stated after R reviewed the incide brakes for R7's whe maintenance updat brakes were ordere 10/3/18. The DON auto brakes would verbally asked ther use. The DON conf by therapy, as a the and the proper form stated she would ha assessment to have timely. The DON st low position when co	al lift for all transfers. The 7's fall on 10/1/18, the IDT ont and implemented auto belchair. She indicated ed her that the wheelchair ed, but not available on stated after she learned the not be readily available, she apy to assess R7's wheelchair firmed R7 was not assessed erapy order was not received in was not completed. She ave expected the therapy e been completed more ated R7's bed should be in the boccupied, and stated she wer R7's bed when he was				
	On 10/17/18, at 2:2 edge of bed with th height. R7 had an E standing transfer ed in front of him. R7 h harness around his the EZ-Way Stand's behind the machine raise the hydraulic move. NA-I stated to removed the batter sitting at the edge of behind him and fee NA-I retrieved a diffused this machine returned to R7's root	¹ 3 p.m. R7 was seated at the e bed approximately at knee EZ-Way Stand (mechanical quipment) positioned directly had a beige (medium) colored back, which was attached to s hydraulic arms. NA-I stood c's controls and attempted to arms, but the machine did not the battery had died, she y and left the room with R7 of the bed, with harness t on the stand's foot plate. As ferent battery, R7 stated he often. At 2:25 p.m. NA-I om and placed a different h. NA-I raised the arms of the				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COMI	E SURVEY PLETED
		00730	B. WING		C 10/19/2018	
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
RAZEE	CARE CENTER		T MAPLE AVE , MN 56544	NUE, PO BOX 96		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF ((X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ige 17	2 830			
	machine which assisted R7 to a semi-standing					
		nto the machine's hand grips				
		is he was unable to hold on to				
		is right hand. The EZ-Stand's				
	harness was under	R7's left arm, but R7's right				
		e middle of the harness on the				
	0	buckle strap was closed				
		s waist. As R7 was raised by				
	0	ne, NA-I stood behind the				
		ot attempt to tighten the				
		strap, around R7's torso. NA-I				
		-Stand, with R7 holding on to ne hand and his right elbow				
		e harness on the right, towards				
		-I stopped before R7's	,			
		R7's pants and an				
		nd pushed R7 and the				
		athroom. NA-I then pushed R7				
		As R7's buttocks neared the				
		aise R7 higher in the				
		buttocks over the arm rest of				
		ned holding onto the machine				
		nd and his elbow rested in the				
		lowered R7 onto the toilet and the EZ-Stand machine and	1			
		At 2:29 p.m. NA-I stated she				
		g agency, and had worked at				
		nonths. At 2:32 p.m. R7 stated				
		the toilet and NA-I entered				
		-I used the machine's controls				
		semi-standing position. NA-I				
	completed perineal	cares and pulled the				
		with R7, out of R7's				
		maneuvered the EZ-Stand				
		ir, the harness around R7				
		s back. R7's right elbow				
		d on the harness, with his				
		osely to his chest. The				
	narness buckle had	l moved up from his lower	1			1

STATEMEN	ota Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
		00730	B. WING			10/19/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE			
RAZEE	CARE CENTER		T MAPLE AVE MN 56544	NUE, PO BOX 96			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	ge 18	2 830				
	abdomen to his upr	per chest and R7's right foot					
		of the foot plate. At 2:34 p.m.					
		nto a bath chair. When R7 was					
		chair, the lower border of the					
	EZ-Stand harness	was around R7's upper back,					
		er of the harness at R7's					
		R7, in the bath chair, was R7's					
		eat of the R7's wheelchair					
		EZ-Lift (mechanical lifting					
) machine. At 2:37 p.m. NA-I					
		f R7's clothing and placed a d pushed the bath chair from					
	R7's room to the tu						
	0. 40/47/40 - + 0.5						
		7 p.m. R7 was seated in the					
		in the bath robe, back in his The EZ-Stand machine was					
		front of him. At 2:59 p.m. NA-I					
		EZ-Stand harness and					
		in the same position as					
		tioned the right side of the					
		right elbow, which was inside					
		ve. NA-I buckled the harness					
	around R7's abdom	nen and pulled the buckle					
		placed R7's feet onto the foot					
		ne calf strap, then used the					
		EZ-Stand's hydraulic arms.					
		holding onto the machine's					
		s left hand, as his right hand robe. As the machine					
		anding position, the harness					
		ne looser, and NA-I did not					
		buckle's strap tighter. At 3:05					
		ed by the machine onto the					
		A-I removed the machine's					
	0	ed R7 to lay flat and assisted					
		9 p.m. NA-I pushed R7's					
		bed and locked the wheels.					
	NA-I then nicked ur	o an EZ-Lift sling that was on					

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00730	B. WING		C 10/19/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
RAZEE	CARE CENTER		T MAPLE AVE , MN 56544	NUE, PO BOX 96		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 19	2 830			
	the wheelchair's seat and placed the sling on a					
		At 3:10 p.m. NA-I moved the				
		to the side of R7's bed near ied to assist R7 to sit up at the				
	the bed rail. NA-I tried to assist R7 to sit up at the edge of the bed, but R7 was unable to assist in					
	the bed mobility. NA-I then placed a transfer belt					
		ne head of R7's bed. NA-I ther ''s upper back with the right	1			
		the transfer belt with the left				
	arm and tried to as	sist R7 to an upright seated				
	position at the side of the bed. R7's right side remained slumped back and leaned to the left.					
		-Stand harness around R7's				
	•	R7 in a seated position				
	utilizing the transfer	r belt. At 3:14 p.m. R7 stated				
		" as NA-I continued to attempt ne's harness. At 3:16 p.m.				
		arness to the EZ-Stand				
		d "you are not seated well",				
		ctions to hold onto the				
		At 3:18 p.m. NA-I started to s mechanical arm, attempting				
		traight in front of the machine.				
	At 3:20 p.m. NA-H	knocked and entered R7's				
		to NA-I "we can lay him down				
		[EZ-Lift], since he is tired". At ked R7 if he preferred to lay in				
		7 answered "yes". NA-I and				
	NA-H removed the	EZ-Stand harness and				
		down, and the two staff				
	the room.	ed, lowered the bed and left				
	On 10/17/18, at 6:5	57 p.m. NA-H stated R7				
		or the majority of cares, but				
		aff could complete some cares				
		with bed mobility and				
	understood instruct	tions. NA-H stated if R7				

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00730	B. WING	B. WING		C 10/19/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
FRAZEE	CARE CENTER		T 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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 830	toilet staff could use NA-H stated R7's a transferred mostly v NA-H indicated the depended on how F he was too tired, sta NA-H stated staff w transfer equipment annually as well. NA questions on R7's of care guides or the r On 10/17/18, at 7:2 required extensive was a fall risk. NA-I something, like go f as he would try to of stated R7 transferre the EZ-Lift, but at ti stated she used the once a shift, as she transfer equipment NA-I stated R7 stru today, and if the tra the Stand we would was good for R7 to machine as he would in the air. NA-I indic instruct how to tran NA-I checked for th find one. At 7:36 p.1 at the nurse's station transferred with two [EZ-Stand]. NA-I indic instruct how to tran NA-I checked for th find one. At 7:36 p.1 at the nurse's station transferred with two [EZ-Stand]. NA-I indic machines, and she machines at a facili	e the EZ-Stand to transfer him. bilities to assist varied, and he with two staff and the EZ-Lift. use of the EZ-Stand R7 was doing that day, and if aff would use the EZ-Lift. rere trained on the mechanical on hire, and thought maybe A-H stated if staff had care they could refer the the)		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
		00730	B. WING			19/2018
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
RAZEE	CARE CENTER		T MAPLE AVE , MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 21	2 830			
	completed on the fa	acility's EZ-Way Lift or Stand.				
	Way Stand Operator indicated "Transfer harness 1) Position upper body of the p harness are betwee resting 2-3 inches b safety of the patien strap around the pa buckle and pull the patient 1) Position p of the harness and on the padded hand in-hand stand beside button. As the patien	ten the safety strap buckled				
	residents are first a therapy to see if the stand. PT-A stated therapy if the reside would get an updat recommendations w R7's last screen wa would have to check harness placement arms, or having one transferring would r PT-A confirmed R7 transfers was 11/17 recommendation w	0 a.m. PT-A stated when admitted they are screened by ey required the transfer lift or after, nursing staff will update ent had changed and we red screen to see if new were needed. PT-A stated as some time ago and he ek R7's records. PT-A stated a t that was not under both e arm under clothing while not be safe. At 10:14 a.m. 's last safety screen with 7, and therapy's ould be to continue to use ff for all transfers for R7's				
	Review of Pro Reh	ab Nursing Referral For				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	0. 00200		A. BUILDING:			
		00730	B. WING			C 19/2018
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
RAZEE	CARE CENTER		T MAPLE AVE MN 56544	NUE, PO BOX 96		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 22	2 830			
	was screened for safety falls and self transfer	ated 11/27/17, indicated R7 afety on 11/13/17, due to two ers. The Screen indicated R7 wo staff with hoyer [EZ-Lift] for n.				
	(CM)-A stated R7 re with all activities of transferred with two times. CM-A stated her expectation for	14 a.m. clinical manager equired maximum assistance daily living and was staff and mechanical lift at all R7 was at risk for falls and staff would be to follow R7's are guides and to use the Ill transfers.				
	required assistance was at risk for falls staff and mechanica DON stated she wa with the EZ-Stand b had reviewed the p equipment with NA- transfers. The DON	42 a.m. the DON stated R7 e with activities of daily living, and injuries, and required two al lift for all transfers. The as aware R7 was transferred by NA-I. DON indicated she roper use of the EZ-Stand -I last evening after R7's I stated all NAs at the facility g full education on EZ-Stand				
	interview with EZ-W (EWPS)-A stated all placing the EZ-Star always. She stated over the harness, o slipping out of the h stated staff should a the EZ-Stand's arm	4 p.m. during a phone Vay product specialist II EZ-Stand training included ad harness under both arms the arms always have to be or there would be a risk of harness and falling. EWPS-A always tighten the harness as is are raised, as the harness as the resident stands.				
	Review of the facilit	ty policy titled				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	`́СОМ	E SURVEY PLETED C
	00730		B. WING		10/19/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
FRAZEE	CARE CENTER		T MAPLE AVE MN 56544	NUE, PO BOX 96		
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 23	2 830			
	Group], last revised strived to promote s interventions to pre policy indicated the plan was to be upda interventions post fa appropriate staff, ar incidents would hav 24 hour report char continue assessme as to further evalua place. Review of the facilit Stand, last revised refer to instructions be used. Staff must safety precautions.	vent avoidable accidents. The resident's individualized care ated with any changes or new all, communicated to nd implemented. Post fall ve continued follow-up on the ting for 72 hours so as to nt for possible injuries as well te the interventions put into cy policy titled, Lift-Sit to 3/1/14, indicated staff would for the facility equipment to to be trained in lift use and The policy further indicated 1. nd sling. 8. Transfer according				
	R40 had intact cognincluded major depincluded major depincention (a conimpairment), convectorvulsions (a meriperson has blindne system (neurological explained by medicinal R40's smoking associated smoking safely use lighter or extinguish cigaretted	ndition which causes visual rsion disorder with seizures or ntal condition in which a ss, paralysis, or other nervous al) symptoms that cannot be	\$			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00730	B. WING		10/19/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
FRAZEE	CARE CENTER		T MAPLE AVE , MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	observed smoking as R40's smoking asso her to remove O2 (i times. Smoking ma station." R40's care plan rev focus: R40 had bee smoke independen smoking materials of in her room. R40 ut remove it independ smoke. The care pl smoking material to the locked medicati cigarette and lighte desired. Staff to ens removed prior to go The facility form title 9/23/18, identified F smoker, with smok nurses station and wanting to go out to Review of R40's pro- through 10/12/18 id - 8/3/18, R40 noted the front door canop on. -9/27/18, the social reported R40 found -9/27/18, A follow u materials removed (cigarettes and ligh policy- Educated at	cigarette in room recently. essment noted,"Staff remind oxygen) prior to smoking at terials to be kept at the nurses rised 10/1/18, identified as a en assessed to be safe to tly but staff to manage due to an incident of smoking ilized oxygen and was able to ently prior to going outside to an interventions directed be stored at nurses station in on room. R40 was to ask for a r from the nurse when sure oxygen tank was bing outside to smoke. ed Aid Care Guide dated R40 as a current independent ing materials housed at the resident to ask nurse when o smoke. ogress notes from 7/10/18 lentified: to be outside of facility under py smoking while oxygen was services designee (SSD) I smoking in room. up note identified- smoking from residents room ter),- Reviewed smoking pout no smoking in the facility ed the nurses are now to	a			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/19/2018	
		00730	B. WING			
NAME OF	IAME OF PROVIDER OR SUPPLIER STREET ADD			TATE, ZIP CODE		
FRAZEE	CARE CENTER		T 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 830	cigarettes and light disperse the items- by the nurse or R40 smoke -Lighter was when done smoking -9/28/18, Nurse obs hand while sleeping An incident report of incident as follows: smoking in her roor her room because as know. The lighter at R40. No injury note During an interview R40 indicated she w independently without designated smoking On 10/17/18, at 2:5 electric wheelchair empty and then to the the dining room and with her outside wh reached the front el oxygen tank from h nursing (DON) aske obtained the smokin responded, "from m own." The DON ex materials were to be became angry and When R40 reached the facility R40 rea pocket and produce cigarettes which he R40 lit the cigarette	er from nurses and they will Oxygen was to be removed o prior to going outside to to be returned to the nurse g. Served R40 clicking lighter in g. Lighter was removed. lated 9/27/18, described the Report by SSD, R40 was m. R40 admitted to smoking in she thought no one would nd cigarettes were taken from d.				

STATEMEN	ota Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 10/19/2018	
					10/	19/2010
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST	NUE, PO BOX 96		
FRAZEE	CARE CENTER		MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 26	2 830			
	returned from the o facility with the elect on the left side of th left the oxygen tank tubing with the nase tubing behind the e oxygen tank on the R40 propelled hers down the hall and o not approach facility materials.	9 a.m. R40 independently utside smoking area to the stric wheelchair. R40 stopped he facility office where she had k. R40 reapplied the oxygen al cannula in the nose and ars. R40 then placed the foot rest between her feet. elf in the electric wheelchair lirectly to her room. R40 did y staff to return the smoking 00 a.m. R40 independently utside smoking area to the				
	facility with the elect herself directly to he oxygen tubing and room prior to exiting did not return smok	etric wheelchair. R40 propelled er room and reapplied the tank which was left in the g the building to smoke. R40 ing materials to facility staff. 22 a.m. LPN-B identified she				
		40 and did not manage				
	stored R40's smoki cart and would give asked. LPN-A iden the smoking materi through he medicat find R40's cigarette looked in the medic unopened pack of N found on the counter	26 a.m. LPN-A verified she ng materials in the medication them to R40 when she tified R40 had not asked for als today. LPN-A looked ion cart and was unable to s and lighter. LPN-A then cation room, where only an New Port cigarettes were er but no lighter. LPN-A ally comes to staff to ask for				
	cigarettes and the I	ighter but does not return the to ask R40 to return them.				

	NT OF DEFICIENCIES	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:		С	
		00730	B. WING		10/19/2018	
AME OF	PROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, ST	ATE, ZIP CODE		
RAZEE	CARE CENTER		T MAPLE AVE , MN 56544	NUE, PO BOX 96		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 27	2 830			
	R40's, however; sh lighter was. LPN-A since R40 had aske	LPN-A indicated the New Port cigarettes were R40's, however; she was unsure where the lighter was. LPN-A indicated it had been a while since R40 had asked her for smoking materials and verified she had not given R40 cigarettes or a lighter today.				
	herself from the dir the facility where sl and tank. R40 prop outside to the desig reached into the rig sweatshirt and proc	38 p.m. R40 propelled ning room to the front entry of he removed her oxygen tubing belled the electric wheelchair gnated smoking area. R40 ht pocket of her gray duced a metal cigarette case dependently lit the cigarette.				
	was the only staff n had access to the F had not requested was not given any. unaware of the rea	9 p.m. LPN-A identified she nember during this shift who R40's smoking materials. R40 smoking materials today and LPN-A indicated she was son R40's smoking materials nursing. LPN-A stated, "it must				
	nursing assistants smoking. NA-A iden to propel herself ou provided her with c indicated R40 was cigarettes and light	26 p.m. NA-A identified the did not assist R40 with ntified R40 was independent itside to smoke after the nurse igarettes and lighter. NA-A able to take the pack of er and upon return from return the smoking materials				
	(RN)-A indicated R self out of the build	7 p.m. Registered nurse 40 independently propelled ing to smoke when R40 icated R40 did not come to				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00730	B. WING	B. WING		C 19/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
FRAZEE	CARE CENTER		T 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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	RN-A to ask to smo On 10/18/18, at 3:5 electric wheel chair the gray sweat shin and I left all my goo cigarettes and light sweat shirt and con area. R40 stated shi smoke independent smoking and doesn going. On 10/18/18, at 3:5 smoking assessme plan as accurate an R40 was required to lighter because R40 room on 9/27/18, at may try again to smi with oxygen in their nurse was responsise materials because for medication cart or n access to these are had cigarettes and 10/17/18, which sho nurse. On 10/19/18, at 9:0	 ke. 2 p.m. R40 propelled the to her room. R40 picked up t and stated," I was going out odies here (indicating er)." R40 picked up the gray tinued outside to the smoking he is free to go outside and tly, has no restrictions with it need to tell anyone she is 4 p.m. the DON verified R40's nt dated 9/26/18, and care and current. The DON verified to turn in the cigarettes and 0 was found smoking in her nd it was a concern that R40 hoke in the facility and also room. The DON indicated the ible for R40's smoking the items were locked in the com and only the nurse has eas. The DON verified R40 a lighter in her possession on the had not received from the 4 a.m. the DON stated R40 		DEFICIENC		
	person last evening with out complaint. On 10/18/18, at 3:4 was independent to area and smoke ind	garette case and lighter on her and did give them to nursing 4 p.m. NA-C indicated R40 go outside to the smoking dependently. NA-C was not ctions for R40's smoking.				

	NT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00730	B. WING	B. WING		19/2018
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
FRAZEE	CARE CENTER		ST MAPLE AVE , MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	age 29	2 830			
	Smoking Policy, ide	y policy titled Resident entified the Purpose: To king program that respects ity of all Residents.				
	The director of nurs develop, review, ar procedures to ensu- lift transfers, fall int interventions were director of nursing	THOD OF CORRECTION: sing (DON) or designee could ind/or revise policies and ure safe resident mechanical erventions, and safe smoking consistently implemented. The (DON) or designee could systems to ensure ongoing	9			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 840	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 2 B Adequate and re; Clean skin	2 840			11/28/18
		or determining adequate and criteria for determining er care include:				
	odors. A bathing p resident's plan of c condition requires t must be given a co other day and more incontinent residen every two hours, an	and freedom from offensive lan must be part of each are. A resident whose that the resident remain in bed mplete bath at least every e often as indicated. An t must be checked at least nd must receive perineal care tode of incontinence.				
	Notwithstanding Mi	 Incontinent residents. Innesota Rules, part ontinent resident must be 				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/19/2018	
			A. BUILDING			
		00730	B. WING			
AME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RAZEE	CARE CENTER		T MAPLE AV MN 56544	ENUE, PO BOX 96		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLET
2 840	Continued From pa	ge 30	2 840			
	written in the reside attending physician interval longer than resident, if compete legally appointed co health care agent o competent, agrees involvement in dete waiver is document] Clean linens or clot	to a specific time interval ent's care plan. The resident's must authorize in writing any two hours unless the ent, or a family member or onservator, guardian, or if a resident who is not in writing to waive physician ermining this interval, and this red in the resident's care plan. hing must be provided the bed or clothing is soiled.				
	Perineal care includ the perineal area. If to keep the bed dry comfort. Special at skin to prevent irrita types of protectors completely covered contact with the res	des the washing and drying of Pads or diapers must be used and for the resident's tention must be given to the ation. Rubber, plastic, or other must be kept clean, be I, and not come in direct sident. Soiled linen and moved immediately from				
	by: Based on observati review the facility fa incontinence care fo were dependent up living.	ent is not met as evidenced ion, interview and document ailed to provide timely or 1 of 3 residents (R38) who ion staff for activities of daily		Corrected		
	Findings include:					
		inimum Data Set (MDS), tified R38 had diagnoses				

STATE FORM

	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00730	B. WING		C 10/19/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
FRAZEE	CARE CENTER		T MAPLE AVE	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 ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 840	which included dem seizure disorder. Th severe cognitive im extensive assistant transfers, personal toileting. Further, th occasionally inconti incontinent of bladd bladder toileting pro R38's care area ass 9/28/18, indicated F and bladder, was u known, unable to si incontinent of bowe CAA also indicated congestive heart fa diuretics to keep flu heart, which increas The CAA further inc skin breakdown and and staff would anti R38's Bowel and Bl dated 9/25/18, indic bowel and bladder, to void/defecate an related to dementia dependent on staff to check/change. R38's current care identified R38 had s urinary incontinence weakness, generali The care plan listed directed staff to check	hentia, heart failure and he MDS identified R38 had pairment and required be of two staff for bed mobility, hygiene, dressing and he MDS identified R38 was inent of bowel and frequently ler, and was not on a bowel or ogram. sessment (CAA) dated R38 was incontinent of bowel nable to make her needs t on the toilet and was el and bladder at all times. The R38 had diagnoses of ilure and was receiving id off of her extremities and se her risk for incontinence. dicated R38 was at risk for d odor related to incontinence to pate R38's needs. adder Functional Evaluation cated R38 had incontinence of unable to feel urge/sensation d had functionally incontinent , impaired mobility and for all cares, ADL's and staff plan revised on 10/15/18, self care deficits related to e, constipation, dementia, zed pain and malnutrition. d various intervention which eck/change for incontinence and after meals, at bedtime				

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		`́СОМ	E SURVEY PLETED
		00730	B. WING		10/19/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
FRAZEE	CARE CENTER		T MAPLE AVE , MN 56544	INUE, PO BOX 96		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO DEFICIENC		ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 840	Continued From pa	ge 32	2 840		·	
	indicated R38 was and directed staff to before and after me check/change with Continual observat 10/17/18 from 5:08 - at 5:08 p.m. R38 v in her room watchir - at 5:15 p.m. R38 n director of nursing peaked at R38 and - at 5:29 p.m. DON via Broda chair dow pushed her up to th - at 5:49 p.m. nursi next to R38, placed chest area, place B and gave R38 a dri - at 5:59 p.m. NA-B supper which const pineapple chicken, - at 6:12 p.m. NA-B eat her supper. - at 6:20 p.m. NA-E eating, wiped her m protector from her o of the dining room her room. NA-E reo slightly, placed call comfortable and lef - at 6:48 p.m. R38 f in her Broda chair a - at 7:02 p.m. R38 f in her Broda chair, closed while she reo	ions were conducted on p.m. to 7:55 p.m. was seated in her Broda chair ng TV. remained the same and the (DON) stopped in room, left the room. wheeled R38 out of her room vn to the dining room and he dining room table. ng assistant (NA)-E sat down d clothing protector on her troda chair in upright position nk of her thickened water. assisted R38 to eat her sted of pureed winter fruit, rice and carrots. continued to assist R38 to asked R38 if she was done nouth, removed her clothing chest area, wheeled R38 out via Broda chair and back to clined R38's Broda chair back light, made resident t her room. remained in her room seated and was watching TV. remained in her room seated TV on and R38's eyes were				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00730	B. WING		C 10/19/2018	
	PROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, ST			
				NUE, PO BOX 96		
RAZEE	CARE CENTER		MN 56544	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETI DATE
2 840	Continued From pa	ge 33	2 840			
	wheeled R38 out of down to the activity singing and having - at 7:22 p.m. R38 r chair while she con the activity room. - at 7:38 p.m. activi her room via Broda - at 7:41 p.m. R38 r in her Broda chair a while she rested. - at 7:45 p.m. NA-D mechanical lift and ready for bed while help. - at 7:51 p.m. NA-D R38 to get ready fo putting her pajama - at 7:55 p.m. NA-D mechanical lift over mechanical lift over mechanical lift over mechanical lift and Broda chair to the k proceeded to roll R the lift sling, NA-D r confirmed R38 was bladder and they pr incontinent product buttocks was noted rectal area which e her buttock crease areas noted. R38 f for a total of 2 hours	b come to activity, activity staff ther room via Broda chair room where they were bible class. remained seated in her Broda tinued to listen to singing in ty staff pushed R38 back to chair and left the room. remained in her room seated and R38's eyes were closed enter R38's room with full began to assist R38 to get NA-E entered the room to and NA-E continued to assist r bed by washing her up and s on her upper body. and NA-E positioned the full R38, hooked R38 to the transferred her from her bed. NA-D and NA-E 38 from side to side, removed removed R38's pants, NA-E incontinent of bowel and roceeded to change R38's s. During observation R38's to be bright red around the xtended to the outer edges of to be more pink with no open had not been check/changed s and 47 minutes even though t upon staff for incontinence k for skin breakdown.				
	was routinely incon	54 a.m. NA-F confirmed R38 tinent of bowel and bladder hecked/changed every two				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00730	B. WING		10/	19/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
FRAZEE	CARE CENTER		T 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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 840	Continued From pa	ge 34	2 840			
	hours.	-				
	nurse (LPN)-B conf incontinent of bowe	16 p.m. licensed practical irmed R38 was routinely I and bladder and had to be Jed every two hours, an was kdown.				
	was at risk for skin	46 a.m. the DON verified R38 breakdown and pressure xpect staff to check/change as re plan.				
	call confirmed R38 staff with all cares a bowel/bladder and NA-E indicated R38 checked/changed h verified R38 had no	er every two hours. NA-E ot been checked/change supper meal and stated we				
	Management revise a system to ensure and bladder inconti treatment and servi	blicy titled, Bowel and Bladder ed on 11/16, indicated there's that each resident with bowel nence will receive appropriate ces to achieve or maintain as nation function as possible.				
	The Director of Nur develop, review, an procedures to ensu provided incontiner and provided appro The DON or design	HOD OF CORRECTION: sing (DON) or designee could d/or revise policies and re incontinent residents are at cares or toilet use timely priate incontinent products. see could develop monitoring ongoing compliance.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED C
		00730	B. WING		10/19/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
FRAZEE	CARE CENTER		⁻ MAPLE AV MN 56544	ENUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 840	Continued From pa	age 35	2 840			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 895	MN Rule 4658.052 Motion	5 Subp. 2.B Rehab - Range of	2 895			11/28/18
	program that is dire deformities through motion must be imp Based on the comp assessment, the di must coordinate the care plan which pro- B. a resident wit receives appropriat	th a limited range of motion te treatment and services to notion and to prevent further				
	by: Based on observati review, the facility f comprehensive ass appropriate interver maintain current rational	ent is not met as evidenced ion, interview and document failed to conduct a sessment and implement ntions to prevent a decline or nge of motion (ROM) abilities (R18) reviewed with limited		Corrected		
	Findings include:					
	8/23/18, identified F included; dementia one side of the bod impairment of langu	inimum Data Set (MDS) dated R18 had diagnoses which , hemiplegia (weakness on ly), and aphasia (an uage, affecting the production of speech and the ability to				

	NT OF DEFICIENCIES I OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00730		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/19/2018	
	PROVIDER OR SUPPLIER		DRESS, CITY, ST		10/	13/2010
				NUE, PO BOX 96		
FRAZEE	CARE CENTER	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 ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 895	read or write). R18' cognition was seve extensive assistance eating, personal hy assistance for trans use. R18's MDS als care, and a function motion on one side extremities. Review of R18's Ca dated 8/29/18, iden verbalized her need for all activities of d cognitive impairment years ago. The CA limited understandin physical behaviors behaviors of yelling not understand, and re-approach. The C partial or total loss of limitation in range of inability to perform a physical assistance R18's care plan, las R18 had decreased hand in flexed positi staff for all ADLs an portion of care plan behaviors section of had verbal and phy related to severe co limited understandin dementia and defic cardiovascular acci behaviors included;	s MDS further identified R18's rely impaired and required with bed mobility, dressing, giene, and required total fers, locomotion, and toilet so identified no rejection of hal limitation in range of of her upper and lower are Area Assessments (CAA) tified R18 rarely/never ds and was dependent on staff aily living (ADL) due to her ht and deficits from her stroke A further identified, R18 had ng of others and would have during cares as she did d staff may have to cAA also identified R18 had of arm movement, functional of motion, hemiplegia, and ADLs without significant				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C	
		00730			10/	10/19/2018
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE NUE, PO BOX 96		
FRAZEE	CARE CENTER		MN 56544	NUE, PU BUX 30		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	ge 37	2 895			
	was not pain relate because someone doesn't understand listed which include occupy her left han as a washcloth, to o behaviors during ca R18's Aide Care Gu identified R18 requi one to two staff, wa tendency to hit out instructed staff to tr left hand to hold du risk for skin concern Review of the phys 5/5/18, indicated it admission history a exam the note indic hand somewhat flea On 10/16/18, at 9:4 seated in a wheelch right hand was clern or material were no right foot was flexed rest of the wheelch was present and st been like that for a visited daily, and wa ROM exercise prog On 10/16/18, at 2:1 back in bed with he	uide Group B, dated 9/23/18, ired extensive assistance from is non-ambulatory, and had a and yell with cares. The guide y and place something in her ring cares, and was a high ns. ician progress note dated was a nursing home ind physical. Under physical cated "Musculoskeletal: Right xed, right hemiparesis". 4 a.m. R18 was observed nair with eyes opened. R18's iched into a fist, and no device ted in the right hand. R18's d and rested against the foot air. Family member (FM)-A ated R18's right hand had long time. FM-A stated he as not aware if R18 had any				

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00730	B. WING			C 19/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
FRAZEE	CARE CENTER		T 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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 895	On 10/17/18, at 1:1 back in bed with the were open and the hand remained cler On 10/17/18, at 5:1 wheelchair, which v dining room table. F positioned in her la clenched in a fist. F flexed and rested o the wheelchair. R18's progress note 10/16/18, revealed -8/29/18, R18 yelled occupation therapy to do passive ROM further ROM. R18 v FMP, PROM bilater upper extremities (I was new to program -9/5/18, R18 denied yelled ow when atter hand. "[S]he holds I tightly". -9/12/18, therapy no different wheelchair posture and sitting -9/14/18, R18 refus -9/18/18, R18 refus	8 p.m. R18 was lying on her e head of the bed raised, eyes television was on. R18's right ached into a fist. 3 p.m. R18 was seated in the vas slightly reclined, at the R18's right hand was p and her right hand remained R18's right foot remained an a pillow on the footrest of es reviewed from 8/1618, to the following: d out when certified assistant (COTA) attempted (PROM) then refused any vould continue with current ral lower extremities (LE) and JP) 3-5 times per week. R18 in that week. d pain when left arm lifted, and empted to mover her right her right hand together ote; R18 was provided with a for use in facility to improve tolerance. ed FMP this date. ed to let COTA touch them his date, so PROM not done				

	ota Department of He	(X1) Provider/Supplier/Clia	(X2) MULTIPLE	ECONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,			PLETED
			B. WING		С	
		00730	1		10/	19/2018
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S T MADI E AVE	TATE, ZIP CODE E NUE, PO BOX 96		
FRAZEE	CARE CENTER		MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 895	Continued From pa	age 39	2 895			
	-9/19/18, refused F	MP this date.				
	-9/25/18, PROM B	LE and UE.				
		3 LE and UE 1 to 3 times per ipation. Continue no change."				
	-10/2/18, R18 not s sleeping.	seen this date for FMP due to				
	-10/3/18, R18 was seen for FMP.	asleep and therefore was not				
	-10/5/18, R18 was attempted to see.	sleeping when COTA				
	-10/10/18, refused	FMP this date.				
	-10/16/18, PROM wrist.	bilateral LE and left elbow and				
	(PT)-A indicated R care and did not ha PT-A stated, if resident term care, they wo	2:08 a.m. physical therapist 18 was admitted for long-term ave admission therapy orders. dents were admitted to long uld be screened for any ated he would check therapy screen.				
	(OT)-A stated R18 care without therap therapy would not resident without the depend on nursing screen would be no maintenance progr would screen resid	:33 occupational therapist was admitted for long term by orders. OT-A indicated, see the newly admitted erapy orders, and would staff to notify therapy staff if a eeded for a possible functional ram (FMP). OT-A stated OT lents with limited ROM or res (condition of fixed high				

	ota Department of He	(X1) provider/supplier/clia	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	ESURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00730	B. WING			C 19/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	IATE, ZIP CODE		
FRA7FF	CARE CENTER	219 WES	T MAPLE AVE	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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	ge 40	2 895			
	resistance to passiv place them on a FM ROM to decrease a confirmed R18 had for a wheelchair as: R18 was on a FMP screen for FMP was On 10/18/18, at 10: room and evaluated contractures. OT-A R18's skin was pale appeared macerated deterioration). OT-A indicated the palm a OT-A stated R18 w hand roll. At 10:44 a room and stated R1 wash cloth in her rig OT-A evaluated R1 R18 would benefit f On 10/18/18, at 10: at risk for worsening R18 had not had a	ve stretch of a muscle) to AP to complete stretching and any further contraction. OT-A only one screen from therapy sessment. OT-A confirmed , but no documentation of a				
	expected the certific assistant (COTA) re R18's FMP to have of R18's right hand the right hand. OT-	ed occupational therapy esponsible for administering updated therapy on the state and R18's refusing FMP to A confirmed therapy had not erns related to R18, other then				
	interview with COT/ responsible for cor scheduled for 1 to 3	6 p.m. during an phone A-A, she stated she was npleting R18's FMP and was 3 times per week. COTA-A entation for the FMP was in				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00730	B. WING		C 10/19/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
FRAZEE	CARE CENTER		MAPLE AVE	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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 895	R18's progress note would work with R1 stated, normally if s to complete her low stated the last time allow her to complete extremity. COTA-A able to touch R18's R18 stating no, or v indicated she would any changes with F indicated R18 was orders, so she assu R18. COTA-A state any device or wash On 10/18/18, at 11: stated if nursing state would update the n out a therapy screet therapy. CM-A state and hemiplegia, an On 10/18/18, at 2:1 (NA)-J stated she re NA-J stated in the r open R18's right hat water due to an odd times place a wash she would have sor On 10/19/18, at 11: (DON) stated if a re contracture, she wo place to address it. staff responsible for or therapy of R18's	ge 41 es. COTA-A indicated she 8 usually once per week. She he could work with R18 it was ver extremity ROM. COTA-A she worked with R18, she did te ROM on R18's left upper stated she had never been right upper extremity due to vould yell at her. She d report to nursing or therapy the facility had a plan for d she had not seen R18 with cloth in her right hand. 06 clinical manager (CM)-A ff noted a contracture, they urse, and the nurse would fill n and get physician orders for ed R18 had diagnoses of CVA d was at risk for contractures. 6 p.m. nursing assistant egularly worked with R18. nornings, she would have to ind and wash it with soap and or. NA-J stated staff would at cloth in R18's left hand so mething to hold on to. 27 a.m. director of nursing esident was admitted with a buld expect something to be in She would have expected the r R18's FMP to update nursing refusal to work with the right ould have been completed.	2 895		· ,	

1UBM11

If continuation sheet 42 of 75

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/19/2018	
		00730	D. WING			
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
FRAZEE	CARE CENTER		MAPLE AVE MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 895	Services Orders da facility provided phy therapy to attain or prevent decline with treatment plan. A policy for identifyind brace use was required provided. SUGGESTED MET The director of nurse educate responsibile restorative nursing comprehensively as designee could corn nursing program to programs are comp	Choicy titled Rehabilitation ted 4/1/08, indicated the ysical, occupational, or speech maintain function and/or in a physician-ordered and contractures, splint or uested and none were CHOD OF CORRECTION: sing and/or designee could e staff to provide a resident program, based on residents' ssessed needs. The DON or iduct audits of the restorative ensure the residents	2 895			
2 900	MN Rule 4658.052 Ulcers Subp. 3. Pressure comprehensive res of nursing services development of a n provides that: A. a resident wh without pressure s pressure sores unle condition demonstr	5 Subp. 3 Rehab - Pressure sores. Based on the ident assessment, the director must coordinate the ursing care plan which o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and	2 900			11/28/18

STATEMEN	ota Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00730		E CONSTRUCTION	(X3) DATE SURVE COMPLETED C 10/19/201	
				10/	19/2010	
	PROVIDER OR SUPPLIER			STATE, ZIP CODE 'ENUE, PO BOX 96		
FRAZEE	CARE CENTER		MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
	receives necessary promote healing, pr new sores from dev This MN Requireme by: Based on observati review, the facility f	ho has pressure sores y treatment and services to revent infection, and prevent veloping. ent is not met as evidenced on, interview, and document ailed to ensure timely	2 900	Corrected		
	(R38) with a history risk for further deve Findings include: R38's admission Mi dated 9/28/18, iden which included dem seizure disorder. Th required extensive mobility and transfe R38 was at risk for ulcers and listed va	ositioning for 1of 1 resident of pressure ulcers and at elopment of pressure ulcers. inimum Data Set (MDS), tified R38 had diagnoses nentia, heart failure and he MDS identified R38 assistance of two staff for bed ers. The MDS further identified the development of pressure rious treatments which elieving devices for chair and				
	9/28/18, indicated F history of skin breat coccyx and open at and remained at ris The CAA also indic relieving mattress a wheelchair, needed mobility, was unabl able to participate w CAA further indicate	sessment (CAA) dated R38 was at risk for and had k down related to pressure to rea, which had been resolved k for further skin breakdown. ated R38 utilized a pressure and pressure relieving pad in I staff assistance for all e to move self in bed and was with staff to reposition. The ed R38 was at risk for ated to malnutrition, chronic or				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00730		CONSTRUCTION	(X3) DATE SURVI COMPLETED C 10/19/20/	
					10/	19/2010
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST T MAPI F AVF	NUE, PO BOX 96		
FRAZEE	CARE CENTER		MN 56544			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 44	2 900			
	end stage renal, liver, heart disease, dementia, immobility and staff were to ensure to do repositioning.					
	Risk form, dated 9// high risk for the dev skin was often very very limited mobility nutrition and had a shearing. The form skin breakdown and	e for Predicting Pressure Sore 25/18, identified R38 was at velopment of pressure ulcers, moist, was chair fast, had y, probably inadequate problem of friction and indicated R38 was at risk for d required total assistance res, activities of daily living y.				
	identified R38 had s breakdown related impaired mobility, w malnutrition and de The care plan direc upon rising, before and with rounds du	0				
	indicated R38 was and directed staff to	de for Group A undated, high risk for skin breakdown o turn and reposition upon fter meals, at bedtime and night shift.				
	10/17/18 from 5:08 - at 5:08 p.m. R38 v in her room watchir - at 5:15 p.m. R38 r director of nursing (looked at R38 and - at 5:29 p.m. DON	was seated in her Broda chair				

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
				с	
	00730	B. WING		10/19/2018	
ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CARE CENTER			NUE, PO BOX 96		
		MN 56544			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLET DATE
Continued From pa	age 45	2 900			
pushed her up to th - at 5:49 p.m. nursi next to R38, placed chest area, place E and gave R38 a dri - at 5:59 p.m. NA-E supper which cons pineapple chicken, - at 6:12 p.m. NA-E eat her supper. - at 6:20 p.m. NA-E removed her clothin area, wheeled R38 Broda chair and ba R38's Broda chair I made resident com the room. - at 6:48 p.m. R38 in her Broda chair a - at 7:02 p.m. R38 in her Broda chair a - at 7:05 p.m. activit asked if she want to wheeled R38 out o down to the activity singing and having - at 7:22 p.m. R38 chair while she con the activity room. - at 7:38 p.m. activit her room via Broda - at 7:41 p.m. R38 in her Broda chair a while she rested. - at 7:45 p.m. NA-E	he dining room table. ng assistant (NA)-E sat down d clothing protector on her Broda chair in upright position ink of her thickened water. E assisted R38 to eat her isted of pureed winter fruit, rice and carrots. E continued to assist R38 to E wiped R38's mouth, ng protector from her chest ack to her room. NA-E reclined back slightly, placed call light, nfortable and immediately left remained in her room seated and was watching TV. remained in her room seated TV on and R38's eyes were ested. ity staff entered R38's room, o come to activity, activity staff f her room via Broda chair / room where they were bible class. remained seated in her Broda antinued to listen to singing in ity staff pushed R38 back to a chair and left the room. remained in her room seated and R38's eyes were closed D enter R38's room with full				
	TOF DEFICIENCIES DF CORRECTION ROVIDER OR SUPPLIER CARE CENTER SUMMARY STA (EACH DEFICIENC REGULATORY OR L Continued From pa pushed her up to th - at 5:49 p.m. nursi next to R38, placed chest area, place E and gave R38 a dr - at 5:59 p.m. NA-E supper which cons pineapple chicken, - at 6:12 p.m. NA-E removed her clothi area, wheeled R38 Broda chair and ba R38's Broda chair made resident com the room. - at 6:48 p.m. R38 in her Broda chair made resident com the room. - at 6:48 p.m. R38 in her Broda chair down to the activity singing and having - at 7:05 p.m. activ asked if she want t wheeled R38 out o down to the activity singing and having - at 7:22 p.m. R38 chair while she cor the activity room. - at 7:38 p.m. activ her room via Broda - at 7:41 p.m. R38 in her Broda chair while she rested. - at 7:45 p.m. NA-E mechanical lift and	DF CORRECTION IDENTIFICATION NUMBER: 00730 STREET AD CARE CENTER STREET AD SUMMARY STATEMENT OF DEFICIENCIES I FRAZEE, SUMMARY STATEMENT OF DEFICIENCIES I FRAZEE, REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 45 pushed her up to the dining room table. - at 5:49 p.m. nursing assistant (NA)-E sat down next to R38, placed clothing protector on her chest area, place Broda chair in upright position and gave R38 a drink of her thickened water. - at 5:59 p.m. NA-E assisted R38 to eat her supper which consisted of pureed winter fruit, pineapple chicken, rice and carrots. - at 6:12 p.m. NA-E continued to assist R38 to eat her supper. - at 6:20 p.m. NA-E wiped R38's mouth, removed her clothing protector from her chest area, wheeled R38 out of the dining room via Broda chair and back to her room. NA-E reclined R38's Broda chair back slightly, placed call light, made resident comfortable and immediately left the room. - at 7:02 p.m. R38 remained in her room seated in her Broda chair, TV on and R38's eyes were closed while she rested. - at 7:05 p.m. activity staff entered R38's room, asked if she want to come to activity, activity staff wheeled R38 out of her room via Broda chair down to the activity room where they were singing and having bible class. - at 7:22 p.m. R38 remained seated in her Broda chair while she continued to listen to singing in the activity room. - at 7:38 p.m. activity staff pushed R38 back to her room via	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING: B. WING OT30 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST CARE CENTER 219 WEST MAPLE AVE FRAZEE, MN 56544 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 45 2 900 pushed her up to the dining room table. - at 5:49 p.m. nursing assistant (NA)-E sat down next to R38, placed clothing protector on her chest area, place Broda chair in upright position and gave R38 a drink of her thickened water. - at 6:20 p.m. NA-E assisted R38 to eat her supper which consisted of pureed winter fruit, pineapple chicken, rice and carrots. - at 6:20 p.m. NA-E wiped R38's mouth, removed her clothing protector from her chest area, wheeled R38 out of the dining room via Broda chair and back to her room. NA-E reclined R38's Broda chair back slightly, placed call light, made resident comfortable and immediately left the room. - at 6:48 p.m. R38 remained in her room seated in her Broda chair, TV on and R38's room, asked if she want to come to activity, activity staff wheeled R38 out of her room via Broda chair down to the activity room where they were singing and having bible class. - at 7:32 p.m. R38 remained in her room. - at 7:38 p.m. activity staff pushed R38 back to her room via Broda chair and R38's eyes were closed while she continued to listen to singing in the activity room. - at 7:34 p.m. R38 remained in her room. - at 7:34 p.m. R38 remained seated in her B	TOP DEFICIENCIES (X1) PROVIDER/SUPPLIENCIAL (X2) MULTIPLE CONSTRUCTION DOF CORRECTION 00730 B. WING	ICP DEFICIENCIES (X1) PROVIDERSUPPLIERCLAIN (V2) MULTIPLE CONSTRUCTION (V3) DATA Def CORRECTION 00730 B. WING (V3) DATA ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CARE CENTER 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544 SUMMARY STATEMENT OF DEFICIENCIES (EACH OBRIGHENK WIST ENRICIENCIES) ID PROVIDERS PLAN OF CORRECTION (EACH OBRIGHENK WIST ENRICIENCIES) SUMMARY STATEMENT OF DEFICIENCIES (EACH OBRIGHENK WIST ENRICIENCIES) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH OBRIGHENK WIST ENRICIENCIES) Continued From page 45 JD Pushed her up to the dining room table. ID PREFIX PREFIX a 15:49 p.m. nursing assistant (NA)-E sat down next to R38, placed clothing protector on her chest area, place Broda chair in upright position and gave R38 a drink of ther thickneed water. 2 900 - at 5:49 p.m. NA-E assisted R38 to eat her supper which consisted of pureed winter fruit, pineapple chicken, rice and carrots. 2 900 - at 6:40 p.m. R38 remained in her room seated in her Broda chair and was watching TV. - at 6:49 p.m. R38 remained in her room seated in her Broda chair and was watching TV. - at 7:30 p.m. activity staff entered R38's room, asked if she want to come where they were singing and having bible class. - at 7:30 p.m. activity staff pushed R38 back to her room via Broda chair and R38's eyes were closed while she rested. - at 7:32 p.m. R38 remained in her room a

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C			
		00730	B. WING		10/19/2018			
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST					
RAZEE	CARE CENTER		ST MAPLE AVENUE, PO BOX 96 E, MN 56544					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE		
2 900	 at 7:51 p.m. NA-D R38 to get ready fo putting her pajama' - at 7:55 p.m. NA-D mechanical lift over mechanical lift over mechanical lift and Broda chair to the b proceeded to roll R the lift sling, NA-D r confirmed R38 was bladder and they pr incontinent product buttocks was noted rectal area which et her buttock crease areas noted. R38 had not offered meals as directed b unable to reposition had not been repos and 47 minutes and ulcers. On 10/18/18 at 11:5 was routinely incon and needed to be re and checked/change On 10/18/18 at 12:7 nurse (LPN)-B confi incontinent of bowe repositioned checked risk for pressure uld On 10/19/18 at 10:4 R38 required total at 	and NA-E continued to assist r bed by washing her up and s on her upper body. and NA-E positioned the full R38, hooked R38 to the transferred her from her bed. NA-D and NA-E 38 from side to side, removed emoved R38's pants. NA-E incontinent of bowel and occeeded to change R38's s. During observation R38's to be bright red around the stended to the outer edges of to be more pink with no open d to reposition before and after by her care plan and was herself independently. R38 itioned for a total of 2 hours d was at high risk for pressure 54 a.m. NA-F confirmed R38 tinent of bowel and bladder epositioned every two hours ged. 16 p.m. licensed practical irmed R38 was routinely I and bladder, needed to be ed/changed and R38 was at	2 900	DEFICIENC	Υ)			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		
ND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED	
		00730	B. WING		C 10/19/2018	
AME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
RA7FF	CARE CENTER	219 WES	T MAPLE AVE	NUE, PO BOX 96		
		FRAZEE,	MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 47	2 900			
	bedtime and with ro DON verified R38 risk for pressure uld staff to turn and rep schedule and to fol On 10/18/18 at 2:5 NA-E confirmed R3 staff with all cares a and bladder and wo indicated she was r pressure ulcers, bu her every two hours NA-E verified R38 h checked/change be	ng, before and after meals, at bunds during night shift. The care plan, verified she was at cers and she would expect bosition R38 as per her low her care plan. 1 p.m. via telephone interview, 8 required assistance of two and was incontinent of bowel ore incontinent products. NA-E not sure if R38 was at risk for t required staff to reposition and not been repositioned or efore or after the supper meal to get in there right away.				
	The director of nurs all residents at risk they are receiving t treatment/services from developing an pressure ulcers. Th designee, could con delivery of care; to	to prevent pressure ulcers d to promote healing of ne director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk for				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 965	MN Rule 4658.060 -Nutritional Status	0 Subp. 2 Dietary Service	2 965			11/28/1
	must ensure that a	nal status. The nursing home resident is offered a diet caloric and nutrient needs as				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		00730	B. WING		C 10/19/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
RAZEE	CARE CENTER		T MAPLE AV MN 56544	ENUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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)	I SHOULD BE	(X5) COMPLET DATE
2 965	determined by the orassessment. Subs	ge 48 comprehensive resident titutes of similar nutritive value residents who refuse food	2 965			
	This MN Requirement is not met as evider by: Based on observation, interview and docur review, the facility failed to comprehensive assess and develop interventions to addre unplanned weight loss for 1 of 2 residents reviewed for nutrition.	on, interview and document ailed to comprehensively o interventions to address oss for 1 of 2 residents (R18)		Corrected		
	8/23/18, identified F included; dementia one side of the bod impairment of lange or comprehension of read or write). R18' cognition was seve extensive assistant no rejection of care dental issues, no sy 167 pounds, mecha unknown weight los	inimum Data Set (MDS) dated R18 had diagnoses which , hemiplegia (weakness on y), and aphasia (an uage, affecting the production of speech and the ability to s MDS further identified R18's rely impaired, required ce with eating, and identified . R18's MDS also identified no wallowing issues, weight of anically altered diet, and no or as of 5 % (percent) or more in 0% in the last 6 months.				
	dated 8/29/18, iden nutritional problem related to her cogni a pureed texture di	are Area Assessments (CAA) tified R18 was at risk for a and potential weight loss tive impairment, her need for et and on her dependence on CAA indicated she rarely/never				

STATEMEN	ota Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	0. 00		A. BUILDING:			
		00730	B. WING			C 19/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
RAZEE	CARE CENTER		T MAPLE AVE MN 56544	NUE, PO BOX 96		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC [\]	HE APPROPRIATE	COMPLET DATE
2 965	Continued From pa	ge 49	2 965			
	for all activities of d cognitive impairmen years ago. The CAA limited understandin physical behaviors behaviors of yelling not understand, and re-approach. The C usually do not happ eat. R18's CAA indis stable since admiss fluctuate, ranging fr indicated R18's goa	ds and was dependent on staff aily living (ADL) due to her nt and deficits from her stroke A further identified, R18 had ng of others and would have during cares and verbal out during cares as she did d staff may have to CAA indicated these behaviors ben when staff assist her to icated her weight had been sion and her meal intakes rom 25 to 100%. The CAA al was to maintain her current hal status with no significant				
	R18 had the potent status related to de dysarthria (conditio use for speech are controlling them), n dependence on sta care plan listed vari included; occupatio language pathology pureed textures and signs and symptom fluid intake with me	st revised 10/19/18, identified ial for decline in nutritional mentia, aphasia, hemiplegia, n in which the muscles you weak or you have difficulty eed for pureed textures, and ff for eating/drinking. R18's ious interventions which anal therapy or speech as ordered, regular diet with d thin liquids, observe for s of dehydration, encourage als and between, provide rence, and provide water with h.				
	identified R18 requi	uide Group B, dated 9/23/18, ired extensive assistance from I was on a pureed texture diet.				
		4 a.m. R18 was observed nair in her room with eyes				

	ota Department of He NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED	
		00730	B. WING	B. WING		C 10/19/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE			
FRAZEE	CARE CENTER		ST MAPLE AVEN , MN 56544	UE, PO BOX 96			
(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 CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE	(X5) COMPLET DATE	
2 965	opened. Family me not eat much at me daily and assisted F On 10/17/18, at 5:2 reclined wheelchair dietary staff membe glasses of liquids, v in front of her. At 5 dining room and ap wheelchair. FM-A u wheelchair to assis position at the table chair beside R18 an assisted R18 with s cup. At 5:44 p.m. R served a supper me bites of pureed food fluids. In between F sit down and take b p.m. he offered R18 shouted "no". FM-A closed her lips tight continued with his r finished his meal ar table assisting anot were going to help member stated they were done assisting already helping. FM At 6:05 p.m. R18 co wheelchair at the di begun holding her f p.m. R18 remained in her left hand as f carrots, rice and ch of her. At 6:12 p.m.	mber (FM)-A stated R18 does als. FM-A indicated he visited R18 to eat some of her meals. 0 p.m. R18 was seated in her at the dining room table. A er approached R18 with two which were placed on the table (21 p.m. FM-A entered the proached the back of R18's sed the controls on the t R18 into an upright seated e. FM-A then sat down in a nd talked. At 5:39 p.m. FM-A tips of juice out of a standard 18 and FM-A were both eal. FM-A assisted R18 with d and alternated with drinks of R18's bites of food FM-A would tites of his own meal. At 5:55 a bite of food and she then tried a drink and R18 dy. FM-A then sat down and neal. At 6:00 p.m. FM-A nd asked staff seated at the ther resident to eat, if they R18 eat. The unidentified staff y would assist R18 when they g the resident they were M-A then left the dining room. tontinued to be seated in the ining room table. R18 had face with her left hand. At 6:10 in the same position with face her supper meal of fruit, icken remained siting in front the unidentified staff member and encouraged her to eat	e f f	DEFICIENCY			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
IND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:			
		00730	B. WING		C 10/19/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
RAZEE	CARE CENTER		ST MAPLE AVE , MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC		DATE
2 965	Continued From pa	ige 51	2 965			
	At 6:17 p.m. R18 refused to eat any more by stating "no" again, and staff assisted to wipe her face. R18 had consumed approximately 25% of the supper meal.					
	On 10/18/18, at 11:57 a.m. R18 was seated in her wheelchair at the dining room table. Dietary staff brought R18 and FM-A lunch which consisted of mashed potatoes, meatballs and brussel sprouts. FM-A assisted R18 with four bites of the lunch meal when R18 yelled out "ow, ow". FM-A stopped attempting to assist R18 with her meal, turned her around in her wheelchair and pushed her wheelchair out of the dining room. At 12:40 p.m. R18's lunch remained at the dining room table.					
		eight record from the cord (EHR) from 8/17/18, to :				
	-8/17/18, 164.6					
	-8/20/18, 167.4					
	-8/24/18, 166.1					
	-8/31/18, 166.4					
	-9/8/18, 167.1					
	-9/14/18, 167.0					
	-9/16/18, 167.0					
	-9/21/18, 165.7					
	-9/28/18,160.7					

Minnesc	ta Department of H	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00730	B. WING		C 10/19/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE	•	
FRAZEE	CARE CENTER			NUE, PO BOX 96		
			MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 965	Continued From pa	age 52	2 965			
	of a 5% weight cha 09/08/2018, 167.1 6.2%, -10.3 pound	R18's EHR showed a warning ange "[Comparison Weight Ibs [pounds], - [negative] s]" R18's EHR showed a warning				
	of a 5% weight cha	ange "[Comparison Weight lbs, - 6.6%, -11.1 pounds]"				
	9/5/18, indicated R liquids. However, a	gned physician orders dated 18 had a pureed diet with thin after further review R18's ers to receive a dietary				
	last 30 days R18's 0-100%, she recei	ectronic record indicated in the meal intakes varied from ved total assistance for eating, four bedtime snacks.	•			
	Dimensions Group was on a regular, p The assessment in restriction, did not prior to admission, nutritional supplem further indicated, F appetite and drank Under the Likes ar was noted. R18 ha alert, did not have denture was worn, swallowing probler indicated R18 used adaptive equipmer assistance. The as comments text box	ietary Profile HDG [Health], dated 8/22/18, indicated R18 bureed diet and regular liquids. indicated R18 was not on a fluid receive a nutrition supplement and did not receive a ment currently. The assessment R18 had regular portions, a fair four cups of fluids per day. ind Dislikes text box only a dash id good hearing and sight, was own teeth, did not indicate if a but had no chewing or ms. The assessment also d regular utensils, did not use it, and required total issessment concluded with a c which indicated R18 was ate other then yes or no				

STATEMEN	ota Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00730		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/19/201	
	PROVIDER OR SUPPLIER		DRESS, CITY, ST		10/	19/2010
				NUE, PO BOX 96		
FRAZEE	CARE CENTER		MN 56544	·····,···		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	ge 53	2 965			
	questions and a far her.	nily member often sat with				
	cares. She indicate her mood and if sta meal right away she R18 did well eating each much at lunch with R18 often and in a while. She state the dining room ear for a car ride. NA-J at a meal, then staf after the meal. NA-d document the pudd weighed weekly by document the weigl weight seemed off s resident.	was a total assist with all d R18's appetite depended on ff get her started with the e does well. NA-J stated if at breakfast, she would not a. NA-J stated FM-A would sit would assist her to eat once ed FM-A took R18 away from ly today due to wanting to go stated if R18 did not eat well f would try a pudding cup later J stated there was no place to ing. She indicated R18 was the NAs, and the NAs would hts in a binder and if the staff were to reweigh the				
	nurse (LPN)-A state all cares, including appetite had been of not feel like eating. eat well at a meal s little, and then let he should know about the NAs don't alway some residents on confirmed R18 was supplement. She st weekly on Fridays b weight in a binder a the EHR. LPN-A sta	6 p.m. licensed practical ed R18 required total assist for eating. LPN-A indicated R18's okay and someday's she did LPN-A stated if R18 did not taff try to encourage her a er rest. She stated the nurses low meal intakes, but stated ys tell us. LPN-A identified nutritional supplements, but not currently receiving a stated R18 was weighed by the NAs, whom place the and the nurse would chart it in ated she did not review and added it must be done				

STATEMEN	ota Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00730	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	`´COM	E SURVEY PLETED C 19/2018
NAME OF I	PROVIDER OR SUPPLIER	L	DRESS, CITY, ST	TATE, ZIP CODE	10/	13/2010
	CARE CENTER	219 WES	T MAPLE AVE	NUE, PO BOX 96		
	SUMMARY STA	TEMENT OF DEFICIENCIES	MN 56544	PROVIDER'S PLAN OF CO		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLET DATE
2 965	Continued From pa	ige 54	2 965			
		t at times, but got frustrated e, then staff would take over.				
	through 10/14/18, in reweigh if wt [weigh or more. Report to R18's weight on 9/2	B Group form, dated 8/27/18, ndicated "Nurses-Please nt] is [up or down] 5 #[pounds] Dietary Manager if continues". 21/18, was 165.7 pounds and 0.7 pounds, however no fied.				
	On 10/18/18, at 2:55 p.m. clinical manager (CM)-A indicated the nurses would chart the weights from the NA binder into the EHR and would look back to see if there were any concerns for changes and update the physician, CM-A, or the director of nursing (DON). CM-A stated the facility had a consultant dietician (CD) that came to the facility monthly. CM-A indicated the CD would be updated if the facility noted a significant weight loss or swallowing problem. CM-A reviewed R18's weights since admission and stated she had lost 9 pounds. CM-A reviewed R18's clinical record and confirmed R18 was not on a nutritional supplement, and R18's record lacked a dietician note or assessment. CM-A stated the facility would update the CD when a 5% weight change was noted and indicated the CD was last at the facility two weeks prior.					
	interview CD-A stat facility and her usua to the facility month between visits via e stated she reviewed anyone else the fac	6 a.m. during a phone red she was the CD for the al process would be to come ily, and would be updated email or phone calls. CD-A d all residents annually, and cility wanted her to assess, idents on tube feedings, those				

	NT OF DEFICIENCIES	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING:				
		00730	B. WING		C 10/19/2018		
AME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE			
RAZEE	CARE CENTER		T MAPLE AVE , MN 56544	NUE, PO BOX 96			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE	
2 965	Continued From pa	ge 55	2 965				
	significant weight Ic or 10% in 180 days email updates from manager (DM)-A. C unaware how the fa- resident weights. C complete the reside CD-A stated R18's over 24.9, so would expect an assessm what was going on On 10/19/18, at 9:3 appetite was not go encouragement to o anything. NA-K indi- with something swe On 10/19/18, at 9:5 staff charted the me chart the resident w did not review reside time and was some meeting on to discu- supplements. DM-A be reviewing reside stated R18's only d admission and indig gather information f CM-A used to be th MDS assessment ri- was transitioning ro aware of R18's weight On 10/19/18, at 11: nurses were to revi- entering into the EH	8 a.m. NA-K stated R18's bod, and took a lot of eat and added R18 never eats cated at times if staff started bet her intake would be better. 0 a.m. DM-A stated dietary eal intakes, and nursing would veights. DM-A indicated she lent intakes or weights at this othing her and the DON were uss weights and nutritional A indicated nursing staff would ents for weight loss. DM-A ietary assessment was on cated the assessment was to for R18's MDS. DM-A stated e one to look at between nutritional needs, but CM-A oles. DM-A stated she was not					

STATEMEN	ota Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00730			C 10/19/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
FRAZEE	CARE CENTER		T MAPLE AVE , MN 56544	NUE, PO BOX 96		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 965	Continued From pa	age 56	2 965			
	significant weight lo week. The DON inc process of reviewin going to start some DON stated R18's i down, and FM-A wi enough and R18 w staff should have a loss after the 9/21/ ⁷ CM-A could have a stated her expectat directions on the W instructed the nurse weight loss and rep Review of the facilit 4/1/08, indicated th parameters of nutri weight and protein	bess was noted. DON stated a bess would be 5 pounds in a dicated CM-A was in the og R18's weights and were a nutritional supplements. The intakes have been up and ill sometimes just say that is ill quit eating. The DON stated lerted CM-A on R18's weight 18, to 9/28/18, weight loss, so lerted the CD. The DON tion for staff was to follow the /eights B Group form which e to reweigh if a five pound bort to the DM. ty policy titled Nutrition, dated is facility maintains acceptable tional status, such as body levels, unless the resident's emonstrates that this was not				
	Long-Term Care Fa Instrument (RAI) 3. 10/2018, identified Swallowing/Nutritio with an intent to as could affect the res	nal Status to be completed sess the many conditions that ident's ability to maintain and hydration. Under K0300:				
		be an important indicator of a lent' s health status or				
	-If significant weigh interdisciplinary tea	t loss is noted, the am should review for possible				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00730	B. WING			10/19/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, S	STATE, ZIP CODE			
RAZEE	CARE CENTER		T MAPLE AV , MN 56544	ENUE, PO BOX 96			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLE DATE	
2 965	Continued From pa	ge 57	2 965				
		intake, changed caloric need, on (e.g., diuretics), or changed					
	continuing basis; w and care planned a	d be monitored on a eight loss should be assessed t the time of detection and not ext MDS assessment."					
	The Dietician could regarding residents	HOD OF CORRECTION: review/revise facility policies at nutritional risk, educate udits to ensure compliance.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21015	MN Rule 4658.061 Requirements- Sa	0 Subp. 7 Dietary Staff nitary conditi	21015			11/28/1	
	procedures and co	conditions. Sanitary nditions must be maintained in dietary department at all					
	by:	ent is not met as evidenced on, interview, and document		Corrected			
	review, the facility f sanitary kitchen en foodborne illness. F to prepare food in a kitchens observed hairnets when walk area. This had the	ailed to ensure a clean and vironment to prevent Furthermore, the facility failed a sanitary manner in 1 of 1 when staff did not utilize ing through the preparation potential to affect 39 of the 41 ved food from the kitchen.					
	Findings include:						

STATE FORM

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00730	B. WING		C 10/19/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	IATE, ZIP CODE		
FRAZEE	CARE CENTER		T MAPLE AVE , MN 56544	NUE, PO BOX 96		
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	COMPLET
21015	Continued From pa	age 58	21015			
	the facility kitchen a following concerns - the coffee maker encrusted hard wat small flakes under At 8:09 a.m. during temperatures of foc blowing above the clean dish area. The on the entire front of blowing away from -at 8:34 a.m. the litt machine in the dini had encrusted hard flakes around the fa and around the ent On 10/19/18 at 9:19 kitchen with the DM were identified: - the little sink next dining room area of hard water lime sca the faucet, the hand the entire outer edg indicated all staff us hands and was not cleaning and de-lim - three compartmer encrusted hard wat flakes around the fa the sink compartme outer edge of the s	in the kitchen area, had ter lime scale build up with the three coffee dispensers. To observations of taking bod items. A white fan was dishwasher and above the te fan had black dust particles of it with pieces of long lint/dirt the fan and into the air. tle sink next to the juice ng room area of the facility d water lime scale build up with aucet, the handles of the sink, ire outer edge of the sink. 5 a.m. during a tour of the <i>I</i> -A the following concerns to the juice machine in the f the facility had encrusted ale build up with flakes around dles of the sink. The DM-A se the sink to wash their sure who was responsible for hing the sink. It sink in the kitchen are had ter lime scale build up with aucet, the handles of the sink, ents and around the entire ink.				
	- the ice machine lo encrusted hard wat	ocated in the kitchen area had ter lime scale build up on the tside of the ice machine lid.				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE : COMPL	
		00730	D. WING		10/	19/2018
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
FRAZEE	CARE CENTER		, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21015	 the air conditioner prepping area was particles on the entillong lint/dirt blowing and into the air. the coffee maker i encrusted hard wat small flakes under the coffee machine was sinks should be clear cleaned weekly. The needed to do a better and ice machine. On 10/19/18 at 10:00 supervisor (MS) con housekeeping staff de-liming the the sink kitchen area. The Many cleaning logs for Review of facility por Sanitation of Dining indicated the food sing service areas throug comprehensive clear and dating food iter SUGGESTED MET The administrator wis services or designed as necessary the por regarding kitchen service areas throug service areas throug comprehensive clear and dating food iter SUGGESTED MET The administrator wis services or designed as necessary the por regarding kitchen service areas throug service areas throug services or designed as necessary the por regarding kitchen service areas throug services or designed as necessary the por regarding kitchen services or designed and dating food iter services or designed as necessary the por regarding kitchen services or designed as necessary the por regarding kitchen services or designed as necessary the por regarding kitchen services or designed as necessary the por regarding kitchen services or designed as necessary the por regarding kitchen services or designed as necessary the por regarding kitchen services or designed as necessary the por regarding kitchen services or designed as necessary the por regarding kitchen services or designed as necessary the por regarding kitchen services or designed as necessary the por regarding kitchen services or designed as necessary the por regarding kitchen services or designed as necessary the por regarding kitchen services or designed as necessary the por regarding kitchen services or designed as necessary the por regarding kitchen services or designed as necessary the por regarding kitchen services or designed as necessary the por regarding kitchen services or designed as necessary the por r	in the window near the blowing and had black dust ire front of it with pieces of g away from the air conditione n the kitchen area, had er lime scale build up with he three coffee dispensers. d the above findings and s to be cleaned weekly, the aned daily and the fans e DM also indicated they er job with de-liming the sinks 01 a.m. the maintenance nfirmed the kitchen and were responsible for nks in the dining room and 1S indicated he did not have or these areas.				

STATEMEN	ota Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		00730		10/	10/19/2018	
NAME OF	PROVIDER OR SUPPLIER					
FRAZEE	CARE CENTER		MAPLE AV MN 56544	ENUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 APPR DEFICIENCY)	JLD BE	(X5) COMPLETI DATE
21015	Continued From pa	ge 60	21015			
	all appropriate staff procedures. The di	on these policies and rector of dietary or designee assure staff are cleaning the				
	TIME PERIOD FOR Twenty-one (21) da					
21325	MN Rule 4658.072 Emergency Oral He	5 Subp. 1 Providing Routine & ealth Ser	21325			11/28/18
	home must provide resource, routine de needs of each resid include dental exan fillings and crowns, oral surgery, bridge orthodontic procede that are provided for	e dental services. A nursing e, or obtain from an outside ental services to meet the dent. Routine dental services ninations and cleanings, root canals, periodontal care, es and removable dentures, ures, and adjunctive services or similar dental patients in the , as limited by third party cies.				
	by: Based on interview facility failed to prov	ent is not met as evidenced and document review, the vide arrangements for dental lents (R28) reviewed for		Corrected		
	Findings include:					
	9/19/18, identified F had diagnoses whic (impairment in moto lower extremities), limitations of activit	imum Data Set (MDS) dated R28 was cognitively intact and ch included paraplegia or or sensory function of the muscle weakness and les due to disability. The MDS ired assistance with personal				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
		00730	B. WING			19/2018
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
RAZEE	CARE CENTER		T MAPLE AVE , MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21325	Continued From pa	ige 61	21325			
	hygiene. R28's ME concerns.	DS further identified no dental				
	had an activities of performance deficit balance and limited further indicated sh	vised 9/25/18, indicated R28 daily living (ADL) self care related to her impaired mobility. R28's care plan e had her own teeth and was ral cares after set up.				
	needed to see a de spoken to her abou facility, and once no	9 a.m. R28 indicated she entist. R28 indicated they had it seeing a dentist at the otified her while she was in the st had come to the facility, but by the dentist.				
	R28's admission as identified R28 had	ssessment dated 3/26/18, her own teeth.				
	Review of R28's ca the following:	re conference notes identified				
	cleaning, has partia	: teeth/dental- due for al plate, does not always wear. 3 attended the meeting.				
	indicated R28 atter	teeth/dental-blank, form ded the meeting. No appointment included.				
		tation indicated R28 was but refused. No reference to included.				
		ation R28 had seen a dentist, 10/18 note identified R28 was				

STATEMEN	ota Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED	
		00730	B. WING	B. WING		10/19/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
FRAZEE	CARE CENTER		ST MAPLE AVE , MN 56544	NUE, PO BOX 96			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21325		ge 62 3 a.m. licensed practical	21325		· ,		
	nurse (LPN)-B indi intact and could infe	cated R28 was cognitively orm you if she wanted indicated R28 had never					
	On 10/19/18, at 8:57 a.m. R28 indicated when she arrived she informed the facility staff she was due for a dental cleaning. R28 stated she would still like to see a dentist, and no one had spoken to her about setting up a dental appointment or transportation.		5				
	(CM)-A indicated sh requested to see a dental exams were conferences. CM-A practice was for the appointments and t she would ask resid a dental exam was	56 a.m. clinical manager ne was not aware R28 dentist. CM-A confirmed discussed at resident care A indicated the usual facility e facility to set up dental ransportation. CM-A indicated dents or responsible parties if needed or wanted and try to tment and transportation if					
	(DON) indicated th dental exams was t admission if they w any concerns. DOI assist the resident had a regular dentis Apple Tree Dental a Apple Tree Dental a Apple Tree Dental a and would screen r floor staff could ass transportation, or th CM-A who could as	42 a.m. director of nursing e facility's usual practice for the residents were asked on anted to see a dentist, or had N indicated they would then to schedule the exam if they st, or could be screened by at the facility. DON indicated came into the facility routinely esidents. DON indicated the sist in scheduling exams and ney could inform herself or sist in arranging the dental ransportation. DON indicated					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00730	B. WING		10/	19/2018
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
FRAZEE	CARE CENTER		T MAPLE AVE , MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21325	Continued From pa	ige 63	21325			
	added to the Apple	ould be for a resident to to Tree Dental list or assisted in int if requested or needed.				
	had just followed u exam. CM-A confir appointment. CM-/ she would arrange	36 p.m. CM-A indicated she p with R28 regarding a dental med R28 still wanted a dental A indicated R28 informed her her appointment herself after asked the facility to arrange				
	-HDGR (Health Dir 9/22/17, identified t provide or obtain ro services to meet th policy further indica assist the resident	tled Dental Services (General) nensions Group) revised he community (facility) would butine and emergency dental e needs of each resident. The ated the community would in making appointments by ation to and from the dentist's	2			
	The Director of Nur review policies and	THOD OF CORRECTION: rsing or designated person to procedures, revise as ed staff on revisions, and compliance.				
	TIME PERIOD FOR Twenty-One (21) da					
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375			11/28/18
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED C 10/19/2018	
		00730	B. WING		
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE		
RAZEE	CARE CENTER		6T MAPLE AVENUE, PO BOX 96 , MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21375	Continued From pa	age 64	21375		
	by: Based on interview	ent is not met as evidenced and document review, the	Corrected		
	infection control pro surveillance data, in illnesses not treated the spread of comm infections. This defi	lement a comprehensive ogram to include timely ncluding viral infections and d with antibiotics to prevent nunicable disease and icient practice had the II 41 residents who currently ty.			
	Findings include:				
	Community Infection	ROL PROGRAM ty forms titled Frazee Care on Control Log from January 018 revealed the following:			
	also included colun room number, signs results, UA (urine a precautions, preser	the month and year. They nns of date, name of resident, s and symptoms, X-Ray nalysis) results, medications, nt on admit, acquired in house All areas were completed on s listed below.			
	wheezing, rhonchi, and fever, treatmer	e resident was identified with diminished breath sounds nt with Augmentin. No further fections were listed.			
	with various sympton	ur residents were identified oms. All were treated with her illnesses or viral infections			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _		(X3) DATE SURVE COMPLETED C		
		00730	B. WING		10/	10/19/2018	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST				
FRAZEE	CARE CENTER		MN 56544	NUE, PO BOX 96			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21375	Continued From pa	ge 65	21375				
	various symptoms.	esidents were identified with All were treated with ner illnesses or viral infections					
	various symptoms.	sidents were identified with All were treated with her illnesses or viral infections					
	various symptoms.	esidents were identified with All were treated with her illnesses or viral infections					
	with various sympton	en residents were identified oms. All were treated with ner illnesses or viral infections					
	various symptoms. antibiotics. First pa sequence from 7/3/ included two reside	dents were identified with All were treated with age identified eight residents in (18, to 7/20/18. Second page ents identified on 7/10/18, then r illnesses or viral infections					
	various symptoms.	residents were identified with All were treated with her illnesses or viral infections					
	identified with vario	fourteen residents were us symptoms. All were treated o further illnesses or viral ed.					
	-October 2018. fou	r residents were identified with					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C		
		00730	B. WING			10/19/2018	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
RAZEE	CARE CENTER		T MAPLE AVE , MN 56544	NUE, PO BOX 96			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21375	Continued From pa	ge 66	21375				
		All were treated with ner illnesses or viral infections					
	(DON) indicated sh control surveillance facility only tracked antibiotic treatment on weekends. DOI progress notes dail checked for any ne	41 a.m. director of nursing e completed the infection forms. DON confirmed the those residents who received and did not complete tracking N indicated she read resident y when she was present and w infections and orders. DON wed the weekend notes for ays.					
	Control (General) resystem was in place reports, investigate communicable dise volunteers, visitors providing service un arrangement and for standards. The pol was in place for sun possible communic	tled Infection Prevention and evised 11/2016, specified a e that prevents, identifies, s, and controls infections and ases for all residents, staff, and other individuals nder a contractual ollowing accepted national licy further identified a system rveillance designed to identify able disease or infections e spread to other persons in					
	The Director of Nur review policies and	HOD OF CORRECTION: sing or designated person to procedures, revise as ed staff on revisions, and compliance.					
	TIME PERIOD FOR Twenty-One (21) da						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00730	B. WING		10/19/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
FRAZEE	CARE CENTER		T MAPLE AVE MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21880	Continued From pa	ge 67	21880			
21880	MN St. Statute 144 Residents of HC Fa	.651 Subd. 20 Patients & ac.Bill of Rights	21880			11/28/18
	their stay in a facilit to understand and a patients, residents, residents may voice changes in policies and others of their of interference, coerci including threat of of grievance procedur well as addresses a Office of Health Fa nursing home ombut Americans Act, sec posted in a conspic					
	residential program 253C.01, every nor facility employing m provides outpatient have a written inter at a minimum, sets followed; specifies t limits for facility res or resident to have advocate; requires grievances; and pro an impartial decision not otherwise resolv hospitals, residentia section 253C.01 wh	inpatient facility, every n as defined in section nacute care facility, and every nore than two people that mental health services shall rnal grievance procedure that, forth the process to be time limits, including time ponse; provides for the patient the assistance of an a written response to written by des for a timely decision by n maker if the grievance is ved. Compliance by al programs as defined in nich are hospital-based programs, and outpatient	ŧ			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COM	E SURVEY PLETED
		00730	B. WING		10/19/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
FRAZEE	CARE CENTER		T MAPLE AV MN 56544	ENUE, PO BOX 96		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	ECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)		COMPLET DATE
21880	Continued From pa	ge 68	21880			
		is deemed to be compliance nt for a written internal re.				
	This MN Requirement is not met as evidenced by:					
	review, the facility	on, interview and document ailed to provide appropriately products to maintain personal sident (R27) observed for		Corrected		
	Findings include:					
	(MDS) assessment diagnoses which in removal of part of th obesity and edema indicated R27 was limited assistance of transfers, walking i assistance of one s further identified R2	ange Minimum Data Set dated 9/14/18, identified cluded previous surgical he digestive tract, morbid (swelling). The MDS also cognitively intact and required of one staff with bed mobility, in his room and extensive taff with toileting. The MDS 27 was frequently incontinent asionally incontinent of bowel g program.				
	Catheter Care Area 9/20/18, indicated F and bowel and atte independently in pr however, staff conti incontinence cares products due to obe	ntinence and Indwelling Assessment (CAA) dated R27 was incontinent of bladder mpted to manage this eparation for discharge, inued to assist him with and changing incontinence esity. R27's CAA further ived diuretic (promotes the				

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STATEMEN	ota Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/19/2018	
		00730	B. WING			
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
FRAZEE	CARE CENTER		T MAPLE AVE , MN 56544	NUE, PO BOX 96		
(X4) ID	X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
21880	Continued From pa	ige 69	21880			
	edema which may urinary urgency and revealed R27 felt th could not make it to R27's care plan, re had urinary retention (narrowing of the tu body) and previous care plan also indic bladder at all times The care plan furth independent with to required extensive incontinence and p directed staff to obs of discomfort on uri observe/record/rep	vised on 9/7/18, identified R27 on, chronic urethral stricture ube that carries urine out of the ly had a urinary catheter. The cated R27 was incontinent of and of bowel occasionally. er indicated R27 was bileting on the commode and assist of 1 staff to complete erineal cares. The care plan serve for signs and symptoms nation and frequency, ort to physician signs and y tract infection and provide	•			
	indicated R27 was bowel, wore a brief	stant guide plan undated, incontinent of bladder and , was independent with ed assistance with washing up episodes.				
	observed to be on a in his room with shi incontinent brief wa episode. Strong oc room and was note stated he needed a waiting for staff to a -At 7:36 a.m. licens exited R27's room a	2 a.m. R27's call light was and R27 was seated in a chair rt on, no bottoms present, and so off due to incontinent dor of urine emanated from the d in the hallway as well. R27 assistance from staff and was assist with incontinence cares. and practical nurse (LPN)-B and call light was turned off. ng assistant (NA)-B was in	,			

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/19/2018	
		00730	B. WING			
NAME OF	AME OF PROVIDER OR SUPPLIER STREET AE			ATE, ZIP CODE		
FRAZEE	CARE CENTER		T 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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
21880	R27's room wiping drops of stool from gloves. NA-B remo- hands, applied clear perineal cares. NA have housekeeping floor. -At 7:53 a.m. R27 s while NA-B attempt incontinence produ only be pulled up ha and part of his scro to have a large cyst area which was visi back. NA-B remove hand hygiene. -At 7:55 a.m. R27 if walker to a chair by seated himself on the was present on sear an incontinence par floor in front of R27 to take the bucket f top of the pad right floor. R27's common placed across the m from R27's chair. On 10/16/18, at 2:2 he wore leaked bech him. R27 stated sime experienced urinary he was independent using a walker but of cleansing and apply after incontinence of	up urine and a couple of R27's floor while wearing oved soiled gloves, washed in gloves and assisted with A-B informed R27 she would is staff come in and clean the stood, holding onto a walker red to apply a pull-up type ct. The pull-up product could alfway leaving R27's buttocks tum exposed. R27 was noted to the upper inner left thigh ible from both the front and ed old gloves and completed independently walked using a of the head of the bed and he chair. An incontinence pace at of the chair. NA-B folded d in half and placed it on the 's feet. NA-B then proceeded rom a commode and place on in front of R27's feet on the bode was observed to be oom, approximately 7 feet 8 p.m. R27 stated the pull-ups cause they were too small for nee the urinary catheter was		DEFICIENCY		

PRINTED: 11/27/2018 FORM APPROVED

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		
		A DOILDING.		(X3) DATE SURVEY COMPLETED	
				с	
00730		B. WING		10/19/2018	
AME OF PROVIDER OR SUPPLIER STREET AI			ATE, ZIP CODE		
ARE CENTER	219 WES	T MAPLE AVE	NUE, PO BOX 96		
	FRAZEE,	MN 56544			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETE DATE
Continued From pa	ge 71	21880			
when he sat in the (- chair to catch the urine that				
urine would then la	nd on the floor. R27 stated				
	•				
chair by his bed wit floor in front of him commode on top of gown covering his I typically wear pants R27 explained he h the closet but did no leaking urine conce informed that day b pull-ups would be c stated he didn't und get the right-sized in On 10/17/18, at 4:5 chair by his bed wa incontinence pad on a bucket from a cor	h an incontinence pad on the and a bucket from his the pad. R27 had a hospital ap. R27 stated he did not and preferred to wear shorts. ad a black pair of shorts in but wear them due to the rn. R27 stated he had been y facility staff that 3 XL sized oming in tomorrow. R27 lerstand why it took so long to ncontinence products in. 9 p.m. R27 was seated in the tching the news on TV with an in the floor in front of him and nmode on top of the pad.				
On 10/17/18, at 7:2	6 p.m. NA-D indicated R27				
incontinence cares.	NA-D further expressed R27				
	(EACH DEFICIENCY REGULATORY OR IS Continued From pa when he sat in the of eaked from the imp stated if the bucket catch the urine, how catch the leaking ur urine would then lan having the bucket a manner didn't make shouldn't have to do he had requested p for him when the ur emoved in Septem a large cyst to his lead ind properly fitting if On 10/17/18, at 2:2 chair by his bed wit loor in front of him commode on top of gown covering his I ypically wear pants R27 explained he h he closet but did no eaking urine conce informed that day b boull-ups would be c stated he didn't und get the right-sized in On 10/17/18, at 4:5 chair by his bed wa ncontinence pad on a bucket from a cor R27 had a hospital On 10/17/18, at 7:2 could not reach ber assistance from nu	urine would then land on the floor. R27 stated having the bucket and pad underneath in this manner didn't make him feel good and stated "I shouldn't have to do this". R27 further explained he had requested pull-ups sized 3 XL be ordered or him when the urinary catheter had been removed in September. R27 also stated he had a large cyst to his left thigh that made it difficult to ind properly fitting incontinence products. On 10/17/18, at 2:22 p.m. R27 was seated in the chair by his bed with an incontinence pad on the loor in front of him and a bucket from his commode on top of the pad. R27 had a hospital gown covering his lap. R27 stated he did not ypically wear pants and preferred to wear shorts. R27 explained he had a black pair of shorts in he closet but did not wear them due to the eaking urine concern. R27 stated he had been nformed that day by facility staff that 3 XL sized bull-ups would be coming in tomorrow. R27 stated he didn't understand why it took so long to get the right-sized incontinence products in. On 10/17/18, at 4:59 p.m. R27 was seated in the chair by his bed watching the news on TV with an ncontinence pad on the floor in front of him and a bucket from a commode on top of the pad. R27 had a hospital gown covering his lap.	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG 21880 21880 Continued From page 71 21880 when he sat in the chair to catch the urine that eaked from the improperly-fitting pull-up. R27 stated if the bucket was in the right spot if would atch the urine, however, sometimes if would not catch the leaking urine and in those instances the urine would then land on the floor. R27 stated having the bucket and pad underneath in this manner didn't make him feel good and stated "I shouldn't have to do this". R27 further explained he had requested pull-ups sized 3 XL be ordered or him when the urinary catheter had been emoved in September. R27 also stated he had a large cyst to his left thigh that made it difficult to ind properly fitting incontinence products. On 10/17/18, at 2:22 p.m. R27 was seated in the chair by his bed with an incontinence pad on the loor in front of him and a bucket from his sommode on top of the pad. R27 had a hospital gown covering his lap. R27 stated he did not ypically wear pants and preferred to wear shorts. R27 explained he had a black pair of shorts in he closet but did not wear them due to the eaking urine concern. R27 stated he had been nformed that day by facility staff that 3 XL sized pull-ups would be coming in tomorrow. R27 stated he didn't understand why it took so long to get the right-sized incontinence products in. On 10/17/18, at 4:59 p.m. R27 was seated in the chair by his bed watching the news on TV with an ncontinence pad on the floor in front of him and a bucket from a commode on top of the pad. R27 had a hospital gown covering his lap. On 10/17/18, at 7:26 p.m. NA-D indicated R27 could not reach behind his back and needed	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) Continued From page 71 21880 when he sat in the chair to catch the urine that eaked from the improperly-fitting pull-up. R27 stated if the bucket was in the right spot it would batch the urine, however, sometimes it would not atch the leaking urine and in those instances the urine would then land on the floor. R27 stated raving the bucket and pad underneath in this manner didn't make him feel good and stated "I shouldn't have to do this". R27 further explained he had requested pull-ups sized 3 XL be ordered or him when the urinary catheter had been emoved in September. R27 also stated he had a large cyst to his left thigh that made it difficult to ind properly fitting incontinence products. Defficience Def	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREFIX TAG (EACH DEFICIENCY ACTON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 71 21880 When he sat in the chair to catch the urine that eaked from the improperly-fitting pull-up. R27 tated if the bucket was in the right spot it would patch the urine, however, sometimes it would not ratch the leaking urine and in those instances the urine would then land on the floor. R27 stated having the bucket and pad underneath in this namer didn't make him feel good and stated "I shouldn't have to do this." R27 further explained the had requested pull-ups sized 3 XL be ordered or him when the urinary catheter had been emoved in September. R27 also stated he had a large cyst to his left thigh that made ti difficult to ind properly fitting incontinence pad on the loor in front of him and a bucket from his sommode on top of the pad. R27 had a hospital pown covering his lap. R27 stated he did not yopically wear pants and preferred to wear shorts. R27 explained he had a black pair of shorts in he closet but did not wear them due to the eaking urine concern. R27 stated he had been nformed that day by facility staff that 3 XL sized pull-ups would be coming in tomorrow. R27 stated he had be had been nformed that day by facility staff that 3 XL sized pull-ups would be coming in tomorrow. R27 stated he had be had been nformed that day by facility staff that 3 XL sized pull-ups would be coming in tomorrow. R27 stated he had be por in front of him and a bucket from a commode on top of the pad. R27 had a hospital gown covering his lap. Dn 10/17/18, at 7:26 p.m. NA-D indicated R27 sould not reach behind his back and needed assistance from nursing staff to complete nontinence cares. NA-D further expressed R27

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		00730	B. WING			10/19/2018	
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE			
RAZEE	CARE CENTER		T MAPLE AVE , MN 56544	NUE, PO BOX 96			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLE DATE	
21880	Continued From pa	ige 72	21880				
	aware when he wa bucket was placed legs, to catch the le stated the pull-ups and did not contain On 10/18/18, at 100 incontinent of urine assistance from sta incontinent episode used to manage R2 small and leaked u bucket from a com R27 on the floor wh to catch the leaking pull-up. NA-B furth R27 used to be to o however R27 would the bathroom and a offered toileting even	17 a.m. NA-B stated R27 was at all times and required aff with perineal cares after es. NA-B stated the pull-ups 27's incontinence were too rine. NA-B indicated the mode was placed in front of nen he was seated in the chair g urine that dripped from R27's er stated the toileting plan for offer toileting every two hours d say he didn't have to go to as a result they no longer ery 2 hours.					
	(MDSC) indicated F facility with a urinar indicated R27 elect catheter removed a urinary incontinence she was aware of t being placed in from in the chair. MDSC toileting plan for R2 and oriented and ca On 10/19/18, at 9:2 records manager (0 supplies for R27 ar	38 a.m. the MDS coordinator R27 was admitted to the y catheter in place. MDSC ted to have the urinary and tried to manage the e instead. MDSC indicated he bucket from the commode nt of R27 when he was seated c stated there was no specific 27 due to the fact he was alert ould use the call light.					
	supplies for R27 ar	nd all residents. OMRM vas the facility's usual supplier					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/19/2018	
		00730	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
FRAZEE	CARE CENTER		T MAPLE AVE , MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y 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) COMPLET DATE
21880	Continued From pa	ige 73	21880			
	researched product size 3 XL disposab and R27 did not wa revealed everything far had not worked continued to resear there had to be sor	ve R27's size and OMRM ts from Tenna. OMRM stated le briefs were ordered, trialed ant the briefs. OMRM g that had been ordered thus for R27. OMRM stated she rch other options and indicated nething out there for R27. re was no current order placed r R27.				
	(DON) stated R27's developed after the removed. After DC DON stated R27 re incontinence and R stated she was not currently being utilit of R27's bottom. D different sized brief expectations. DON the briefs as they d preferred the pull u interventions could R27's urinary incon commode closer, s	88 a.m. director of nurses a urinary incontinence a urinary catheter was N reviewed R27's care plan, equired assistance with urinary 27 dribbled constantly. DON aware the pull-up brief zed for R27 only covered half ON stated attempts to order is had not met R27's I stated R27 didn't want to use id not cover his cyst and ps. DON expressed other have been tried to manage tinence such as: moving the etting up his room better, ice and trying new products.				
	dated April 1st, 200 his or her individua for residents in a m	tled, Dignity Quality of Life, 8, stated in full recognition of lity, the facility promoted care anner and in an environment enhanced each resident's				
	The director of nurs	THOD FOR CORRECTION: sing (DON) or designee could e policies and procedures to				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		с	
		00730	B. WING			
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
RAZEE	CARE CENTER		ST MAPLE AVE , MN 56544	NUE, PO BOX 96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21880	Continued From pa	age 74	21880			
	dignified manor. The ducate the appropolicies/procedure	continence is managed in a he DON or designee could priate staff on the s. The DON or designee could ing system to ensure ongoing				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES			7	6299029	FORM APPROVE OMB NO. 0938-039	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>'</i>	TIPL	E CONSTRUCTION 01 - MAIN BUILDING	(X3) DAT	E SURVEY IPLETED
		245299	B. WING			10/	16/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER		_		19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR(DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	ĸ	000			
	FIRE SAFETY						
	ALLEGATION OF C DEPARTMENTS A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
	ONSITE REVISIT (CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departm Fire Marshal Divisio Frazee Care Cente not in compliance w participation in Mec Subpart 483.70(a), 2012 edition of Nat Association (NFPA) Code (LSC), Chapt	Survey was conducted by the nent of Public Safety, State on. At the time of this survey r 01 Main Building was found with The requirements for licare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection) Standard 101, Life Safety er 19 Existing Health Care n of NFPA 99, Health Care]	
		ne E-POC process, a paper correction is not required."			EPOC		
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY					
LABORATORY	OIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electron	ically Signed						11/14/2018

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/19/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		E CONSTRUCTION 01 - MAIN BUILDING		E SURVEY PLETED
		245299	B. WING	-		10/1	6/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	HEALTH CARE FIF STATE FIRE MARS 444 CEDAR STRE ST. PAUL, MN 551 By e-mail to both: FM.HC.Inspections THE PLAN OF COD DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pro 3. The name and/or responsible for corr prevent a reoccurre The facility was ins Frazee Care Cented different times. The constructed in 1977 basement and was II(111) construction addition was built. I basement, was det (000) construction, fire barriers from th the 1979 building ir addition to the west entrance addition to determined to be T the business / main	RE INSPECTIONS SHAL DIVISION ET, SUITE 145 01-5145, or @state.mn.us RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date.	K	000			

Facility ID: 00730

If continuation sheet Page 2 of 8

TEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MILL T	IPLE CONSTRUCTION	T	0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IG 01 - MAIN BUILDING		PLETED
		245299	B. WING		10/*	16/2018
ME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RAZEE	CARE CENTER			219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
X4) ID REFIX T A G	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 000	Continued From pa	ge 2	K 00	00		
	has a fire alarm sys throughout the corr	letely sprinkler protected and stem with smoke detection idor system and in the at is monitored for automatic ification.				
	The facility has a ca census of 41 at the	apacity of 60 beds and had a time of the survey.				
	NOT MET.	42 CFR, Subpart 483.70(a) is				
	Hazardous Areas - CFR(s): NFPA 101	Enclosure	K 32	21		11/28/18
	having 1-hour fire m fire rated doors) or system in accordan When the approved system option is us separated from oth partitions and doors Doors shall be self- and permitted to ha protective plates the from the bottom of Describe the floor a	re protected by a fire barrier esistance rating (with 3/4 hour an automatic fire extinguishing ice with 8.7.1 or 19.3.5.9. d automatic fire extinguishing ed, the areas shall be er spaces by smoke resisting s in accordance with 8.4. closing or automatic-closing ive nonrated or field-applied at do not exceed 48 inches				
	b. Laundries (largei	Automatic Sprinkler A Fired Heater Rooms • than 100 square feet) Ince, and Paint Shops				

Facility ID: 00730

If continuation sheet Page 3 of 8

	(X1) PROVIDER/SUPPLIER/CLIA	. ,			E SURVEY IPLETED
of CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING) 01 - MAIN BUILDING		
	245299	B, WING		10/	16/2018
PROVIDER OR SUPPLIEF					
CARE CENTER			/		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETIO DATE
d. Soiled Linen Ro e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square fe g. Laboratories (if Hazard - see K322 This REQUIREME by: Based on observa facility to construc accordance with th (NFPA 101) section condition could all corridor making it and efficient exitin an undetermined a Findings include: On the facility tour on 10/19/2018 obs following rooms w storage over 50 so closing doors. Rooms, 100, 101,	borns (exceeding 64 gallons) n Rooms lons) prage Rooms/Spaces bet) classified as Severe 2) ENT is not met as evidenced ation and staff interview the t 4 hazardous storage rooms in the 2012 Life Safety Code in 19.3.2.1.3. This deficient ow smoke or fire to enter the untenable and affect the quick g for all of the 60 residents and amount of staff and visitors. The between 8:00 am to 12:00 pm servations revealed the ere converted to combustible g, ft. and did not have self 404 and a storage room across	K 321	All equipment in Rooms 100 and have been moved out so they are longer storage rooms. Storage w moved to 402 and 404. Walls we checked and completely sealed. Self closing devices will be added three storage room doors. Routine audits will be done to ass empty resident rooms do not beco storage rooms. Audits will be reviewed annually in	no as re to the ure ome n QAPI	
facility Administrat Maintenance. Cooking Facilities	or and the Director of	K 324	1		11/28/18
	CARE CENTER SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From p d. Soiled Linen Ro e. Trash Collection (exceeding 64 gall f. Combustible Sto (over 50 square fe g. Laboratories (if Hazard - see K322 This REQUIREME by: Based on observa facility to construc accordance with th (NFPA 101) section condition could allow corridor making it and efficient exitin an undetermined a Findings include: On the facility tour on 10/19/2018 observations following rooms w storage over 50 so closing doors. Rooms, 100, 101, from resident room This deficient cond facility Administrated Maintenance. Cooking Facilities CFR(s): NFPA 10 ⁻	DEF CORRECTION IDENTIFICATION NUMBER: 245299 PROVIDER OR SUPPLIER CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 d. Solied Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility to construct 4 hazardous storage rooms in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for all of the 60 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 10/19/2018 observations revealed the following rooms were converted to combustible storage over 50 sq. ft. and did not have self closing doors. Rooms, 100, 101, 404 and a storage room across from resident room 207. This deficient condition was confirmed by the facility Administrator and the Director of Maintenance.			

Facility ID: 00730

If continuation sheet Page 4 of 8

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	11/19/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	LE CONSTRUCTION 01 - MAIN BUILDING		E SURVEY PLETED
		245299	B. WING		10/ ⁻	6/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER			219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		6
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 324	appliances such as toasters) are used f cooking in accordar * cooking facilities of compartments with with the conditions or * cooking facilities in 30 or fewer patients 18.3.2.5.4, 19.3.2.5 Cooking facilities pr per 9.2.3 are not re- hazardous areas, b corridor.	g equipment (i.e., small microwaves, hot plates, for food warming or limited nce with 18.3.2.5.2, 19.3.2.5.2 open to the corridor in smoke 30 or fewer patients comply under 18.3.2.5.3, 19.3.2.5.3, n smoke compartments with a comply with conditions under .4. rotected according to NFPA 96 quired to be enclosed as ut shall not be open to the 18.3.2.5.4, 19.3.2.5.1 through	K 324			
	by: Based on observat facility failed to insta the cooking equipm Safety Code (NFPA 9.2.3 & NFPA 96 se practice could allow could not reach the undetermined amou Findings include: On the facility tour to on 10/19/2018 obse	NT is not met as evidenced ion and staff interview the all the protection devices of ent as stated in the Life .101) 2012 edition section ction 10.5.1. This deficient for the spread of fire if staff device, affecting an unt of staff and visitors.		The kitchen hood pull station was r by Summit Companies to more than feet from the appliance.		

If continuation sheet Page 5 of 8

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		01 - MAIN BUILDING	COM	PLETED
		245299	B. WING		10/16/2018	
AME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
RAZEE	CARE CENTER			219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE IATE	(X5) COMPLETIC DATE
K 324	Continued From pa	age 5	K 324			
		ition was confirmed by the or and the Director of				
	Fire Alarm System CFR(s): NFPA 101	- Testing and Maintenance	K 345			11/28/18
	Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain the smoke detection system as required by the Life Safety Code,(LSC) 2012 edition, section 9.6.1.5 and NFPA 72, The National Fire Alarm and Signaling Code, 2010 edition, section 14.3.1. This deficient condition could delay alarm notification in case of a fire and affect all 60 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 10/19/2018 documentation review revealed the smoke detector near the nurses office in the 200 wing and a smoke detector in the corridor near room 119 was shown as not tested on the sensitivity report.			Detectors near the nurse's office in 200 wing and the detector near roor will be tested by Summit Companies results of the sensitivity testing will b reviewed annually in QAPI meeting Maintenance Director.	n 119 s. The be	

If continuation sheet Page 6 of 8

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:		01 - MAIN BUILDING	COMPLETED		
		245299	B. WING		10/16/2018		
IAME OF F	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE			
RAZEE	CARE CENTER		219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE		
K 345		age 6 or and the Director of	K 345				
	Maintenance. Sprinkler System - CFR(s): NFPA 101	Maintenance and Testing	K 353		11/28/ <i>*</i>		
	Automatic sprinkle inspected, tested, a with NFPA 25, Star Testing, and Maint Protection Systems maintenance, insp maintained in a se available.	Maintenance and Testing r and standpipe systems are and maintained in accordance ndard for the Inspection, aining of Water-based Fire s. Records of system design, ection and testing are cure location and readily system last checked					
	b) Who provided						
	Provide in REMAR any non-required c system. 9.7.5, 9.7.7, 9.7.8, This REQUIREME by:	KS information on coverage for r partial automatic sprinkler		The 5 year obstruction inspection v	will be		
	facility failed to ma accordance with th (NFPA 101) and Ni testing and mainte section 14.2.1. Thi cause the sprinkled properly and allow could affect all 60 of	intain the sprinkler system in e 2012 Life Safety Code FPA 25 The standard for nance of sprinkler systems, s deficient condition could r system not to function for the spread of fire. This of the residents and an ount of staff and visitors.		completed by Summit Companies. results of the obstruction inspectior be reviewed annually in QAPI meet the Maintenance Director.	The ns will		

Facility ID: 00730

If continuation sheet Page 7 of 8

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING	(X3) DATE	E SURVEY PLETED
		245299	B. WING			10/*	6/2018
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 353	on 10/19/2018 doct there was no record inspection. This deficient cond	age 7 between 8:00 am to 12:00 pm umentation review revealed d of a 5 year obstruction ition was confirmed by the or and the Director of	K 3	53			
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 1UBM2	21	Fa	cility ID: 00730 If continu	uation she	et Page 8 of 8

PRINTED: 11/19/2018



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 7, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5299032, H5299010, H5299011, and H5299012

Dear Administrator:

The above facility was surveyed on October 15, 2018 through October 19, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5299010. In addition, at the time of the October 19, 2018 standard survey, the Minnesota Department of Health, completed an investigation of complaint number H5299011, and H5299012 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Frazee Care Center November 7, 2018 Page 2

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Gail Anderson, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota 56537-3858 Email: gail.anderson@state.mn.us Phone: (218) 332-5140 Fax: (218) 332-5196

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			•		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0		0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	`́сом	E SURVEY PLETED
		245299	B. WING				C 19/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments		EC	00			
F 000	Emergency Prepare conducted on , duri The facility is in cor	iance with CMS Appendix Z edness Requirements, was ng a recertification survey. npliance with the Appendix Z edness Requirements. IS	FC	000			
	15-19, 2018, and co also completed at t survey. Investigatio and H5299012, we that was found to b related deficiency is	rvey was conducted October omplaint investigations were he time of the standard ons of H5299010, H5299011, re completed. The complaint e substantiated along with the s as follows: ncy issued at F Tag # 686.					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.					
F 550 SS=D	an on-site revisit of conducted to valida	ercise of Rights	F 5	50			11/28/18
	self-determination, access to persons	right to a dignified existence, and communication with and and services inside and					
		ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electron	ically Signed						11/14/2018

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

PRINTED: 11/27/2018

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM /	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMF	E SURVEY PLETED
		245299	B. WING			(10/1	, 9/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 550	this section. §483.10(a)(1) A fac with respect and dig resident in a manner promotes maintenan her quality of life, re- individuality. The fa promote the rights of §483.10(a)(2) The fa access to quality can severity of conditionr must establish and practices regarding provision of servicer residents regardles §483.10(b) Exercise The resident has thrights as a resident or resident of the U §483.10(b)(1) The fresident can exercise interference, coerci- from the facility. §483.10(b)(2) The re- free of interference, reprisal from the fac- rights and to be sup- exercise of his or her subpart. This REQUIREMEN	including those specified in ility must treat each resident grity and care for each er and in an environment that nce or enhancement of his or ecognizing each resident's cility must protect and of the resident. Facility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and transfer, discharge, and the s under the State plan for all s of payment source. e of Rights. e right to exercise his or her of the facility and as a citizen nited States. Facility must ensure that the se his or her rights without on, discrimination, or reprisal resident has the right to be n coercion, discrimination, and cility in exercising his or her oported by the facility in the er rights as required under this NT is not met as evidenced	F	550			
	Based on observat	ion, interview and document			Submission of this Response and F	Plan of	

Facility ID: 00730

If continuation sheet Page 2 of 106

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION (X3)	NO. 0938-0 DATE SURVEY COMPLETED	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COMPLETED	
		245299	B. WING			10/19/2018	
NAME OF F	PROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
F 550	 review, the facility failed to provide appropriately fitting incontinence products to maintain personal dignity for 1 of 1 resident (R27) observed for incontinence care. Findings include: R27's significant change Minimum Data Set (MDS) assessment, dated 9/14/18, identified diagnoses which included previous surgical removal of part of the digestive tract, morbid obesity and edema (swelling). The MDS also indicated R27 was cognitively intact and required limited assistance of one staff with bed mobility, 		F 5	50	correction is not a legal admission that deficiency exists or that this Statement Deficiency was correctly cited, and is a not to be construed as an admission of fault by the facility, the Executive Direct or any employees, agents or other individuals who draft or may be discuss in this Response and Plan of Correction In addition, preparation and submission this Plan of Correction does not constit an admission or agreement of any kind the facility of the truth of any facts alleg or the correctness of any conclusions a forth in the allegations. Accordingly, the	t of also f ctor sed on. n of tute d by ged set	
	transfers, walking assistance of one s further identified R2 of bladder and occa and had no toileting R27's Urinary Incor	in his room and extensive staff with toileting. The MDS 27 was frequently incontinent asionally incontinent of bowel g program. htinence and Indwelling			Facility has prepared and submitted thi Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to	is on y ate	
	9/20/18, indicated I and bowel and atter independently in pr however, staff cont incontinence cares products due to ob- indicated R27 rece increased production edema which may urinary urgency and	Assessment (CAA) dated R27 was incontinent of bladder mpted to manage this reparation for discharge, inued to assist him with and changing incontinence esity. R27's CAA further ived diuretic (promotes the on of urine) medication for have contributed to R27's d incontinence. The CAA he urge to urinate but stated o the toilet in time.			 participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility s credible allegation of compliance. R27 has had a comprehensive box and bladder assessment and plan of caupdated to reflect care of incontinence accordance with his preferences. Other residents with incontinence were reviewed to ensure proper fit of incontinence product Education provided to nursing department on the need for properly fit incontinence 	are in	
	had urinary retention	vised on 9/7/18, identified R27 on, chronic urethral stricture ube that carries urine out of the			incontinence products to maintain resident dignity o Audits of properly fitting incontinen products will be done on 3 residents tw		

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			O	FORM / MB NO.	11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245299	B. WING				_ 9/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	body) and previous care plan also indic bladder at all times The care plan furthe independent with to required extensive incontinence and p directed staff to obs of discomfort on uri observe/record/rep symptoms of urinar prompt incontinenc R27's nursing assis indicated R27 was bowel, wore a brief toileting and require after incontinence e On 10/15/18, at 7:3 observed to be on a in his room with shi incontinent brief was episode. Strong oc room and was note stated he needed a waiting for staff to a -At 7:36 a.m. licens exited R27's room a -At 7:45 a.m., nursi R27's room wiping drops of stool from gloves. NA-B remo hands, applied clea perineal cares. NA have housekeeping floor.	ly had a urinary catheter. The ated R27 was incontinent of and of bowel occasionally. er indicated R27 was bileting on the commode and assist of 1 staff to complete erineal cares. The care plan serve for signs and symptoms nation and frequency, ort to physician signs and y tract infection and provide e cares. etant guide plan undated, incontinent of bladder and , was independent with ed assistance with washing up	F	550	times weekly for four weeks, then 1 per week for a month, then monthly months o DON/ Designee will report result trends of all audits to QAPI Commi 3 months to review and follow-up a needed o Compliance date 11/28/2018	y for 2 Ilts and ttee for	

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		AND HUMAN SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	COM	E SURVEY PLETED
		245299	B. WING				C 19/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	while NA-B attempt incontinence produ- only be pulled up ha and part of his scro to have a large cyst area which was visi back. NA-B remove hand hygiene. -At 7:55 a.m. R27 if walker to a chair by seated himself on the was present on sea an incontinence part floor in front of R27 to take the bucket fit top of the pad right floor. R27's common placed across the me from R27's chair. On 10/16/18, at 2:2 he wore leaked become him. R27 stated sim removed in Septem experienced urinary he was independent using a walker but of cleansing and apply after incontinence part from the commode when he sat in the of leaked from the imp stated if the bucket catch the urine, how catch the leaking un urine would then lat	ed to apply a pull-up type ct. The pull-up product could alfway leaving R27's buttocks tum exposed. R27 was noted t to the upper inner left thigh ible from both the front and ed old gloves and completed independently walked using a the head of the bed and he chair. An incontinence pad at of the chair. NA-B folded d in half and placed it on the 's feet. NA-B then proceeded rom a commode and place on in front of R27's feet on the bode was observed to be oom, approximately 7 feet	F	550			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/27/2018 APPROVED . 0938-0391	
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245299	B. WING	í		C 10/19/2018		
NAME OF F	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	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 550	manner didn't make shouldn't have to do he had requested p for him when the ur removed in Septem a large cyst to his le find properly fitting On 10/17/18, at 2:2 chair by his bed wit floor in front of him commode on top of gown covering his I typically wear pants R27 explained he h the closet but did no leaking urine conce informed that day b pull-ups would be c stated he didn't und get the right-sized in On 10/17/18, at 4:5 chair by his bed wa incontinence pad or a bucket from a cor R27 had a hospital On 10/17/18, at 7:2 could not reach ber assistance from nut incontinence cares. could not control his aware when he was bucket was placed legs, to catch the le	e him feel good and stated "I o this". R27 further explained pull-ups sized 3 XL be ordered rinary catheter had been hber. R27 also stated he had eft thigh that made it difficult to incontinence products. 22 p.m. R27 was seated in the th an incontinence pad on the and a bucket from his f the pad. R27 had a hospital lap. R27 stated he did not s and preferred to wear shorts. had a black pair of shorts in ot wear them due to the ern. R27 stated he had been by facility staff that 3 XL sized coming in tomorrow. R27 derstand why it took so long to incontinence products in. 69 p.m. R27 was seated in the atching the news on TV with an in the floor in front of him and mmode on top of the pad. gown covering his lap. 26 p.m. NA-D indicated R27 hind his back and needed rsing staff to complete . NA-D further expressed R27 is urine stream and was not s incontinent. NA-D stated the in front of R27, in between his eaking urine. NA-D further used for R27 were too small		550				

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		AND HUMAN SERVICES			FORM	: 11/27/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		245299	B. WING			C 19/2018	
NAME OF F	PROVIDER OR SUPPLIER		ç	STREET ADDRESS, CITY, STATE, ZIP CODE			
FRAZEE	CARE CENTER			219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 550	Continued From pa	ige 6	F 550				
	incontinent of urine assistance from sta incontinent episode used to manage R2 small and leaked un bucket from a comm R27 on the floor wh to catch the leaking pull-up. NA-B furth R27 used to be to of however R27 would the bathroom and a offered toileting even On 10/18/18, at 11: (MDSC) indicated F facility with a urinamindicated R27 elect catheter removed a urinary incontinence she was aware of the being placed in from in the chair. MDSC toileting plan for R2 and oriented and como On 10/19/18, at 9:2 records manager (C supplies for R27 amindicated Medline v for incontinence pro Medline did not hav researched product size 3 XL disposabli and R27 did not wa	 at all times and required aff with perineal cares after as. NA-B stated the pull-ups 27's incontinence were too rine. NA-B indicated the mode was placed in front of the ne was seated in the chair gurine that dripped from R27's the stated the toileting plan for offer toileting every two hours d say he didn't have to go to as a result they no longer ery 2 hours. as a.m. the MDS coordinator R27 was admitted to the ry catheter in place. MDSC ted to have the urinary and tried to manage the e instead. MDSC indicated he bucket from the commode to fR27 when he was seated C stated there was no specific 27 due to the fact he was alert ould use the call light. a.m. office and medical OMRM stated we R27's size and OMRM stated ant the briefs. OMRM stated the briefs were ordered, trialed ant the briefs. OMRM g that had been ordered thus 					

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245299	B. WING				0 19/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	continued to resear there had to be som OMRM verified there for 3 XL pull-ups for On 10/19/18, at 9:3 (DON) stated R27's developed after the removed. After DC DON stated R27 re incontinence and R stated she was not currently being utiliz of R27's bottom. D different sized brief expectations. DON the briefs as they d preferred the pull u interventions could R27's urinary incon commode closer, se increasing assistan The facility policy til dated April 1st, 200 his or her individual for residents in a m that maintained or of dignity and respect	for R27. OMRM stated she ch other options and indicated nething out there for R27. re was no current order placed r R27. 8 a.m. director of nurses s urinary incontinence a urinary catheter was N reviewed R27's care plan, quired assistance with urinary 27 dribbled constantly. DON aware the pull-up brief zed for R27 only covered half ON stated attempts to order s had not met R27's I stated R27 didn't want to use id not cover his cyst and ps. DON expressed other have been tried to manage tinence such as: moving the etting up his room better, ce and trying new products. tled, Dignity Quality of Life, 8, stated in full recognition of lity, the facility promoted care anner and in an environment enhanced each resident's		550			
		5)(i)-(iv)(6)(7) esident has a right to organize	F 5	65			11/28/18
	and participate in re (i) The facility must group, if one exists	esident groups in the facility. provide a resident or family , with private space; and take vith the approval of the group,					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245299	B. WING				_ 19/2018	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 565	to make residents a upcoming meetings (ii) Staff, visitors, or resident group or fa the respective grou (iii) The facility mus person who is appr group and the facili providing assistance requests that result (iv) The facility mus resident or family g the grievances and groups concerning life in the facility. (A) The facility mus response and ration (B) This should not facility must implem request of the resid §483.10(f)(6) The re participate in family §483.10(f)(7) The re family member(s) o representative(s) m families or resident residents in the faci This REQUIREMEN by: Based on interview facility failed to take grievances from resident	and family members aware of a in a timely manner. other guests may attend amily group meetings only at p's invitation. t provide a designated staff oved by the resident or family ty and who is responsible for e and responding to written from group meetings. t consider the views of a roup and act promptly upon recommendations of such issues of resident care and t be able to demonstrate their hale for such response. be construed to mean that the nent as recommended every ent or family group. esident has a right to groups. esident has a right to have r other resident neet in the facility with the representative(s) of other lity. NT is not met as evidenced y and document review, the e prompt action to resolve sident council for 5 of 11 R33, R39, R40) with	F 5	565	 R31 and R39 no longer reside community. R9, R33, and R40 have been interviewed for grievance on missir clothing and resolutions determine o All interviewable residents interviewed for missing clothing an 	ng d		

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UMAN SERVICES DICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
OVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED		
245299	B. WING				, 19/2018
		ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
			-		
PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
following residents R4, R8, R9, R11, and R40. During the erns were voiced: a about clothing being ng residents. The vas a concern with R33 stated staff were clothing for her, it noticed one day ing one of R33's shirts. y were informed by themselves and were hing shirts, t-shirts, nd R31 had received him. R31 stated he y staff several times. he was missing nat at this time. R33 e owned came back to huge hole in them. ed to laundry staff and balized the pants had to wo pairs of slacks, ers. R9 stated it had raff and at resident /18, a grievance form he missing bra and com of the form a staff	F 5	565	last 3 months reviewed and grievan addressed if indicated. o A representative for the non-interviewable residents will be interviewed for missing clothing and follow up as indicated o All reports of missing clothing/grievances brought up duri resident council will be treated and followed up on using the establishe grievance process, which includes communication back to the resident regarding any concerns. o Education provided to IDT on expected resident council follow up grievance process o Audit resident council grievance interviewing 5 residents two times p week for four weeks and then once week for a month and then monthly two months o E.D. will review all grievances a assure follow-up within timeline per o DON/ Designee will report resu trends of all audits to QAPI Commit	and and and and ber per for and policy Its and tee for	
	DICAID SERVICES DVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	DICAID SERVICES DVIDER/SUPPLIER/CLIA NTIFICATION NUMBER: 245299 B. WING DF DEFICIENCIES E PRECEDED BY FULL IFYING INFORMATION) PREFI TAG PRESCEDED BY FULL IFYING INFORMATION) F S a resident council following residents R4, R8, R9, R11, and R40. During the erns were voiced: s about clothing being ng residents. The vas a concern with R33 stated staff were clothing for her, it noticed one day ing one of R33's shirts. y were informed by themselves and were sing shirts, t-shirts, hd R31 had received him. R31 stated he y staff several times. he was missing nat at this time. R33 e owned came back to huge hole in them. ed to laundry staff and balized the pants had of two pairs of slacks, ers. R9 stated it had <td>DICAID SERVICES DVIDER/SUPPLIER/CLIA VITIFICATION NUMBER: 245299 B. WING 245299 B. WING 21 PRECEDED BY FULL IFFING INFORMATION) PREFIX TAG F 565 a resident council following residents R4, R8, R9, R11, and R40. During the erns were voiced: s about clothing being ng residents. The vas a concern with R33 stated staff were clothing for her, it noticed one day ing one of R33's shirts. y were informed by themselves and were sing shirts, t-shirts, hod R31 had received him. R31 stated he y staff several times. he was missing hat at this time. R33 e owned came back to huge hole in them. ed to laundry staff and balized the pants had taff and at resident /18, a grievance form he missing bra</td> <td>DICAID SERVICES ON DVIDERSUPPLIER/CLIA ITTFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING 245299 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544 DF DEFICIENCIES FRAZEE, MN 56544 D PROVIDERS PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) a resident council following residents R4, R8, R9, R11, and R40. During the erns were voiced: F 565 a sobut clothing being ng residents. The ras a concern with R33 stated staff were clothing for her, it noticed one day ing one of R3's shirts. y were informed by themselves and were staff several times. he was missing at at this time. R33 e owned came back to huge hole in them. ad to laundry staff and balized the pants had F 515 If wo pairs of slacks, rs. R9 stated it had taff and at resident r18, a grievance form he missing bra and balized the pants had Compliance date. 11/28/2018</td> <td>DicAID SERVICES ONB NO. DVIDERSUPPLIER/CLIA TIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE COM 245299 B. WING (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE COM 245299 B. WING TIFICATION NUMBER: (X3) DATE COM 245299 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544 DF DEFICIENCIES IFVING INFORMATION) ID PREFIX PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY a resident council following residents R4, R8, R9, R11, and R40. During the erns were voiced: F 565 a about clothing being ing residents. The ras a concern with R33 stated staff were clothing for her, it noticed one day ing one of R33's shirts. y were informed by themselves and were vstaff several times. S Hill Popots of missing clothing/grievances brought up during resident council will be treated and follow up as indicated o Ault reports of missing clothing/grievance process, which includes communication back to the resident regarding any concerns. o Education provided to IDT on expected resident council grievances by interviewing 5 resident swo times per week for a month and then monthy for two months he was missing e owned came back to hup ehole in them. at at this time. R33 e owned came back to hup ehole in them. at at at resident tradif and at resident tradin at resident tradif a</td>	DICAID SERVICES DVIDER/SUPPLIER/CLIA VITIFICATION NUMBER: 245299 B. WING 245299 B. WING 21 PRECEDED BY FULL IFFING INFORMATION) PREFIX TAG F 565 a resident council following residents R4, R8, R9, R11, and R40. During the erns were voiced: s about clothing being ng residents. The vas a concern with R33 stated staff were clothing for her, it noticed one day ing one of R33's shirts. y were informed by themselves and were sing shirts, t-shirts, hod R31 had received him. R31 stated he y staff several times. he was missing hat at this time. R33 e owned came back to huge hole in them. ed to laundry staff and balized the pants had taff and at resident /18, a grievance form he missing bra	DICAID SERVICES ON DVIDERSUPPLIER/CLIA ITTFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING 245299 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544 DF DEFICIENCIES FRAZEE, MN 56544 D PROVIDERS PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) a resident council following residents R4, R8, R9, R11, and R40. During the erns were voiced: F 565 a sobut clothing being ng residents. The ras a concern with R33 stated staff were clothing for her, it noticed one day ing one of R3's shirts. y were informed by themselves and were staff several times. he was missing at at this time. R33 e owned came back to huge hole in them. ad to laundry staff and balized the pants had F 515 If wo pairs of slacks, rs. R9 stated it had taff and at resident r18, a grievance form he missing bra and balized the pants had Compliance date. 11/28/2018	DicAID SERVICES ONB NO. DVIDERSUPPLIER/CLIA TIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE COM 245299 B. WING (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE COM 245299 B. WING TIFICATION NUMBER: (X3) DATE COM 245299 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544 DF DEFICIENCIES IFVING INFORMATION) ID PREFIX PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY a resident council following residents R4, R8, R9, R11, and R40. During the erns were voiced: F 565 a about clothing being ing residents. The ras a concern with R33 stated staff were clothing for her, it noticed one day ing one of R33's shirts. y were informed by themselves and were vstaff several times. S Hill Popots of missing clothing/grievances brought up during resident council will be treated and follow up as indicated o Ault reports of missing clothing/grievance process, which includes communication back to the resident regarding any concerns. o Education provided to IDT on expected resident council grievances by interviewing 5 resident swo times per week for a month and then monthy for two months he was missing e owned came back to hup ehole in them. at at this time. R33 e owned came back to hup ehole in them. at at at resident tradif and at resident tradin at resident tradif a

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		AND HUMAN SERVICES			FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245299	B. WING			C 19/2018
NAME OF F	PROVIDER OR SUPPLIER		ç	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER			219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 565	worked with the res made it to laundry. indicated he or she had thrown the clot Nothing was docum resolution page of t R40 indicated she w underwear and had Review of Resident through 9/28/18 rev On 5/23/18, one res of socks. On 6/29/18, no repo On 7/30/18, resider clothing was missin missing clothing ite On 8/24/18, one res jacket and another pairs of jeans, two s On 9/28/18, resider clothing was freque indicated they had that don't belong to stated if they don't l doesn't get done ar after one trip to the assistant (NA) atter revealed NA always laundry in the laund	sident and the clothes never The staff member further believed the student nurses hing in the wrong bin. hented on the grievance the form. was missing 36 pairs of a reported it to "everyone." t Council Minutes from 5/23/18 vealed the following: sident reported missing a pair orts of missing laundry. hts questioned why their ng all of the time. No new ms reported at this meeting. sident reported missing a resident reported missing a resident reported missing two shirts and some underwear. hts again questioned why their ently missing. Residents received many clothing items them. Residents further label their own clothing it d clothing items become lost laundry room. One nursing nded this meeting and s had to dig through piles of dry room to search for resident r indicated these searches for	F 565			

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		AND HUMAN SERVICES & MEDICAID SERVICES				F	ORM	11/27/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		245299	B. WING) 19/2018		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BI		(X5) COMPLETION DATE	
F 565	Continued From pa	ge 11	F 5	65					
	(NA-D) stated wher laundry staff complet and placed it in the indicated staff were immediate search of for the missing item staff are responsible for all residents. N/ delivered to the wrot frequently and on a On 10/18/18, at 9:5 stated when new re- staff bagged the clo- resident and deliver room. H-C indicate on the bag that ider was. H-C further st responsible for mar resident. When clo H-C revealed staff v laundry slip if the cl a thorough search I further revealed the stored at each nurs room. H-C indicate with residents herse missing clothing. On 10/18/18, at 10: assistant (SSA) sta resident council me verified residents w meeting had expresi	6 p.m., nursing assistant a resident reported missing eted a missing laundry form out basket. NA-D further expected to conduct an of the laundry room to search as well. NA-D stated laundry e for marking clothing items A-D revealed laundry being ong resident happened n almost daily basis. 3 a.m., housekeeper (H)-C sidents are admitted nursing thing belonging to the new red the bag to the laundry d the nursing staff left a note ntified who the new resident ated laundry staff are king the clothing for each thing was reported missing, were to complete a missing othing cannot be located once had been completed. H-C missing laundry slips are ing station and in the laundry d she attempted to follow-up elf on the status of their 40 a.m., social services ted September was the first eting he had attended. SSA ho attended the September ssed concerns about missing er indicated there was a rends were noted with missing							

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245299	B. WING	i			C 19/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 565 F 604 SS=D	clothing and there were the process for kee Review of facility por expressed there nee the process for kee Review of facility por expressed there nee the process for kee Review of facility por existence of the process for kee Review of facility por existence of the process for kee Review of facility por existence of the process for kee Review of facility por existence of the process for kee Review of facility por existence of the process for kee Review of facility por existence of the process for kee Review of facility por existence of the process for kee Review of facility por existence of the process for kee Review of facility por existence of the process for kee Review of facility por existence of the process for kee Review of the resident has a respect and dignity §483.10(e)(1) The physical or chemica purposes of disciplic required to treat the process for kee Review for the resident has a respect and dignity solution for the process for kee Review for the resident has a respect and dignity solution for the process for kee Review for the resident has a respect and dignity solution for the process for the resident has a respect and dignity solution for the resident has a respect and dignity solution for the process for the resident has a respect and dignity solution for the process for the respect and dignity solution for the process for the respect and the process for the process for the respect and the process for the proces for the process for the process for the	were intentions to have a he process with SSA, I-C. SSA verified the meeting d. 7 a.m., director of nurses are expected to complete a m, look for the missing and in the laundry room. dry staff reported at the daily when a resident was missing cated the daily meetings are nd Administrator and they issing item needed to be DN further stated a grievance npleted as well. DON eded to be improvement in ping track of resident clothing. Dicy titled, Grievance Process indicated the facility would s to resolve grievances. The ted investigation and evance would be completed a and no later than five the grievance was submitted. m Physical Restraints 1), 483.12(a)(2) t and Dignity. right to be treated with , including: right to be free from any al restraints imposed for ne or convenience, and not		565			11/28/18

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	ORM A	11/27/2018 PPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (X3	(X3) DATE SURVEY COMPLETED		
		245299	B. WING	i		C 10/19/2018		
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
F 604	Continued From pa	ge 13	FØ	604				
	neglect, misappropriand exploitation as includes but is not I corporal punishmer any physical or cheitreat the resident's §483.12(a) The fact §483.12(a)(2) Ensufrom physical or cheipurposes of discipli are not required to a symptoms. When the indicated, the facilitaternative for the leadocument ongoing restraints. This REQUIREMENT by: Based on observator review, the facility for residents (R5) was restraints. Findings include: R5's face sheet data diagnoses which inticated and any construction of the set of the set of the set of the facility for the fact of the set of the set of the fact	ility must- re that the resident is free emical restraints imposed for ne or convenience and that treat the resident's medical ne use of restraints is y must use the least restrictive east amount of time and re-evaluation of the need for NT is not met as evidenced tion, interview and document ailed to ensure 1 of 1 free from the use of physical ed 10/19/18, indicated R5 had cluded vascular dementia with nce, anxiety disorder and			 R5 has had restraint removed events we hours and with meals per plan of a sing restraints Education provided on use of restraints to include releasing restraint every two hours and during meal time well as the use of wheelchair brakes a restraint Audit of restraint use to be done to the times per week for one month and the monthly for two months DON/ Designee will report results trends of all audits to QAPI Committee 	care as nt es as as a two en en en s and		

Facility ID: 00730

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM /	11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245299	B. WING				_ 19/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 604	two staff for bed mo also required exten for transfers, dressi hygiene, and walkir R5 utilized a chair r and personal alarm wheelchair. R5's Physical Restr (CAA) dated 1/30/1 tray on her wheel c transfer attempts as falls due to self trar of dementia and dis impairment with ori- term memory issue safety awareness a had contributed to R R5's care plan revis used an external de self or to others cha injury/falls, impaired related to cognitive agitation. The care interventions which device every two ho Stand, reposition, w Off during meals. T physician ordered r and reposition ever The care plan furth- methods before usi If restraint still requ R5's Aide Guide Gr	obility. The MDS indicated R5 isive assistance of one staff ing, eating, toileting, personal ng. The MDS further indicated restraint daily to prevent rising is used while in bed and in the raint Care Area Assessment 18, indicated R5 utilized a lap thair to prevent rising and self s R5 has history of frequent insferring. R5 had a diagnosis splayed severe cognitive entation, short term and long es. R5 also had very poor and decision making which her past falls and the lap tray. sed on 2/8/18, indicated R5 evice for prevention of injury to aracterized by high risk for d mobility, physical aggression impairment and motor plan listed various n included: lap tray restraint ours while in wheel chair. walk in hallways and reapply. The care plan also indicated restraint of lap tray, release ry two hours and off at meals. er indicated to try alternative ing physical restraints with R5. uired, place in	F	604	3 months to review and follow-up as needed o Compliance date. 11/28/2018	3	

		AND HUMAN SERVICES			FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245299	B. WING			C 19/2018
NAME OF I	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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 604	two hours, stand up device and off at m included the followi times, release and off at meals. During observations main dining room o was seated in her w tray attached to the attempting to pedal with her feet. - at 5:55 p.m. dietan food which consiste carrots, pineapple o glass of thickened w sitting on the table. black lap tray attack she tried to propel h kitchen area. -at 6:02 p.m. nursin R5 back to the dinin with attached lap tra- begin eating her foo of milk. - at 6:07 p.m. R5 re wheelchair with the room while NA-E en her what she had o - at 6:14 a.m. R5 w with the attached la about two feet from of nursing (DON) a if she wanted to eat DON tried to give R juice and R5 refuse	staff to release lap tray every o/walk, reposition, replace eals. Miscellaneous directions ng in bold type: lap tray at all off load every two hours and s of the supper meal in the n 10/17/18 at 5:30 p.m. R5 wheelchair with a black lap wheelchair arms. R5 was herself into the kitchen area ry staff brought R5 a plate of ed of pureed mixed fruit, chicken and rice. R5 had a water, milk and cranberry juice R5 continued to have the hed to her wheelchair while herself backwards into the ag assistant (NA)-E assisted ng room table via wheelchair ay and encouraged R5 to od while she gave R5 a drink emained seated in her attached lap tray in the dining ncouraged her to eat by telling in her plate. as seated in her wheelchair ap tray in the dining room in the table, when the director pproached R5 and asked her t, R5 refused to respond. The R5 a drink of her cranberry	F 604	4		

		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245299	B. WING				C 19/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 604	table with her lap tr down next to R5 an chicken with rice. - at 6:25 p.m. R5 w table in her wheeld while the DON cont meal. R5's lap tray supper meal to rele During observation: 10/19/18 at 8:52 a.t wheelchair with an room table. Both wl and R5's tip toes pr R5 was not able to NA-B assisted R5 t - at 8:58 a.m. NA-B cereal and continue meal. - at 9:00 a.m. NA-B eating and R5 indic breakfast. R5 rema with attached lap ta pressed against the wheelchair while Na breakfast. - at 9:01 a.m. NA-B clothing protector, to wheelchair, placed pedals and wheeled into the hallway. R5 locked and the lap the breakfast meal During observation at 12:29 p.m. R5 w with an attached lap	ay in place, got a chair, sat ad gave R5 a bite of her as seated at the dining room hair with the attached lap tray tinued to feed R5 her supper was not removed during the	F 6	04			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	E SURVEY PLETED
		245299	B. WING				C 19/2018
NAME OF F	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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 604	while her tip toes pr R5 was not able to NA-G assisted R5 t - at 12:32 p.m. NA- her lunch while her her wheelchair and attached to the whe - at 12:36 p.m. licer confirmed R5's whe and a lap tray was a while NA-G fed her locked the brakes of fidgeting. She verif R5's lap tray neede meals. On 10/18/18 at 2:15 needed staff assista of daily living (ADL' lap tray restraint at removed every two On 10/18/18 at 2:45 needed staff assista LPN-B verified R5 u all times and it was hours and off to the On 10/19/18 at 11:0 care plan and indica assistance with mer verified R5 utilized a as a restraint due to family request. The was to be removed meals. The DON in the lap tray being re	ressed up against the floor. move in her wheelchair while o eat her lunch. G continued to assist R5 eat braked remained locked on her lap tray remained eelchair. msed practical nurse (LPN)-B eelchair brakes were locked attached to R5's wheelchair lunch. NA-G indicated they on R5 wheelchair due to her ied she was not aware that d to be removed during 5 p.m. NA-F confirmed R5 ance for eating and activities s). NA-F verified R5 utilized a all times and it was to be hours and during meals. D p.m. LPN-B confirmed R5 ance for eating and all ADL's. utilized a lap tray restraint at to be removed every two	F	504			

Facility ID: 00730

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				FORM	: 11/27/2018 APPROVED . 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
	245299	B. WING			C 1 9/2018
PROVIDER OR SUPPLIER					
CARE CENTER					
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD) BE	(X5) COMPLETION DATE
indicated she would care plan as written remove the lap tray staff should not be brakes, which would On 10/19/18 at 12:3 needed staff assista of daily living (ADL' lap tray restraint at removed every two NA-B indicated she lap tray during the r been taken off durin R5's brakes had be and indicated staff wheelchairs.	d expect staff to follow R5's and would expect staff to during all meals and verified locking R5's wheelchair d also be a restraint. B2 p.m. NA-B confirmed R5 ance for eating and activities s). NA-B verified R5 utilized a all times and it was to be hours and during meals. had forgotten to remove the meal and stated it should have ng meals. NA-B also verified en locked during the meal were not to lock the brakes on	F 604			
restraints were only appropriately to trea symptoms and to pr function for the resi indicated a restrain purpose of disciplin Notice Requiremen CFR(s): 483.15(c)(3) §483.15(c)(3) Notic Before a facility tran resident, the facility (i) Notify the residen representative(s) of the reasons for the language and man	v used when they were used at the residents medical romote an optimal level of dent. The policy also t may never be used for the e or staff convenience. ts Before Transfer/Discharge 3)-(6)(8) e before transfer. nsfers or discharges a must- nt and the resident's the transfer or discharge and move in writing and in a ner they understand. The	F 623			11/28/18
	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER CARE CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa indicated she would care plan as written remove the lap tray staff should not be l brakes, which would On 10/19/18 at 12:3 needed staff assista of daily living (ADL' lap tray restraint at removed every two NA-B indicated she lap tray during the r been taken off durin R5's brakes had be and indicated staff wheelchairs. Review of facility po Care revised on 4/1 restraints were only appropriately to treas symptoms and to pr function for the resi indicated a restrain purpose of disciplin Notice Requiremen CFR(s): 483.15(c)(3) S483.15(c)(3) Notic Before a facility tran- resident, the facility (i) Notify the resident representative(s) of the reasons for the language and mann- facility must send a	DF CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 245299 PROVIDER OR SUPPLIER CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 18 indicated she would expect staff to follow R5's care plan as written and would expect staff to remove the lap tray during all meals and verified staff should not be locking R5's wheelchair brakes, which would also be a restraint. On 10/19/18 at 12:32 p.m. NA-B confirmed R5 needed staff assistance for eating and activities of daily living (ADL's). NA-B verified R5 utilized a lap tray restraint at all times and it was to be removed every two hours and during meals. NA-B indicated she had forgotten to remove the lap tray during the meal and stated it should have been taken off during meals. NA-B also verified R5's brakes had been locked during the meal and indicated staff were not to lock the brakes on wheelchairs. Review of facility policy titled, Restraint Free Care revised on 4/1/2016, indicated physical restraints were only used when they were used appropriately to treat the residents medical symptoms and to promote an optimal level of function for the resident. The policy also indicated a restraint may never be used for the purpose of discipline or staff convenience. Notice Requirements Before Transfer/Discharge	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIP A. BUILDING 245299 B. WING CARE CENTER 2 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX Continued From page 18 indicated she would expect staff to follow R5's care plan as written and would expect staff to remove the lap tray during all meals and verified staff should not be locking R5's wheelchair brakes, which would also be a restraint. F 604 On 10/19/18 at 12:32 p.m. NA-B confirmed R5 needed staff assistance for eating and activities of daily living (ADL's). NA-B verified R5 utilized a lap tray restraint at all times and it was to be removed every two hours and during meals. NA-B indicated she had forgotten to remove the lap tray during the meal and stated it should have been taken off during meals. NA-B also verified R5's brakes had been locked during the meal and indicated staff were not to lock the brakes on wheelchairs. F 623 Review of facility policy titled, Restraint Free Care revised on 4/1/2016, indicated physical restraints were only used when they were used appropriately to treat the residents medical symptoms and to promote an optimal level of function for the resident. The policy also indicated a restraint may never be used for the purpose of discipline or staff convenience. Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (I) Notify the resident and the resident's representative(s) of the transfer or discharge and the	Import of HEALTH AND HUMAN SERVICES O SFOR MEDICARE & MEDICAID SERVICES O OF DEFICIENCIES O OF DEFICIENCIES O OF DEFICIENCIES O PROVIDER OR SUPPLIER 245299 CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS OF UNITY MS INFORMATION REQUENTION OF LISE DEPICIENCIES PROVIDERS PLAN OF CORRECTION IEACH OPTICENCY MUST BE PRECEDED BY FULL PROVIDERS PLAN OF CORRECTION OF CORRECTION OF UNITY MS INFORMATION Continued From page 18 Indicated she would expect staff to follow R5's care plan as written and would expect staff to remove the lap tray during all meals and verified R5 utilized a lap tray restraint at all times and it was to be removed every two hours and during meals. NA-B confirmed R5 needed staff assistance for eating and activities of daily living (ADL's). NA-B confirmed R5 needed staff assistance for eating and activities and it was to be removed every two hours and during meals. NA-B also verified R5 strakes and been locked during the meal and indicated she would when they were used appropriately to treat the residents medical symptoms and to promote an optimal level of function for the resident. The policy also underline estraint Tree Care revised on 41/1/2016, indicated physical restraint may never be used for the purpose of discipline or staff convenience. Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3). House before transfer. Before a facility must- (1) Notify the resident mof the residents medical symptoms and to promo	IMENT OF HEALTH AND HUMAN SERVICES FORM SS FOR MEDICARE & MEDICAID SERVICES OMB NO O'COP DEFICIENCIES (X1) PROVIDERSUPLIENCIAN (X2) MULTIPLE CONSTRUCTION (X2) DAT A BULDING 245299 B. WING (X2) DAT PROVIDER OR SUPPLIER 245299 B. WING (X2) DAT CARE CENTER STREET ADDRESS, CITY, STATE, ZP CODE 10 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 10 CARE CENTER PROVIDER'S PLAN OF CORRECTION PRAZEE, NN 56544 WILLACH OR OR LSC DENTIFYING INFORMATION PREXE, NN 56544 FAZEE, NN 56544 Continued From page 18 In PREVIDER'S PLAN OF CORRECTION ECONFECTION INFORMATION PREVIDER'S PLAN OF CORRECTION ECONFECTION INFORMATION Continued From page 18 In PREVIDER'S PLAN OF CORRECTION ECONFECTION INFORMATION PREVIDER'S PLAN OF CORRECTION ECONFECTION ECONFECTION INFORMATION Continued From page 18 Indicated she would expect staff to follow R5's care plan as written and would expect staffs to states that the resolution to remove the lap tray during all meals and verified staff would not be locking R5's wheelchair F 604 On 10/19/18 at 12:32 p.m. NA-B confirmed R5 F 604 F 604 Review of facility nolicy titled, Restraint. F 604 F 604 NA-B indicated she had forgotten to remove the lap tray during the meal and stated it should have bee case

Facility ID: 00730

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION	`́СОМ	E SURVEY PLETED C
		245299	B. WING	' <u> </u>			0 19/2018
NAME OF P	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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 623	discharge in the res accordance with pa and (iii) Include in the ne paragraph (c)(5) of §483.15(c)(4) Timin (i) Except as specifi (c)(8) of this section discharge required made by the facility resident is transferr (ii) Notice must be r before transfer or d (A) The safety of in- be endangered und this section; (B) The health of in be endangered, und this section; (C) The resident's h allow a more immed under paragraph (c (D) An immediate tr required by the resi under paragraph (c (E) A resident has r days. §483.15(c)(5) Conte notice specified in p must include the fol (i) The reason for t (ii) The effective da	mbudsman. ons for the transfer or sident's medical record in aragraph (c)(2) of this section; otice the items described in this section. and of the notice. ied in paragraphs (c)(4)(ii) and h, the notice of transfer or under this section must be rat least 30 days before the red or discharged. made as soon as practicable lischarge when- dividuals in the facility would der paragraph (c)(1)(i)(C) of dividuals in the facility would der paragraph (c)(1)(i)(D) of health improves sufficiently to diate transfer or discharge, b)(1)(i)(B) of this section; ransfer or discharge is ident's urgent medical needs, b)(1)(i)(A) of this section; or not resided in the facility for 30 ents of the notice. The written baragraph (c)(3) of this section llowing: ransfer or discharge; te of transfer or discharge; which the resident is	F	623	3		

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245299	B. WING				C 19/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	(iv) A statement of t including the name, and telephone num receives such reque to obtain an appeal completing the form hearing request; (v) The name, addr telephone number of Long-Term Care Or (vi) For nursing faci and developmental disabilities, the mail telephone number of the protection and a developmental disa C of the Developmental disabilities, the mail telephone number of the protection and a developmental disa C of the Developmental disorder or related of email address and agency responsible advocacy of individ established under the for Mentally III Indiv §483.15(c)(6) Chan If the information in effecting the transfer must update the red as practicable once becomes available. §483.15(c)(8) Notic In the case of faciliti is the administrator	he resident's appeal rights, address (mailing and email), ber of the entity which ests; and information on how form and assistance in and submitting the appeal ess (mailing and email) and of the Office of the State mbudsman; lity residents with intellectual disabilities or related ling and email address and of the agency responsible for advocacy of individuals with bilities established under Part ental Disabilities Assistance ct of 2000 (Pub. L. 106-402, C. 15001 et seq.); and lity residents with a mental disabilities, the mailing and telephone number of the for the protection and uals with a mental disorder he Protection and Advocacy iduals Act. eges to the notice.	F	523			

CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ОМ	FORM A IB NO. (X3) DATE	11/27/2018 APPROVED 0938-0391 E SURVEY PLETED
		245299	B. WING			10/1	19/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	to the State Survey State Long-Term Ca the facility, and the well as the plan for relocation of the res 483.70(I). This REQUIREMEN by: Based on interview facility failed to noti Ombudsman of a fa 1 resident (R7) revi Findings include: R7's quarterly Minir assessment dated moderately impaire diagnoses which in hemiplegia (one-sic and Diabetes Mellit required extensive daily living (ADLs) a Review of R7's prop 10/19/18, revealed: -10/1/18, R7 was for roommate came to pressure to lacerati emergency medica transported to Detro	Agency, the Office of the are Ombudsman, residents of resident representatives, as the transfer and adequate sidents, as required at § NT is not met as evidenced and document review, the fy the Long Term Care (LTC) acility initiated transfer for 1 of ewed for hospitalization. num Data Set (MDS) 7/25/18, identified R7 had d cognition, and had cluded schizophrenia, led weakness of the body) us. The MDS indicated R7 assistance with activities of and had a history of falls. gress notes from 10/1/18, to bund on the floor after get the nurse. Staff applied on above right eye until ls services (EMS) arrived and bit Lakes. ansferred to an Emergency t Essentia hospital. R7 to forehead. There was no idsman had been notified of	F 6	23	 o Long Term Care Ombudsman habeen notified of R7 emergency room on 10/1/2018 o All other residents with hospitalitibeginning October 22, 2018 have bereviewed and Long Term Care Ombudsman update per requiremer o Education provided to IDT on fat communication form required month update Ombudsman of transfers and discharges, including emergency ca o Administrator or designee to aud monthly for 3 months o Audits will be reviewed by QAPI months to review and recommend for up as needed. o Compliance date: 11/28/2018 	n visit zation een nt x nly to d ure. dit l for 3	

	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245299	B. WING _				C 19/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 623	Continued From pa	ige 22	F 62	23			
	(CM)-A stated R7 fe and was sent to the process the facility	14 a.m. clinical manager ell and hit his head on 10/1/18, e ED. CM-A was unsure what utilized for updating the LTC illity initiated transfers.					
	administrator indica updated the LTC O	30 a.m. interim facility ated she was unaware who mbudsman of facility initiated d have to reference the					
	operations manage Ombudsman of disc part of her role and discharges to the L every month. The of information on resid Ombudsman was g electronic health re Admit/Discharge To the information for a returning would not resident would not The operations man had to update the L initiated discharges	10 p.m. the facility's er stated updating the LTC charges and transfers was sent a list of all transfers and TC Ombudsman at the end of operations manager stated the dents to send to the LTC gathered from a report on the cord system, titled b/From Report. She indicated a resident going to the ED and t show up on the report as the be discharged or transferred. nager was unaware the facility TC Ombudsman of facility s when a resident was cute care facility on an					
	Transfer and Disch [Health Dimensions indicated it was the state and federal re	olicy titled, Admission, arge (General)- HDGR s Group], last revised 9/22/17, e facility policy to follow all egulations regarding ers, and discharges to and					

Facility ID: 00730

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PRINTED: 11/27/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURV COMPLETER NAME OF PROVIDER OR SUPPLIER 245299 STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544 10/19/20			I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/27/2018 APPROVED . 0938-0391
245299 B. WING 10/19/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE FRAZEE CARE CENTER 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544 FRAZEE, MN 56544	STATEMENT OF DEFICIENC	ICIES	(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
FRAZEE CARE CENTER 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544			245299	B. WING				
FRAZEE CARE CENTER FRAZEE, MN 56544	NAME OF PROVIDER OR	≀ SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	FRAZEE CARE CENT	ITER						
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PREFIX (EACH I	DEFICIENCY				CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETION DATE
F 623 Continued From page 23 F 623 from the skilled nursing facility. The policy indicated "6. Timings of notice: a) The notice of F 623 indicated "6. Timings of notice: a) The notice of transfer or discharge is made by the facility at Ieast 30 days before the resident is to be F 623 transferred or discharged. Notice will be provided to resident and resident representative as well as F 623 state Ombudsman. b) Notice is made as soon as practicable before transfer or discharge when: Iii. An immediate transfer or discharge is required by the resident's urgent medical needs;" Iii.	from the sl indicated " transfer or least 30 da transferred to resident state Omb practicable iii. An imm by the resi Notice of E SS=D CFR(s): 48 §483.15(d s483.15(d s483.15(d) s483.15(d) s483.15(d) iii. An imm by the resi cFR(s): 48 s483.15(d) s483.15(d) nursing fac or the resider specifies- (i) The dur any, during return and facility; (ii) The resi plan, unde (iii) The nu bed-hold p paragraph resident to (iv) The inf of this sect s483.15(d) the time of hospitaliza	skilled nur "6. Timing or discharg lays befor ed or disch tand resi- budsman. le before tan addent's ur Bed Hold 183.15(d)(d) Notice of addity trans- ident goes acility trans- acility trans- ident goes acility trans- acility trans- acility frans- acility mus baserve beco- er § 447.4 ursing fac periods, w h (e)(1) of o return; a aformation ction. d)(2) Bed- of transfer ation or th	rsing facility. The policy gs of notice: a) The notice of ge is made by the facility at re the resident is to be harged. Notice will be provided ident representative as well as . b) Notice is made as soon as transfer or discharge when: ansfer or discharge is required gent medical needs;" Policy Before/Upon Trnsfr (1)(2) of bed-hold policy and return- ce before transfer. Before a sfers a resident to a hospital s on therapeutic leave, the st provide written information to dent representative that the state bed-hold policy, if he resident is permitted to residence in the nursing d payment policy in the state 40 of this chapter, if any; cility's policies regarding which must be consistent with t this section, permitting a and n specified in paragraph (e)(1)					11/28/18

If continuation sheet Page 24 of 106

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			F(OMB	ORM / BNO.	11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3		SURVEY PLETED
		245299	B. WING _				9/2018
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				9 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 625	specifies the duratic described in paragr This REQUIREMEN by: Based on interview facility failed to prov and/or resident repu- hold policy at the tir for 1 of 1 resident (thospitalization. Findings include: R7's quarterly Minir assessment dated moderately impaire diagnoses which in hemiplegia (one-sid and Diabetes Mellit required extensive daily living (ADLs) a Review of R7's prov 10/19/18, revealed: -10/1/18, R7 was for roommate came to pressure to lacerati emergency medica transported to Detro -10/2/18, R7 was tr Department (ED) a received 3 sutures On 10/18/18, at 9:2	tive written notice which on of the bed-hold policy aph (d)(1) of this section. NT is not met as evidenced and record review, the vide notification to the resident resentative of the facility's bed me of an emergency transfer R7), reviewed for num Data Set (MDS) 7/25/18, identified R7 had d cognition, and had cluded schizophrenia, led weakness of the body) us. The MDS indicated R7 assistance with activities of and had a history of falls. gress notes from 10/1/18, to pund on the floor after get the nurse. Staff applied on above right eye until ls services (EMS) arrived and bit Lakes. ansferred to an Emergency t Essentia hospital. R7	F 62	25	 o R7 returned to the facility prior to receiving bed hold o Other residents have received bethold per policy o Education provided to IDT and licensed nurses to obtain signed bed I on all transfers including emergency or Administrator or designee to audit with each transfer for one month and monthly for 2 months o Audits will be reviewed by QAPI for months to review and recommend foll up as needed. o Compliance date: 11/28/2018 	hold care it	

		AND HUMAN SERVICES			FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245299	B. WING			C 19/2018
NAME OF F	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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 625	resident to the hosp their emergency co LPN-A stated "we a a bed hold], but sor LPN-A indicated a f time of the transfer nurse that was tran stated she was not for residents transfe if the resident was f On 10/18/18, at 9:3 designee (SSD)-A i facility's bed hold p On 10/18/18, at 11: (CM)-A indicated if the nurse on the flo offer the bed hold for would be filled out b of the resident's me filed under the Soci after the resident re- stated staff would no resident was going they would not be a resident was admitt ED, then staff would at that time. On 10/18/18, at 11: administrator stated should be offered to the door, if possible possible to offer up completed within a	bital we ask the resident or ntact of they want a bed hold. are supposed to ask [regarding netimes it gets missed". form would be filled out at the called Bed Hold Policy, by the sferring the resident. LPN-A sure that the form was used erred to the ED, but was used to be admitted to the hospital. 8 a.m. social service ndicated he had no part of the	F 625			

Facility ID: 00730

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		AND HUMAN SERVICES			FOI	ED: 11/27/2018 RM APPROVED IO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			OATE SURVEY OMPLETED
		245299	B. WING			C I 0/19/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From pa	ge 26	F 6	325		
F 677 SS=D	medical record and offered to R7 on 10 the ED and not bein A facility policy titled Re-Admission, last before a resident w placed on therapeu was provided to the representative. ADL Care Provided CFR(s): 483.24(a)(2) §483.24(a)(2) A res out activities of dail necessary services grooming, and pers This REQUIREMEN by: Based on observat review the facility fa incontinence care for were dependent up living. Findings include: R38's admission Mi dated 9/28/18, iden which included dem seizure disorder. Th severe cognitive im extensive assistand transfers, personal toileting. Further, th	revised 11/16, indicated as transferred to a hospital or tic leave, written notification e resident, and/or the resident for Dependent Residents	F6	\$77	 R38 had discharged from the community Other residents identified as dependent on staff for incontinence have been reviewed and provided care timely Education provided to nursing staff timely incontinence care for dependent residents DON or designee to audit 3 resident two times weekly for four weeks and the weekly for one month and then monthly for 2 months Audits will be reviewed by QAPI for months to review and recommend follow up as needed. Compliance date: 11/28/2018 	/ on ts en / 3

Facility ID: 00730

		AND HUMAN SERVICES			FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT COM	E SURVEY IPLETED
		245299	B. WING			C 19/2018
NAME OF F	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	(EACH DEFICIENCY	TEMENT 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)	LD BE	(X5) COMPLETION DATE
F 677	bladder toileting pro R38's care area ass 9/28/18, indicated F and bladder, was u known, unable to si incontinent of bowe CAA also indicated congestive heart fai diuretics to keep flu heart, which increas The CAA further inc skin breakdown and and staff would anti R38's Bowel and Bl dated 9/25/18, indic bowel and bladder, to void/defecate and related to dementia dependent on staff to check/change. R38's current care p identified R38 had s urinary incontinence weakness, generali The care plan listed directed staff to che upon rising, before and with night round Review of Aide Guid indicated R38 was and directed staff to	ler, and was not on a bowel or ogram. sessment (CAA) dated R38 was incontinent of bowel nable to make her needs t on the toilet and was and bladder at all times. The R38 had diagnoses of ilure and was receiving id off of her extremities and se her risk for incontinence. dicated R38 was at risk for d odor related to incontinence cipate R38's needs. ladder Functional Evaluation cated R38 had incontinence of unable to feel urge/sensation d had functionally incontinent , impaired mobility and for all cares, ADL's and staff plan revised on 10/15/18, self care deficits related to e, constipation, dementia, zed pain and malnutrition. d various intervention which eck/change for incontinence and after meals, at bedtime ds and as needed. de for Group A undated, incontinent of bowel/bladder o check/change upon rising, eals, at bedtime and	F 677			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245299	B. WING				C 19/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 677	Continued From pa	ge 28	Fe	677			
	10/17/18 from 5:08 - at 5:08 p.m. R38 v in her room watchir - at 5:15 p.m. R38 r director of nursing (peaked at R38 and - at 5:29 p.m. DON via Broda chair dow pushed her up to th - at 5:49 p.m. nursin next to R38, placed chest area, place B and gave R38 a dri - at 5:59 p.m. NA-E supper which consi pineapple chicken, - at 6:12 p.m. NA-E supper which consi pineapple chicken, - at 6:20 p.m. NA-E eat her supper. - at 6:20 p.m. NA-E eating, wiped her m protector from her co of the dining room v her room. NA-E reco slightly, placed call comfortable and lef - at 6:48 p.m. R38 r in her Broda chair a - at 7:02 p.m. R38 r in her Broda chair, closed while she re - at 7:05 p.m. activit asked if she want to wheeled R38 out of down to the activity singing and having	was seated in her Broda chair ng TV. remained the same and the DON) stopped in room, left the room. wheeled R38 out of her room on to the dining room and the dining room table. ng assistant (NA)-E sat down I clothing protector on her roda chair in upright position nk of her thickened water. assisted R38 to eat her sted of pureed winter fruit, rice and carrots. continued to assist R38 to asked R38 if she was done nouth, removed her clothing chest area, wheeled R38 out via Broda chair and back to lined R38's Broda chair back light, made resident t her room. remained in her room seated and was watching TV. remained in her room seated TV on and R38's eyes were sted. ty staff entered R38's room, o come to activity, activity staff her room via Broda chair room where they were					

DEPARTMENT OF HEALTH A					FORM	: 11/27/2018 APPROVED 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
	245299	B. WING				0 19/2018
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE CARE CENTER				9 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
the activity room. - at 7:38 p.m. activity her room via Broda of - at 7:41 p.m. R38 ref in her Broda chair ar while she rested. - at 7:45 p.m. NA-D of mechanical lift and br ready for bed while N help. - at 7:51 p.m. NA-D of R38 to get ready for putting her pajama's - at 7:55 p.m. NA-D of mechanical lift over N mechanical lift over N mechanical lift and the Broda chair to the be proceeded to roll R3 the lift sling, NA-D ref confirmed R38 was if bladder and they prof incontinent products buttocks was noted the rectal area which ext her buttock crease to areas noted. R38 has for a total of 2 hours she was dependent care and was at risk On 10/18/18 at 11:54 was routinely incontia and needed to be ch- hours. On 10/18/18 at 12:10	inued to listen to singing in y staff pushed R38 back to chair and left the room. emained in her room seated nd R38's eyes were closed enter R38's room with full began to assist R38 to get NA-E entered the room to and NA-E continued to assist bed by washing her up and on her upper body. and NA-E positioned the full R38, hooked R38 to the ransferred her from her ed. NA-D and NA-E 88 from side to side, removed emoved R38's pants, NA-E incontinent of bowel and beceded to change R38's 5. During observation R38's to be bright red around the tended to the outer edges of o be more pink with no open ad not been check/changed and 47 minutes even though upon staff for incontinence	F 6	577			

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245299 B. WING 10/19/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE CARE CENTER FRAZEE, MN 56544 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 677 Continued From page 30 F 677 incontinent of bowel and bladder and had to be checked and changed every two hours, an was at risk for skin breakdown. On 10/19/18 at 10:46 a.m. the DON verified R38 was at risk for skin breakdown and pressure ulcers and would expect staff to check/change as identified by the care plan. On 10/18/18 at 2:51 p.m. NA-E called via phone call confirmed R38 required assistance of two staff with all cares and was incontinent of bowel/bladder and wore incontinent products. NA-E indicated R38 required staff to checked/changed her every two hours. NA-E verified R38 had not been checked/change before or after the supper meal and stated we tried to get in there right away. Review of facility policy titled, Bowel and Bladder Management revised on 11/16, indicated there's a system to ensure that each resident with bowel and bladder incontinence will receive appropriate treatment and services to achieve or maintain as much normal elimination function as possible. F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer F 686 11/28/18 CFR(s): 483.25(b)(1)(i)(ii) SS=D §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00730

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PRINTED: 11/27/2018

FORM APPROVED

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			ON	FORM / IB NO.	11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (E SURVEY PLETED
		245299	B. WING				_ 19/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	necessary treatmer with professional st promote healing, pr new ulcers from de This REQUIREMEN by: Based on observat review, the facility f assistance with rep (R38) with a history risk for further deve Findings include: R38's admission Mi dated 9/28/18, iden which included dem seizure disorder. Th required extensive mobility and transfe R38 was at risk for ulcers and listed va included pressure r bed. R38's care area ass 9/28/18, indicated F history of skin breat coccyx and open at and remained at ris The CAA also indic relieving mattress a wheelchair, needed mobility, was unabl able to participate v CAA further indicate	and services, consistent andards of practice, to event infection and prevent	F	\$\$86	 o R38 has discharged from the community o All other residents identified at r pressure ulcers have had an assess and care plan review and revised as indicated o Education provided to nursing s timely repositioning to prevent press injury development o Audit of interventions to prevent pressure ulcers will be completed or residents two times weekly for four v and then weekly for one month and monthly for two months o DON/ Designee will report result trends of all audits to QAPI Committ 3 months to review and follow-up as needed. o Compliance date 11/28/2018 	sment s staff on sure t n 3 weeks lts and tee for	

If continuation sheet Page 32 of 106

		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			COM	E SURVEY IPLETED
		245299	B. WING				C 19/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	repositioning. R38's Braden Scale Risk form, dated 9// high risk for the dev skin was often very very limited mobility nutrition and had a shearing. The form skin breakdown and from staff for all car (ADL's) and mobilit R38's current care identified R38 had s breakdown related impaired mobility, v malnutrition and de The care plan direct upon rising, before and with rounds du Review of Aide Gui indicated R38 was and directed staff to rising, before and a with rounds during Continual observati 10/17/18 from 5:08 - at 5:08 p.m. R38 v in her room watchir - at 5:15 p.m. R38 r	F were to ensure to do a for Predicting Pressure Sore 25/18, identified R38 was at velopment of pressure ulcers, moist, was chair fast, had v, probably inadequate problem of friction and indicated R38 was at risk for d required total assistance res, activities of daily living y. plan revised on 10/15/18, self care deficits and skin to dementia, incontinence, veakness, generalized pain, pendent on staff for all cares. ted staff to turn and reposition and after meals, at bedtime ring night hours. de for Group A undated, high risk for skin breakdown o turn and reposition upon fter meals, at bedtime and night shift. fons were conducted on p.m. to 7:55 p.m. was seated in her Broda chair	F	586			
	- at 5:29 p.m. DON	immediately left the room. wheeled R38 out of her room wn to the dining room and					

		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	COM	E SURVEY IPLETED C
		245299	B. WING				19/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	pushed her up to th - at 5:49 p.m. nursin next to R38, placed chest area, place B and gave R38 a dri - at 5:59 p.m. NA-E supper which consi pineapple chicken, - at 6:12 p.m. NA-E eat her supper. - at 6:20 p.m. NA-E removed her clothir area, wheeled R38 Broda chair and ba R38's Broda chair to made resident com the room. - at 6:48 p.m. R38 r in her Broda chair a - at 7:02 p.m. R38 r in her Broda chair a - at 7:05 p.m. activit asked if she want to wheeled R38 out of down to the activity singing and having - at 7:38 p.m. activit her room via Broda - at 7:41 p.m. R38 r in her Broda chair a while she rested. - at 7:45 p.m. NA-D mechanical lift and	ie dining room table. Ing assistant (NA)-E sat down I clothing protector on her proda chair in upright position nk of her thickened water. assisted R38 to eat her sted of pureed winter fruit, rice and carrots. Continued to assist R38 to wiped R38's mouth, ng protector from her chest out of the dining room via ck to her room. NA-E reclined back slightly, placed call light, fortable and immediately left remained in her room seated and was watching TV. remained in her room seated TV on and R38's eyes were sted. ty staff entered R38's room, o come to activity, activity staff f her room via Broda chair room where they were	F	586			

		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED . 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY IPLETED
		245299	B. WING				/19/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	help. - at 7:51 p.m. NA-D R38 to get ready fo putting her pajama' - at 7:55 p.m. NA-D mechanical lift over mechanical lift over mechanical lift over mechanical lift over mechanical lift over mechanical lift and Broda chair to the b proceeded to roll R the lift sling, NA-D r confirmed R38 was bladder and they princontinent product buttocks was noted rectal area which end her buttock crease areas noted. R38 had not offered meals as directed b unable to reposition had not been reposed and 47 minutes and ulcers. On 10/18/18 at 11:5 was routinely incom and needed to be read on 10/18/18 at 12:7 nurse (LPN)-B confi incontinent of bower repositioned checker risk for pressure ulow	 and NA-E continued to assist or bed by washing her up and 's on her upper body. and NA-E positioned the full r R38, hooked R38 to the transferred her from her bed. NA-D and NA-E '38 from side to side, removed R38's pants. NA-E is incontinent of bowel and roceeded to change R38's is. During observation R38's is During observation R38's to be bright red around the xtended to the outer edges of to be more pink with no open d to reposition before and after by her care plan and was in herself independently. R38 sitioned for a total of 2 hours d was at high risk for pressure 54 a.m. NA-F confirmed R38 thinent of bowel and bladder epositioned every two hours ged. 16 p.m. licensed practical firmed R38 was routinely el and bladder, needed to be ed/changed and R38 was at 	F 6	586			

Facility ID: 00730

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT COM	E SURVEY PLETED
		245299	B. WING	i			C 19/2018
NAME OF F	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686 F 688 SS=D	routinely incontinent needed to be check reposition upon risit bedtime and with ro DON verified R38 or risk for pressure uld staff to turn and rep schedule and to foll On 10/18/18 at 2:57 NA-E confirmed R3 staff with all cares a and bladder and wo indicated she was r pressure ulcers, bu her every two hours NA-E verified R38 f checked/change be and stated we tried Increase/Prevent D CFR(s): 483.25(c)(1) §483.25(c)(1) The f resident who enters range of motion door range of motion und condition demonstr- of motion is unavoid §483.25(c)(2) A res motion receives appropriat	t of bowel and bladder, ked/changed, turned and ng, before and after meals, at bunds during night shift. The care plan, verified she was at cers and she would expect bosition R38 as per her low her care plan. 1 p.m. via telephone interview, 8 required assistance of two and was incontinent of bowel bre incontinent products. NA-E not sure if R38 was at risk for t required staff to reposition and checked/changed her. and not been repositioned or efore or after the supper meal to get in there right away. ecrease in ROM/Mobility 1)-(3) cacility must ensure that a a the facility without limited es not experience reduction in ess the resident's clinical ates that a reduction in range		586 588			11/28/18

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED
		245299	B. WING			(10/*	_ 9/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	the maximum pract reduction in mobility unavoidable. This REQUIREMEN by: Based on observat review, the facility f comprehensive ass appropriate interven maintain current ran for 1 of 2 residents ROM. Findings include: R18's admission Mi 8/23/18, identified F included; dementia. one side of the bod impairment of langu or comprehension of read or write). R18' cognition was seve extensive assistance eating, personal hy assistance for trans use. R18's MDS als care, and a functior motion on one side extremities. Review of R18's Ca dated 8/29/18, iden verbalized her need for all activities of d cognitive impairmen years ago. The CA	icable independence unless a / is demonstrably NT is not met as evidenced ion, interview and document ailed to conduct a essment and implement ntions to prevent a decline or nge of motion (ROM) abilities (R18) reviewed with limited	F	588	 o R18 has been screened and caplan revised for proper intervention contracture o All other residents with contract screened and care plans revised as indicated o Education will be provided to nu admin., functional maintenance O.T therapy on the need for screening residents with contractures on adm and routinely to ensure appropriate treatment to maintain or prevent de in range of motion. o Audit to assure ROM and splint used as indicated/ordered on 5 resit two times weekly for four weeks and then motifor two months to prevent decline in ROM. o DON/ Designee will report resut trends of all audits to QAPI Commit review for 3 months and follow up a needed o Compliance date 11/28/2018 	for tures s ursing f. and ission cline ts are idents d then nthly n lts and ttee for	

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	`́СОМ	E SURVEY PLETED C
		245299	B. WING				0 19/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	physical behaviors behaviors of yelling not understand, and re-approach. The C partial or total loss of limitation in range of inability to perform a physical assistance R18's care plan, las R18 had decreased hand in flexed positi staff for all ADLs an portion of care plan behaviors section of had verbal and phy related to severe co limited understandin dementia and defice cardiovascular acci behaviors included; to bite during cares cares, often yelling was not pain related because someone doesn't understand listed which include occupy her left han as a washcloth, to of behaviors during care as the care of the to the to the to the staff to th	during cares and verbal out during cares as she did d staff may have to CAA also identified R18 had of arm movement, functional of motion, hemiplegia, and ADLs without significant a. st revised 10/19/18, identified d mobility of right hand due to tion. R18 was dependent on no mobility. R18's ADLs listed FMP as allows. R18's of the care plan indicated R18 sical behaviors during cares ognitive impairment and ng due to her diagnosis of its as a result of her ident (CVA) (stroke). Target ; hitting slapping and attempt . She would yell out during "owa". Husband stated this d but feels she yells "owa" is touching her and she . Various interventions were ed; "give her something to d when providing cares, such distract her from physical are". uide Group B, dated 9/23/18, ired extensive assistance from and yell with cares. The guide y and place something in her ring cares, and was a high	F	588			

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	COM	E SURVEY PLETED C
		245299	B. WING	i			_ 19/2018
NAME OF F	ROVIDER 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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 688	Continued From pa	ge 38	F	688	3		
	5/5/18, indicated it v admission history a exam the note indic hand somewhat flex On 10/16/18, at 9:4 seated in a wheelch right hand was clem or material were no right foot was flexed rest of the wheelch was present and sta been like that for a visited daily, and wa ROM exercise prog On 10/16/18, at 2:1 back in bed with he was on. R18's right a fist. On 10/17/18, at 1:1	0 p.m. R18 was lying on her r eyes open and the television hand remained clenched into 8 p.m. R18 was lying on her e head of the bed raised, eyes television was on. R18's right					
	wheelchair, which w dining room table. F positioned in her lap clenched in a fist. F flexed and rested o the wheelchair.	3 p.m. R18 was seated in the was slightly reclined, at the R18's right hand was p and her right hand remained R18's right foot remained n a pillow on the footrest of					
	10/16/18, revealed	es reviewed from 8/1618, to the following:					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245299	B. WING				19/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	Continued From pa	ge 39	F	888			
	to do passive ROM further ROM. R18 v FMP, PROM bilater	assistant (COTA) attempted (PROM) then refused any vould continue with current ral lower extremities (LE) and JP) 3-5 times per week. R18					
	yelled ow when atte	d pain when left arm lifted, and empted to mover her right her right hand together					
		ote; R18 was provided with a for use in facility to improve tolerance.					
	-9/14/18, R18 refus	ed FMP this date.					
		ed to let COTA touch them his date, so PROM not done refusal.					
	-9/19/18, refused Fl	MP this date.					
	-9/25/18, PROM B	LE and UE.					
		LE and UE 1 to 3 times per pation. Continue no change."					
	-10/2/18, R18 not se sleeping.	een this date for FMP due to					
	-10/3/18, R18 was a seen for FMP.	asleep and therefore was not					
	-10/5/18, R18 was s	sleeping when COTA					

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		AND HUMAN SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245299	B. WING			C 10/19/2018	
NAME OF F	ROVIDER 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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	wrist. On 10/18/18, at 10 (PT)-A indicated R1 care and did not ha PT-A stated, if resid term care, they wou concerns. PT-A star records for R18's se On 10/18/18, at 10: (OT)-A stated R18 y care without therap therapy would not se resident without the depend on nursing screen would be ne maintenance progra would screen reside possible contracture resistance to passiv place them on a FM ROM to decrease a confirmed R18 had for a wheelchair as R18 was on a FMP screen for FMP was On 10/18/18, at 10: room and evaluated contractures. OT-A	FMP this date. illateral LE and left elbow and :08 a.m. physical therapist 8 was admitted for long-term ve admission therapy orders. lents were admitted to long uld be screened for any ted he would check therapy creen. 33 occupational therapist was admitted for long term y orders. OT-A indicated, see the newly admitted erapy orders, and would staff to notify therapy staff if a beded for a possible functional am (FMP). OT-A stated OT ents with limited ROM or es (condition of fixed high //e stretch of a muscle) to AP to complete stretching and any further contraction. OT-A only one screen from therapy sessment. OT-A confirmed , but no documentation of a s available. 41 a.m. OT-A entered R18's d R18's right hand for possible opened R18's right hand and	F	588	,		
	R18's skin was pale	e/white in appearance and ed (moist, soft and in a state of					

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245299	B. WING			10/19/2018	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	deterioration). OT-A indicated the palm a OT-A stated R18 w hand roll. At 10:44 a room and stated R1 wash cloth in her rig OT-A evaluated R1 R18 would benefit f On 10/18/18, at 10: at risk for worsening R18 had not had a while at the facility. expected the certific assistant (COTA) re R18's FMP to have of R18's right hand the right hand. OT-A received any conce her wheelchair scree On 10/18/18, at 2:4 interview with COTA responsible for cor scheduled for 1 to 3 indicated all docum R18's progress note would work with R1 stated, normally if s to complete her low stated the last time allow her to complet extremity. COTA-A able to touch R18's R18 stating no, or w indicated she would any changes with F	A held R18's hand open and and finger area had to dry out. ould benefit from a splint or a.m. FM-A entered R18's 18 used to have a roll or a ght hand at a previous facility. 8's right foot and indicated from a brace to the right foot. 45 a.m. OT-A stated R18 was g contractures, and confirmed splint, brace, or hand roll OT-A stated she would have ed occupational therapy esponsible for administering updated therapy on the state and R18's refusing FMP to A confirmed therapy had not erns related to R18, other then	F	\$88			

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245299	B. WING			C 10/19/2018	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	R18. COTA-A state any device or wash On 10/18/18, at 11: stated if nursing sta would update the n out a therapy scree therapy. CM-A state and hemiplegia, an On 10/18/18, at 2:1 (NA)-J stated she ro NA-J stated in the r open R18's right ha water due to an odd times place a wash she would have sor On 10/19/18, at 11: (DON) stated if a re contracture, she wo place to address it. staff responsible for or therapy of R18's hand so a screen c Review of facility po Services Orders da facility provided phy therapy to attain or prevent decline with treatment plan. A policy for identifyi	ge 42 umed the facility had a plan for d she had not seen R18 with cloth in her right hand. 06 clinical manager (CM)-A off noted a contracture, they urse, and the nurse would fill n and get physician orders for ed R18 had diagnoses of CVA d was at risk for contractures. 6 p.m. nursing assistant egularly worked with R18. nornings, she would have to and and wash it with soap and or. NA-J stated staff would at cloth in R18's left hand so mething to hold on to. 27 a.m. director of nursing esident was admitted with a puld expect something to be in She would have expected the r R18's FMP to update nursing refusal to work with the right ould have been completed. Dicy titled Rehabilitation ted 4/1/08, indicated the vsical, occupational, or speech maintain function and/or n a physician-ordered	Fθ	588			
F 689	provided.	azards/Supervision/Devices	F 6	89			11/28/18

		AND HUMAN SERVICES & MEDICAID SERVICES			F	FORM /	11/27/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED		
		245299	B. WING			(10/1	; 9/2018	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
FRAZEE	CARE CENTER		219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689 SS=D	-	-	F6	689				
	supervision and ass accidents. This REQUIREMEN by:	resident receives adequate sistance devices to prevent NT is not met as evidenced						
	review, the facility fa interventions for 1 of for accidents, and fa transfer requirement observed using a m facility failed to impli- interventions for 1 of	ion, interview and document ailed to implement fall of 2 residents (R7) reviewed ailed to implement safe its for 1 of 2 residents (R7) nechanical lift. In addition, the lement safe smoking of 3 residents (R40) who nage smoking materials.			 o R7 had O.T screen for safe whee chair positioning 10/18/2018 o R7 had anti-roll brakes added to wheelchair 10/18/2018 o R7 has been using total lift per caplan o R40 has been re-educated on he smoking assessment and requirement have facility staff store her smoking 	are		
	Findings include: FALLS R7's significant cha Set (MDS), dated 4 severe cognitive im which included her weakness of the bo Diabetes Mellitus. T required total assist and extensive assist toilet use, and perse further indicated R7 Review of R7's qua	nage smoking materials. nge in status Minimum Data /26/18, identified R7 had pairment and had diagnoses hiparesis (one-sided dy), schizophrenia, and The MDS indicated R7 tance from staff for transfers, stance for bed mobility, eating, onal hygiene. The MDS Thad a history of falling. rterly MDS, dated 7/25/18, oderately impaired cognition,			have facility staff store her smoking material, additionally, R40 was re-educated on the policy and acknowledgment for smoking at Fraz Care Center. o All residents who had falls in the 30 days have been reviewed to ensu stated interventions are in place o All residents care guides reviewe ensure proper lift is reflected for safe transfer o All residents identified as smoken have had their assessment reviewed care plan and care guide updated to reflect current assessment findings o All residents have had smoking p reviewed and sign acknowledgement understanding	e last ure ed to ers I and policy		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245299	B. WING		C 10/19/2018	
AME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	10,	10/2010
RAZEE	CARE CENTER			219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETIO DATE
F 689	and had diagnoses (managing the sym life-limiting and chr schizophrenia, and indicated R7 requir transfers with two of indicated R7 had two assessment. Review of R7's Car dated 5/9/18, ident judgement and safe decision making as transfer, which resu indicated R7 believ attempted to do so the wheelchair to b R7 had a history of right sided hemipar stand, was a fall rist for transfers. Review of R7's car indicated R7 was a history of falls due R7 believed he cou incontinence, balar hemiparesis. R7's of interventions which therapy to assess f status post fall, and with total assist of the Review of the Aide 9/23/18, indicated I high-low bed, requir activities of daily live	a which included palliative care ptoms and side-effects of onic illness), hemiparesis, I Diabetes Mellitus. The MDS red total assistance for or more staff. The MDS further wo or more falls since the last re Area Assessments (CAA), ified R7 displayed poor ety awareness with poor s evidenced by attempts to self ulted in falls. The CAA red he could stand and in order to self transfer from bed. The CAA also indicated, f a stroke which resulted in resis, was unable to walk or sk, and required a full body lift e plan, last revised 10/5/18, at risk for falls related to a to self transfer attempts, as uld still stand and walk, nce issues, and right sided care plan listed various n included a low bed, physical for proper wheelchair fitting d mechanical lift to transfer	F 68	 o Nursing staff and IDT educate falls and the importance of interve to reduce or minimize risk of injuit o Nursing staff educated on foll what care guide designates for set transfers o Nursing staff educated with r demonstration on proper use of t machines o Employees will be given train facility expectations related to sm policy and procedure including th following: designated resident sm areas that can be used for smoki policy; residents are not allowed smoking materials or assist other residents in smoking. Additionall to follow the safety expectations result in loss of smoking privilege o Audits of new interventions of two times weekly for four weeks weekly for one month and then m for 2 months o Audits of proper transfer lift u occur two times weekly for four we 3 residents and then weekly for on month and then monthly for two r o Audits of following individuali smoking plan to be completed for residents two times per week for weeks and then weekly for one n and then monthly for two months o DON/ Designee will report re trends of all audits to QAPI Comr 3 months to review and follow-up needed. o Compliance Date 11/28/2018 	entions y. lowing afe eturn he lift ing on loking e hoking ng, per to share y, failure may s. vill occur and then loonthly se will reeks on one nonths zed 2 four honth sults and nittee for as	

		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	Сом	E SURVEY IPLETED
		245299	B. WING				C 19/2018
NAME OF F	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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 45	Fe	589			
	was lying in a low b positioned next to the wheelchair brakes we was able to get him without help from sib bathroom independ had fallen a couple R7 stated he went for sutures for a head we Review of R7's program 10/19/18, revealed: -10/1/18, R7 was for roommate came to pressure to lacerati emergency medica transported to Detro -10/2/18, interdiscip review R7's fall. R7 wheelchair to bed a his forehead. R7 has increased fall risk, a transfers. Discusse noted R7 does not wheelchair and was own. IDT decided to (device that automa whenever the person wheelchair for impri- -10/3/18, R7's auto yet at facility. Physi for proper wheelchair	gress notes from 10/1/18, to bund on the floor after get the nurse. Staff applied on above right eye until ls services (EMS) arrived and bit Lakes. blinary team (IDT) met to attempted a self transfer from and fell to the floor, lacerating ad right sided weakness that and used a full body lift for d with nursing staff and was frequently apply brakes to the s unable to bear weight on his o add auto[matic] brakes atically locked the wheels on stands or sits) to					

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245299	B. WING				C 19/2018
NAME OF F	PROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPN DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	-	F 6	89			
	propels. Staff will a arrive at facility.	dd auto brakes when they					
	wheelchair and was nursing assistant (N (DON) followed the mechanical lift. At 6 to bed by NA-H and were completed. A lowered to the floor NA-H placed the wi NA-H and the DON wheelchair brakes wheelchair lacked a	were not locked and the					
	required two staff for once in bed one sta as R7 could assist understood instruct	or the majority of cares, but aff could complete some cares with bed mobility and tions. She stated staff placed ie to many self transfer					
	required extensive was a fall risk. NA-l something, like go	7 p.m. NA-I stated R7 assistance with cares and I stated when R7 wanted to do to bed, you have to be quick do things on his own.					
	nurse (LPN)-A state assist with two staf mechanical lift and	26 a.m. licensed practical ed R7 required extensive f for cares, and required a two staff for all transfers. 7 was at risk for falls due to ots.					
	On 10/18/18, at 9:4	0 a.m. PT-A indicated R7 had					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C	
		245299	B. WING	B. WING			_ 19/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	On 10/18/18, at 2:0 with eyes closed. T elevated approxima R7's wheelchair pos wheelchair's locks w wheelchair lacked a R7's room and state laid R7 in bed after fall risk and should occupied. NA-A low left the room as R7' unlocked. On 10/18/18, at 11: (CM)-A stated R7 re with all activities of transferred with two times. CM-A stated her expectation for care plan and the c had a fall on 10/1/1 the emergency dep implemented wheel intervention to prev indicated she was r brakes had not bee On 10/19/18, at 11: required assistance was at risk for falls staff and mechanica DON stated after R reviewed the incide	valuated by therapy. 8 p.m. R7 was lying in bed he bed frame remained ately two feet off the floor, with sitioned near the bed. The were not applied and the auto brakes. NA-A entered ed the day shift would have lunch. NA-A stated R7 was a be in a low bed when vered R7's bed to the floor and 's wheelchair remained 14 a.m. clinical manager equired maximum assistance	F	589			
	maintenance updat	ed her that the wheelchair d, but not available on					

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245299	B. WING	i			
NAME OF I	PROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	10/3/18. The DON auto brakes would verbally asked ther use. The DON conf by therapy, as a the and the proper form stated she would has assessment to have timely. The DON st low position when of expected staff to low lain in bed. In addition: MECHANICAL LIF On 10/17/18, at 2:2 edge of bed with th height. R7 had an E standing transfer ed in front of him. R7 f harness around his the EZ-Way Stand's behind the machine raise the hydraulic move. NA-I stated the removed the batter sitting at the edge of behind him and fee NA-I retrieved a diffused this machine returned to R7's roo battery. At 2:26 p.m machine which ass position. R7 held or with his left hand, a the machine with his	stated after she learned the not be readily available, she apy to assess R7's wheelchair firmed R7 was not assessed erapy order was not received n was not completed. She ave expected the therapy e been completed more ated R7's bed should be in the occupied, and stated she wer R7's bed when he was	F	589			

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	TH AND HUMAN SERVICES RE & MEDICAID SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245299	B. WING	i			C 19/2018
NAME OF PROVIDER OR SUPPLI	ER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
right. The harnes loosely around F the standing mac machine and did harness's buckle then moved the the machine with pushing against R7's bathroom. I bathroom, removincontinent brief, machine into the into the bathroor toilet, NA-I had t EZ-Stand to get the toilet. R7 rem with only his left harness. NA-I th left him attached left the bathroom worked for a nur the facility for tw he was done usi R7's bathroom. I and raised R7 to completed perim EZ-Stand machi bathroom. As NA towards a bath of began sliding up remained positio right hand pulled harness buckle I abdomen to his was positioned of NA-I lowered R7	page 49 the middle of the harness on the as buckle strap was closed R7's waist. As R7 was raised by chine, NA-I stood behind the not attempt to tighten the ed strap, around R7's torso. NA-I EZ-Stand, with R7 holding on to none hand and his right elbow the harness on the right, towards NA-I stopped before R7's ved R7's pants and an and pushed R7 and the bathroom. NA-I then pushed R7 n. As R7's buttocks neared the o raise R7 higher in the his buttocks over the arm rest of nained holding onto the machine hand and his elbow rested in the en lowered R7 onto the toilet and to the EZ-Stand machine and n. At 2:29 p.m. NA-I stated she sing agency, and had worked at o months. At 2:32 p.m. R7 stated ng the toilet and NA-I entered NA-I used the machine's controls a semi-standing position. NA-I eal cares and pulled the ne, with R7, out of R7's A-I maneuvered the EZ-Stand thair, the harness around R7 his back. R7's right elbow ned on the harness, with his I closely to his chest. The had moved up from his lower upper chest and R7's right foot off of the foot plate. At 2:34 p.m. onto a bath chair. When R7 was th chair, the lower border of the		689			

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		AND HUMAN SERVICES				FOF	ED: 11/27/2018 RM APPROVED IO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		DATE SURVEY COMPLETED
		245299	B. WING	i		1	10/19/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 689	EZ-Stand harness with the upper bord upper neck. Near R wheelchair. In the s was a sling for the I transfer equipment) removed the rest of bath robe on R7 an R7's room to the tul On 10/17/18, at 2:5 bath chair, covered room after a bath. T again positioned in picked up the beige placed it behind R7 above, except posit harness onto R7's i the bathrobe's slee around R7's abdom strap tighter. NA-I p plate and applied th controls to raise the R7 stood up, while hand grips using his was inside the bath assisted R7 to a sta buckle strap becam attempt to pull the b p.m. R7 was lowere edge of the bed. NA harness and assiste R7 to dress. At 3:05 wheelchair near the NA-I then picked up the wheelchair's se stand near the bed.	was around R7's upper back, ler of the harness at R7's R7, in the bath chair, was R7's seat of the R7's wheelchair EZ-Lift (mechanical lifting) machine. At 2:37 p.m. NA-I f R7's clothing and placed a ad pushed the bath chair from	F	689			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COMI	E SURVEY PLETED
		245299	B. WING	i			C 19/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	the bed rail. NA-I tri edge of the bed, but the bed mobility. N/ on R7 and raised th grabbed around R7 arm and held onto the arm and tried to assis position at the side remained slumped NA-I placed the EZ- back, while holding utilizing the transfer "I'm not sitting right to place the machine NA-I attached the h machine and stated and gave R7 instruct machines handle. A raise the EZ-Stands to assist R7 to sit si At 3:20 p.m. NA-H stated and use the hoyer [3:22 p.m. NA-H stated and use the hoyer [3:22 p.m. NA-H ask bed and nap and R NA-H removed the assisted R7 to lay of boosted R7 up in bo the room. On 10/17/18, at 6:5 required two staff fo once in bed one stat as R7 could assist to understood instruct wanted to use the of toilet staff could use	ge 51 ed to assist R7 to sit up at the t R7 was unable to assist in A-I then placed a transfer belt he head of R7's bed. NA-I then 's upper back with the right the transfer belt with the left sist R7 to an upright seated of the bed. R7's right side back and leaned to the left. -Stand harness around R7's R7 in a seated position belt. At 3:14 p.m. R7 stated ' as NA-I continued to attempt he's harness. At 3:16 p.m. arness to the EZ-Stand ' you are not seated well", ctions to hold onto the at 3:18 p.m. NA-I started to smechanical arm, attempting traight in front of the machine. knocked and entered R7's to NA-I "we can lay him down EZ-Lift], since he is tired". At ad R7 if he preferred to lay in 7 answered "yes". NA-I and EZ-Stand harness and down, and the two staff ed, lowered the bed and left 7 p.m. NA-H stated R7 or the majority of cares, but aff could complete some cares with bed mobility and ions. NA-H stated if R7 commode (portable toilet) or e the EZ-Stand to transfer him. bilities to assist varied, and he	F	589			

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	Сом	E SURVEY PLETED C
		245299	B. WING				0 19/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	transferred mostly v NA-H indicated the depended on how F he was too tired, sta NA-H stated staff w transfer equipment annually as well. M questions on R7's of care guides or the r On 10/17/18, at 7:2 required extensive was a fall risk. NA-I something, like go as he would try to of stated R7 transferre the EZ-Lift, but at ti stated she used the once a shift, as she transfer equipment NA-I stated R7 stru today, and if the tra the Stand we would was good for R7 to machine as he would in the air. NA-I indic instruct how to tran NA-I checked for th find one. At 7:36 p.1 at the nurse's station transferred with two [EZ-Stand]. NA-I indic machines, and she machines at a facilii she was not aware	with two staff and the EZ-Lift. use of the EZ-Stand R7 was doing that day, and if aff would use the EZ-Lift. rere trained on the mechanical on hire, and thought maybe A-H stated if staff had care they could refer the the	F	589			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245299	B. WING	i			_ 19/2018
NAME OF F	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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 53	F	689			
	Way Stand Operato indicated "Transfern harness 1) Position upper body of the p harness are betwee resting 2-3 inches to safety of the patient strap around the patient strap around the patient of the harness and on the padded hand in-hand stand beside button. As the paties simultaneously tigh around their torso." On 10/18/18, at 9:4 residents are first a therapy to see if the stand. PT-A stated therapy if the reside would get an updat recommendations of R7's last screen wa would have to check harness placement arms, or having one transferring would r PT-A confirmed R7 transfers was 11/17 recommendation w EZ-Lift and two stat safety.	ten the safety strap buckled 0 a.m. PT-A stated when dmitted they are screened by ey required the transfer lift or after, nursing staff will update ent had changed and we ed screen to see if new were needed. PT-A stated is some time ago and he k R7's records. PT-A stated a that was not under both e arm under clothing while not be safe. At 10:14 a.m. 's last safety screen with					

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			O	FORM MB NO.	: 11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION	`́сом	E SURVEY PLETED C
		245299	B. WING	·			
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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Therapy Screen, da was screened for si falls and self transfe was now assist of tr all transfers in room On 10/18/18, at 11: (CM)-A stated R7 re with all activities of transferred with two times. CM-A stated her expectation for care plan and the c mechanical lift for a On 10/19/18, at 11: required assistance was at risk for falls staff and mechanica DON stated she wa with the EZ-Stand the had reviewed the p equipment with NA- transfers. The DON would be completin use. On 10/19/18, at 1:0 interview with EZ-W (EWPS)-A stated at placing the EZ-Stard always. She stated over the harness, o slipping out of the h stated staff should a the EZ-Stand's arm	ated 11/27/17, indicated R7 afety on 11/13/17, due to two ers. The Screen indicated R7 wo staff with hoyer [EZ-Lift] for n. 14 a.m. clinical manager equired maximum assistance daily living and was o staff and mechanical lift at all R7 was at risk for falls and staff would be to follow R7's are guides and to use the	F	589	3		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE COMI	E SURVEY PLETED
		245299	B. WING				C 19/2018
NAME OF I	PROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Review of the facilit Accidents/Falls-HD Group], last revised strived to promote s interventions to pre policy indicated the plan was to be upda interventions post fa appropriate staff, ar incidents would hav 24 hour report char continue assessme as to further evalua place. Review of the facilit Stand, last revised refer to instructions be used. Staff must safety precautions. Obtain correct lift at to manufacture dire SMOKING R40's significant MI R40 had intact cogr included major dep degeneration (a corr impairment), conve convulsions (a mer person has blindnes system (neurologica explained by medic R40's smoking asse identified R40 was a	y policy titled, GR [Health Dimensions 12/14, indicated the facility safety by providing vent avoidable accidents. The resident's individualized care ated with any changes or new all, communicated to nd implemented. Post fall ve continued follow-up on the ting for 72 hours so as to nt for possible injuries as well te the interventions put into y policy titled, Lift-Sit to 3/1/14, indicated staff would for the facility equipment to be trained in lift use and The policy further indicated 1. nd sling. 8. Transfer according ction guidelines.	F	589			

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245299	B. WING	i			C 1 9/2018
NAME OF F	PROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 689	safely use lighter or extinguish cigarette oxygen before goin observed smoking asse her to remove O2 (c times. Smoking mar- station." R40's care plan rev focus: R40 had bee smoke independent smoking materials of in her room. R40 ut remove it independ smoke. The care pl smoking material to the locked medicati cigarette and lighter desired. Staff to ens removed prior to go The facility form title 9/23/18, identified F smoker, with smok nurses station and wanting to go out to Review of R40's pro- through 10/12/18 id - 8/3/18, R40 noted the front door canop on. -9/27/18, the social reported R40 found -9/27/18, A follow u materials removed	r matches and safely e, however; forgets to remove g out at times and was cigarette in room recently. essment noted, "Staff remind oxygen) prior to smoking at terials to be kept at the nurses rised 10/1/18, identified as a en assessed to be safe to tly but staff to manage due to an incident of smoking ilized oxygen and was able to ently prior to going outside to an interventions directed be stored at nurses station in for room. R40 was to ask for a r from the nurse when sure oxygen tank was bing outside to smoke. ed Aid Care Guide dated R40 as a current independent ing materials housed at the resident to ask nurse when o smoke. ogress notes from 7/10/18 lentified: to be outside of facility under py smoking while oxygen was services designee (SSD)	F	689			

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	COM	E SURVEY PLETED C
		245299	B. WING				19/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	policy- Educated at at any time-Explain house her smoking nurses station-Resi cigarettes and light disperse the items- by the nurse or R40 smoke -Lighter was when done smoking -9/28/18, Nurse obs hand while sleeping An incident report of incident as follows: smoking in her room her room becauses know. The lighter a R40. No injury note During an interview R40 indicated she v independently with designated smoking On 10/17/18, at 2:5 electric wheelchair empty and then to t the dining room and with her outside wh reached the front el oxygen tank from h nursing (DON) aske obtained the smokin responded, "from m own." The DON ex materials were to b became angry and	bout no smoking in the facility ed the nurses are now to materials locked at the ident was to request er from nurses and they will Oxygen was to be removed D prior to going outside to s to be returned to the nurse g. served R40 clicking lighter in g. Lighter was removed. dated 9/27/18, described the Report by SSD, R40 was m. R40 admitted to smoking in she thought no one would nd cigarettes were taken from ed.	F	589			

Facility ID: 00730

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/27/2018 APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	` ́сом	E SURVEY IPLETED C
		245299	B. WING	i			0 19/2018
NAME OF I	PROVIDER OR SUPPLIER		·	S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	the facility R40 real pocket and produce cigarettes which he R40 lit the cigarette into the pack and in On 10/18/18, at 9:0 returned from the o facility with the elect on the left side of th left the oxygen tank tubing with the nasa tubing behind the e oxygen tank on the R40 propelled herse down the hall and of not approach facility materials. On 10/18/18, at 11: returned from the o facility with the elect herself directly to he oxygen tubing and room prior to exiting did not return smok On 10/18/18, at 11: did not work with R smoking materials f On 10/18/18, at 11: stored R40's smoki cart and would give asked. LPN-A iden the smoking material	ached into her sweatshirt ed a pack of New Port eld 2 cigarettes and a lighter. e and placed the lighter back into her sweatshirt pocket. 09 a.m. R40 independently butside smoking area to the ctric wheelchair. R40 stopped he facility office where she had k. R40 reapplied the oxygen al cannula in the nose and ears. R40 then placed the e foot rest between her feet. self in the electric wheelchair directly to her room. R40 did ty staff to return the smoking c00 a.m. R40 independently butside smoking area to the ctric wheelchair. R40 propelled her room and reapplied the tank which was left in the g the building to smoke. R40 king materials to facility staff. c22 a.m. LPN-B identified she c40 and did not manage	F	689			

Facility ID: 00730

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		AND HUMAN SERVICES & MEDICAID SERVICES				FC	TED: 11/27/20 RM APPROV NO. 0938-03	ΈD
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED	
		245299	B. WING				C 10/19/2018	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
FRAZEE	CARE CENTER				PRAZEE, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETI DATE	ON
F 689	unopened pack of N found on the counter indicated R40 typical cigarettes and the li items causing staff LPN-A indicated the R40's, however; shi lighter was. LPN-A since R40 had aske and verified she had a lighter today. On 10/18/18, at 12: herself from the din the facility where sh and tank. R40 prop outside to the desig reached into the rig sweatshirt and prop and lighter. R40 ind On 10/18/18, at 2:1 was the only staff m had access to the F had not requested s was not given any. unaware of the reas were managed by m be the facility policy On 10/18/18, at 2:2 nursing assistants of smoking. NA-A idem to propel herself ou provided her with ci-	 ation room, where only an New Port cigarettes were er but no lighter. LPN-A ally comes to staff to ask for ighter but does not return the to ask R40 to return them. a New Port cigarettes were e was unsure where the indicated it had been a while ed her for smoking materials d not given R40 cigarettes or 38 p.m. R40 propelled ing room to the front entry of he removed her oxygen tubing elled the electric wheelchair gnated smoking area. R40 ht pocket of her gray duced a metal cigarette case lependently lit the cigarette. 9 p.m. LPN-A identified she hember during this shift who R40's smoking materials. R40 smoking materials. R40 smoking materials. R40 smoking materials today and LPN-A indicated she was son R40's smoking materials today and LPN-A stated, "it must 	Fθ	\$89				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	`́сом	E SURVEY PLETED
		245299	B. WING	;			C 19/2018
NAME OF F	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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	outside needed to r to the nurse. On 10/18/18, at 3:4 (RN)-A indicated R self out of the buildi chooses. RN-A indi RN-A to ask to smo On 10/18/18, at 3:5 electric wheel chair the gray sweat shir and I left all my goo cigarettes and light sweat shirt and con area. R40 stated shi smoke independent smoking and doesn going. On 10/18/18, at 3:5 smoking assessme plan as accurate ar R40 was required to lighter because R40 room on 9/27/18, at may try again to sm with oxygen in the r nurse was responsi materials because to medication cart or r access to these are had cigarettes and 10/17/18, which she nurse. On 10/19/18, at 9:0	eturn the smoking materials 7 p.m. Registered nurse 40 independently propelled ing to smoke when R40 cated R40 did not come to		689			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245299	B. WING				C 19/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689 F 692 SS=D	with out complaint. On 10/18/18, at 3:4 was independent to area and smoke inc aware of any restrice The undated facility Smoking Policy, ide provide a safe smoothe rights and dignit Nutrition/Hydration CFR(s): 483.25(g)(§483.25(g) Assisted (Includes naso-gast both percutaneous percutaneous endo enteral fluids). Bast comprehensive asse ensure that a reside §483.25(g)(1) Main of nutritional status, desirable body weig balance, unless the demonstrates that the preferences indicate §483.25(g)(2) Is offi- maintain proper hyde §483.25(g)(3) Is offi- there is a nutritional	4 p.m. NA-C indicated R40 go outside to the smoking dependently. NA-C was not ctions for R40's smoking. policy titled Resident entified the Purpose: To king program that respects ty of all Residents. Status Maintenance 1)-(3) d nutrition and hydration. tric and gastrostomy tubes, endoscopic gastrostomy and scopic jejunostomy, and ed on a resident's essment, the facility must ent- tains acceptable parameters such as usual body weight or ght range and electrolyte resident's clinical condition his is not possible or resident e otherwise; ered sufficient fluid intake to dration and health; ered a therapeutic diet when I problem and the health care		589			11/28/18
	§483.25(g)(2) Is off maintain proper hyd §483.25(g)(3) Is off there is a nutritiona provider orders a th	ered sufficient fluid intake to dration and health; ered a therapeutic diet when I problem and the health care					

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245299 B. WING 10/19/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE CARE CENTER FRAZEE, MN 56544 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 692 Continued From page 62 F 692 Based on observation, interview and document o R18 has been comprehensively review, the facility failed to comprehensively assessed and interventions in place to assess and develop interventions to address address weight loss unplanned weight loss for 1 of 2 residents (R18) All other residents with unplanned 0 reviewed for nutrition. weight loss will be reviewed and interventions determined to address Findings include: weight loss 0 Education will be provided to IDT and R18's admission Minimum Data Set (MDS) dated licensed nurses on tracking weights and 8/23/18, identified R18 had diagnoses which comprehensive assessment and included; dementia, hemiplegia (weakness on interventions needed to address one side of the body), and aphasia (an unplanned weight loss impairment of language, affecting the production Audit of residents with unplanned 0 or comprehension of speech and the ability to weight loss to assure appropriate read or write). R18's MDS further identified R18's interventions are in place will be done two times weekly for four weeks and then cognition was severely impaired, required extensive assistance with eating, and identified weekly for four weeks and monthly for two no rejection of care. R18's MDS also identified no months. dental issues, no swallowing issues, weight of DON/ Designee will report results and 0 167 pounds, mechanically altered diet, and no or trends of all audits to QAPI Committee for unknown weight loss of 5 % (percent) or more in review for 3 months and follow up as the last month or 10% in the last 6 months. needed Compliance date 11/28/2018 0 Review of R18's Care Area Assessments (CAA) dated 8/29/18, identified R18 was at risk for a nutritional problem and potential weight loss related to her cognitive impairment, her need for a pureed texture diet and on her dependence on staff to eat. R18's CAA indicated she rarely/never verbalized her needs and was dependent on staff for all activities of daily living (ADL) due to her cognitive impairment and deficits from her stroke years ago. The CAA further identified, R18 had limited understanding of others and would have physical behaviors during cares and verbal behaviors of yelling out during cares as she did not understand, and staff may have to re-approach. The CAA indicated these behaviors

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/27/2018

FORM APPROVED

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY PLETED C
		245299	B. WING	i			_ 19/2018
NAME OF F	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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	usually do not happ eat. R18's CAA indi- stable since admiss fluctuate, ranging fr indicated R18's goa weight and nutrition weight loss. R18's care plan, las R18 had the potent status related to de dysarthria (condition use for speech are controlling them), n dependence on sta- care plan listed vari included; occupatio language pathology pureed textures and signs and symptom fluid intake with me fluids per her prefer meals and between R18's Aide Care Gu identified R18 requi one to two staff and On 10/16/18, at 9:4 seated in a wheelch opened. Family me not eat much at me daily and assisted F On 10/17/18, at 5:2 reclined wheelchair dietary staff member	ben when staff assist her to icated her weight had been sion and her meal intakes om 25 to 100%. The CAA al was to maintain her current hal status with no significant st revised 10/19/18, identified ial for decline in nutritional mentia, aphasia, hemiplegia, n in which the muscles you weak or you have difficulty eed for pureed textures, and ff for eating/drinking. R18's ious interventions which nal therapy or speech y as ordered, regular diet with d thin liquids, observe for is of dehydration, encourage als and between, provide rence, and provide water with	F	692			

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED C
		245299	B. WING	i			19/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	in front of her. At 5 dining room and ap wheelchair. FM-A u wheelchair to assis position at the table chair beside R18 at assisted R18 with s cup. At 5:44 p.m. R served a supper me bites of pureed food fluids. In between F sit down and take b p.m. he offered R18 shouted "no". FM-A closed her lips tight continued with his r finished his meal at table assisting anot were going to help member stated they were done assisting already helping. FM At 6:05 p.m. R18 co wheelchair at the d begun holding her f p.m. R18 remained in her left hand as f carrots, rice and ch of her. At 6:12 p.m. approached R18 ar some fruit. R18 did At 6:17 p.m. R18 res stating "no" again, a face. R18 had cons the supper meal. On 10/18/18, at 11:	ge 64 :21 p.m. FM-A entered the proached the back of R18's sed the controls on the t R18 into an upright seated a. FM-A then sat down in a nd talked. At 5:39 p.m. FM-A ips of juice out of a standard 18 and FM-A were both eal. FM-A assisted R18 with d and alternated with drinks of R18's bites of food FM-A would ites of his own meal. At 5:55 8 a bite of food and she then tried a drink and R18 dy. FM-A then sat down and neal. At 6:00 p.m. FM-A nd asked staff seated at the ther resident to eat, if they R18 eat. The unidentified staff y would assist R18 when they g the resident they were 1-A then left the dining room. ontinued to be seated in the ining room table. R18 had face with her left hand. At 6:10 in the same position with face her supper meal of fruit, icken remained siting in front the unidentified staff member nd encouraged her to eat take a few more bites of fruit. fused to eat any more by and staff assisted to wipe her sumed approximately 25% of 57 a.m. R18 was seated in he dining room table. Dietary	F	692			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	Сом	E SURVEY PLETED C
		245299	B. WING	;			_ 19/2018
NAME OF F	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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 692	staff brought R18 a consisted of mashe brussel sprouts. FM bites of the lunch m ow". FM-A stopped her meal, turned he and pushed her wh room. At 12:40 p.m dining room table. Review of R18's we electronic health re 10/12/18, revealed: -8/17/18, 164.6 -8/20/18, 167.4 -8/24/18, 166.1 -8/31/18, 166.1 -9/8/18, 167.1 -9/14/18, 167.0 -9/16/18, 167.0 -9/16/18, 167.0 -9/21/18, 165.7 -9/28/18,160.7 -10/5/18, 156.8 : R of a 5% weight cha 09/08/2018, 167.1 I 6.2%, -10.3 pounds	 18's EHR showed a warning nge "[Comparison Weight by from the cond (EHR) for manual to the con	F	692			

Facility ID: 00730

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		AND HUMAN SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245299	B. WING				_ 19/2018
NAME OF F	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				I9 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	of a 5% weight cha 09/14/2018, 167.0 f Review of R18's sig 9/5/18, indicated R liquids. However, a orders had no orde supplement. Review of R18's ele last 30 days R18's 0-100%, she receiv and had accepted f Review of R18's Di Dimensions Group] was on a regular, p The assessment in restriction, did not r prior to admission, nutritional supplem further indicated, R appetite and drank Under the Likes an was noted. R18 had alert, did not have of denture was worn, swallowing problem indicated R18 used adaptive equipmen assistance. The ass comments text box hard to communica questions and a far her. On 10/18/18, at 2:1	nge "[Comparison Weight bs, - 6.6%, -11.1 pounds]" gned physician orders dated 18 had a pureed diet with thin fter further review R18's rs to receive a dietary ectronic record indicated in the meal intakes varied from red total assistance for eating, four bedtime snacks. etary Profile HDG [Health , dated 8/22/18, indicated R18 ureed diet and regular liquids. dicated R18 was not on a fluid eceive a nutrition supplement and did not receive a ent currently. The assessment 18 had regular portions, a fair four cups of fluids per day. d Dislikes text box only a dash d good hearing and sight, was own teeth, did not indicate if a but had no chewing or ns. The assessment also regular utensils, did not use t, and required total sessment concluded with a which indicated R18 was te other then yes or no nily member often sat with 6 p.m. nursing assistant	F 6	92			
	(INA)-J SIALEO R 18 V	was a total assist with all					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT OF AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION	` ´COM	E SURVEY PLETED C
		245299	B. WING				19/2018
NAME OF PRO	OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE C	ARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
chrrRewirthfcaadwdwre Onaaneliisthscsvwtwbae	er mood and if sta heal right away she a heal right away she he dining room ear or a car ride. NA-J t a meal, then staff ffer the meal. NA-J t a meal staff ffer the meal. NA-J t a meal staff ffer the meal. NA-J t a meal staff ffer the meal. NA-Staff hould know about the NAs don't alway ome residents on n onfirmed R18 was upplement. She staff yeight in a binder a the EHR. LPN-A staff yeights in the EHR by the upper manage ssisted R18 to eat a heal staff and will leave	ge 67 d R18's appetite depended on ff get her started with the e does well. NA-J stated if at breakfast, she would not . NA-J stated FM-A would sit would assist her to eat once ed FM-A took R18 away from ly today due to wanting to go stated if R18 did not eat well f would try a pudding cup later J stated there was no place to ing. She indicated R18 was the NAs, and the NAs would nts in a binder and if the staff were to reweigh the 6 p.m. licensed practical ed R18 required total assist for eating. LPN-A indicated R18's okay and someday's she did LPN-A stated if R18 did not taff try to encourage her a er rest. She stated the nurses low meal intakes, but stated vs tell us. LPN-A identified nutritional supplements, but not currently receiving a ated R18 was weighed by the NAs, whom place the ind the nurse would chart it in ated she did not review and added it must be done gement. She stated FM-A at times, but got frustrated e, then staff would take over. B Group form, dated 8/27/18,	F	592			

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		AND HUMAN SERVICES				FORM	D: 11/27/2018 APPROVED 0. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION) CON	TE SURVEY MPLETED
		245299	B. WING				C / 19/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 692	through 10/14/18, in reweigh if wt [weigh or more. Report to I R18's weight on 9/2 on 9/28/18, was 160 reweigh was identif On 10/18/18, at 2:5 (CM)-A indicated th weights from the N// would look back to concerns for chang CM-A, or the director stated the facility has that came to the face the CD would be up significant weight lo CM-A reviewed R18's clin R18 was not on a n R18's record lacked assessment. CM-A update the CD whe noted and indicated two weeks prior. On 10/19/18, at 9:1 interview CD-A stat facility and her usua to the facility month between visits via e stated she reviewed anyone else the face which included res with stage III presso	ndicated "Nurses-Please nt] is [up or down] 5 #[pounds] Dietary Manager if continues". 21/18, was 165.7 pounds and 0.7 pounds, however no ied. 55 p.m. clinical manager the nurses would chart the A binder into the EHR and see if there were any les and update the physician, or of nursing (DON). CM-A ad a consultant dietician (CD) cility monthly. CM-A indicated potated if the facility noted a poss or swallowing problem. 8's weights since admission lost 9 pounds. CM-A nical record and confirmed putritional supplement, and	F	692			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	COM	E SURVEY PLETED
		245299	B. WING	i			_ 19/2018
NAME OF F	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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	email updates from manager (DM)-A. C unaware how the far resident weights. C complete the reside CD-A stated R18's over 24.9, so would expect an assessm what was going on On 10/19/18, at 9:3 appetite was not go encouragement to a anything. NA-K indi with something swe On 10/19/18, at 9:5 staff charted the me chart the resident w did not review reside time and was some meeting on to discu supplements. DM-A be reviewing reside stated R18's only d admission and indic gather information f CM-A used to be th MDS assessment m was transitioning ro aware of R18's weig On 10/19/18, at 11: nurses were to revie entering into the EF CM-A, MDS coordin significant weight lo	CM-A, DON, or the dietary D-A indicated she was acility reviewed or tracked D-A stated the DM would ents' quarterly assessments. body max index (BMI) was I be less concerned, but would ent to be completed to see with R18. 8 a.m. NA-K stated R18's bod, and took a lot of eat and added R18 never eats cated at times if staff started bet her intake would be better. 0 a.m. DM-A stated dietary eal intakes, and nursing would veights. DM-A indicated she ent intakes or weights at this thing her and the DON were these weights and nutritional A indicated nursing staff would ints for weight loss. DM-A ietary assessment was on cated the assessment was to for R18's MDS. DM-A stated e one to look at between putritional needs, but CM-A les. DM-A stated she was not	F	692			

Facility ID: 00730

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		AND HUMAN SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION	COM	E SURVEY PLETED C
		245299	B. WING	i			_ 19/2018
NAME OF	PROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	week. The DON inc process of reviewin going to start some DON stated R18's i down, and FM-A wi enough and R18 wi staff should have al loss after the 9/21/1 CM-A could have a stated her expectat directions on the W instructed the nurse weight loss and rep Review of the facilit 4/1/08, indicated the parameters of nutri weight and protein clinical condition de possible. The Centers for Me Long-Term Care Fa Instrument (RAI) 3. 10/2018, identified Swallowing/Nutritio with an intent to ass could affect the resi adequate nutrition a Weight Loss Planni "-Weight loss may change in the resid environment. -If significant weigh interdisciplinary tea	dicated CM-A was in the g R18's weights and were nutritional supplements. The ntakes have been up and Il sometimes just say that is ill quit eating. The DON stated lerted CM-A on R18's weight 18, to 9/28/18, weight loss, so lerted the CD. The DON ion for staff was to follow the eights B Group form which to reweigh if a five pound for to the DM. by policy titled Nutrition, dated e facility maintains acceptable tional status, such as body levels, unless the resident's emonstrates that this was not edicare and Medicaid (CMS) focility Resident Assessment 0 User's Manual dated Section K: nal Status to be completed sess the many conditions that ident's ability to maintain and hydration. Under K0300: ng for Care: be an important indicator of a ent's health status or	F	692	2		

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM): 11/27/2018 APPROVED . 0938-0391			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION (X3) DAT	TE SURVEY IPLETED			
		245299	B. WING		10	C / 19/2018			
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
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F 692	change in medication fluid volume status. - Weight loss should	on (e.g., diuretics), or changed d be monitored on a	F٥	692					
F 695 SS=D	and care planned a delayed until the ne Respiratory/Trache	eight loss should be assessed t the time of detection and not ext MDS assessment." ostomy Care and Suctioning	F6	695		11/28/18			
	The facility must en needs respiratory c care and tracheal s care, consistent wit practice, the compr care plan, the resid and 483.65 of this s	and tracheal suctioning. sure that a resident who are, including tracheostomy uctioning, is provided such h professional standards of ehensive person-centered ents' goals and preferences,							
	Based on observat review, the facility fa tracheotomy suction the neck into the tra direct access to the residents (R10) obs suctioning while rec	tion, interview and document ailed to provide safe ning (surgical opening through achea (windpipe) to allow breathing tube) for 1 of 1 served during tracheostomy quiring mechanical ventilation designed to replace normal ction).			 R10 has been provided tracheostomy suctioning according to standard of practice All other residents needing tracheostomy suctioning will be assessed for safe suctioning Education provided to licensed nurses on proper procedure for safe tracheostomy suctioning Audits for assessment of 				
	8/2/18, identified R required total assist living (ADL) and wa	imum Data Set (MDS) dated 10 was cognitively intact, tance with activities of daily is able to use his electric idently with supervision.			tracheostomy suctioning will be done two times per week for four weeks and then weekly for one month and then monthly for two months o DON/ Designee will report results and trends of all audits to QAPI Committee for 3 months to review and follow-up as				

Facility ID: 00730

		AND HUMAN SERVICES				FORM	11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	COM	E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	R10's MDS also ide included cerebral pa disorder that usually anxiety and respirat further identified he suctioning, tracheos R10's care plan last ventilator depender chronic respiratory which the body or ro of oxygen). R10's of suction tracheostom least 1 time per shift On 10/17/18, at 2:3 with the head of be nurse (RN)-A was in ready for suctioning suction kit, when R2 the top drawer of th indicated to RN-A h perform the suction kit on the bedside ta suctioning. R10's v he said it would sto completed. RN-A of tracheostomy ventil suctioning. R10 to she was done. RN- proceeded to dip th catheter tube into th suction catheter, the second time. R10's color during the second RN-A then closed th allowed R10 to result	entified diagnoses which alsy (permanent movement y appeared in early childhood) tory failure. R10's MDS used oxygen, required stomy care and ventilation. t reviewed 8/7/18, identified and tracheostomy due to failure with hypoxia (condition egion of the body is deprived care plan further indicated to ny PRN (as needed) and at	Fé	695	needed. o Compliance date 11/28/2018		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION	COM	E SURVEY PLETED
		245299	B. WING				C 19/2018
NAME OF I	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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	wanted to be suction her two times he was RN-A to close the of indicated that she of between suctioning indicated yes that in was dependent on On 10/17/18, at 6:5 had received trainin complete suctioning while completing su while she cleansed closed the cap to all before she repeated On 10/18/18, at 2:1 nurse (LPN)-A indic R10's suctioning, sl between suctioning breath. LPN-A indic suctioning two or m the cap in between On 10/19/18, at 9:5 (CM)-A indicated sh ventilation machine when they were him nurses orientated in techniques. CM-A Respiratory compar- licensed nurses and suctioning also. CM required suctioning were to close the ca allow for the ventila could have a couple	 aned again, and he informed as good. R10 then reminded ap between suctioning. RN-A lid not need to close the cap with another resident. R10 may be, but informed RN-A he his ventilator. 9 p.m. RN-A indicated she ng by observing another nurse g, then she was observed actioning. RN-A indicated the catheter, she should have llow R10 to catch his breath 	F	395	5		

		AND HUMAN SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		245299	B. WING	i			C 19/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	his ventilator and sl nurses to give him a closing the cap and working. CM-A indi red when coughing On 10/19/18, at 10: (DON) indicated CM training for the licer were concerns she regarding concerns policy. RN-A's training pro Policy and training Caring for Resident Mechanical Ventilat	he would expect the licensed a break between suctioning by a a lowing the ventilator to be icated R10's face would turn or having spasms. 15 a.m. director of nursing M-A provided the suctioning used nursing staff, and if there would have to defer to CM-A and technique and review the vided included the forms titled for Nursing assistants on ts on Ventilators and tion Management Protocol	F	695			
F 726 SS=D	RN-A and trainer. suctioning needs. The facility policy til dated 12/23/13, ide ensure and maintai with tracheotomy al procedures include review resident is c complete suctioning Competent Nursing CFR(s): 483.35(a)(§483.35 Nursing Se The facility must hat the appropriate com provide nursing and resident safety and practicable physica	3)(4)(c)	F	726			11/28/18

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (2	(X3) DATE SURVEY COMPLETED			
		245299	B. WING	i		(10/1	; 9/2018		
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
FRAZEE	CARE CENTER			219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 726	resident assessmer care and considerin diagnoses of the far accordance with the at §483.70(e). §483.35(a)(3) The f licensed nurses hav and skill sets neces needs, as identified assessments, and o §483.35(a)(4) Provi limited to assessing implementing reside to resident's needs. §483.35(c) Proficien The facility must en to demonstrate com techniques necessa needs, as identified assessments, and o This REQUIREMEN by: Based on observat review, the facility fa staff possessed neo skill sets to meet re needs for 1 of 2 (RT accidents. Findings include: Review of R7's qua identified R7 had m and had diagnoses	And and individual plans of ag the number, acuity and cility's resident population in a facility assessment required facility must ensure that we the specific competencies sary to care for residents' through resident described in the plan of care. ding care includes but is not g, evaluating, planning and ent care plans and responding her of nurse aides. sure that nurse aides are able apetency in skills and ary to care for residents'	F	726	 R7 has been transferred with tot in accordance with plan of care All residents care guides reviewe ensure proper lift is reflected for safe transfer Nursing staff educated on follow what care guide designates for safe transfers Nursing staff educated with return demonstration on proper use of the l machines Audit of proper use of mechanicato to be completed two times weekly for 	ed to e ring rn lift al lift			

Facility ID: 00730

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPR CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938								
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			COMF	E SURVEY PLETED	
		245299	B. WING			0 10/1) 19/2018	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 726	life-limiting and chro schizophrenia, and indicated R7 requir transfers with two of indicated R7 had tw assessment. Review of R7's Car dated 5/9/18, identi judgement and safe decision making as transfer, which resu- indicated R7 believ attempted to do so the wheelchair to b R7 had a history of right sided hemipar stand, was a fall ris for transfers. Review of R7's card- indicated R7 was a history of falls due R7 believed he cou- incontinence, balar hemiparesis. R7's of interventions which therapy to assess f status post fall, and with total assist of t Review of Aide Car 9/23/18, indicated F high-low bed, requi activities of daily liv assist of two staff a	onic illness), hemiparesis, Diabetes Mellitus. The MDS ed total assistance for or more staff. The MDS further wo or more falls since the last re Area Assessments (CAA), fied R7 displayed poor ety awareness with poor evidenced by attempts to self ulted in falls. The CAA ed he could stand and in order to self transfer from ed. The CAA also indicated, a stroke which resulted in resis, was unable to walk or k, and required a full body lift e plan, last revised 10/5/18, t risk for falls related to a to self transfer attempts, as ild still stand and walk, nee issues, and right sided care plan listed various included a low bed, physical or proper wheelchair fitting i mechanical lift to transfer	F 7	726	weeks for 3 residents and then wee one month and monthly for two mo o DON/ Designee will report resu trends of all audits to QAPI Commi 3 months to review and follow-up a needed. o Compliance date 11/28/2018	nths ilts and ttee for		

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	COM	E SURVEY PLETED C
		245299	B. WING	i			0 19/2018
NAME OF	PROVIDER OR SUPPLIER		I	S	STREET ADDRESS, CITY, 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 726	edge of bed with the height. R7 had an E standing transfer ed in front of him. R7 h harness around his the EZ-Way Stand's behind the machine raise the hydraulic a move. NA-I stated t removed the battery sitting at the edge of behind him and fee NA-I retrieved a diff used this machine of returned to R7's root battery. At 2:26 p.m machine which assi position. R7 held or with his left hand, a the machine with hi harness was under elbow rested on the right. The harness H around R7's waist. standing machine, H machine and did no harness's buckled s then moved the EZ- the machine with or pushing against the R7's bathroom. NA- bathroom, removed incontinent brief, ar machine into the bat into the bathroom. A collet, NA-I had to ra EZ-Stand to get his	age 77 be bed approximately at knee EZ-Way Stand (mechanical quipment) positioned directly had a beige (medium) colored is back, which was attached to is hydraulic arms. NA-I stood e's controls and attempted to arms, but the machine did not the battery had died, she y and left the room with R7 of the bed, with harness et on the stand's foot plate. As ferent battery, R7 stated he often. At 2:25 p.m. NA-I om and placed a different n. NA-I raised the arms of the sisted R7 to a semi-standing nto the machine's hand grips as he was unable to hold on to is right hand. The EZ-Stand's r R7's left arm, but R7's right e middle of the harness on the buckle was closed loosely As R7 was raised by the NA-I stood behind the ot attempt to tighten the strap, around R7's waist. NA-I Stand, with R7 holding on to ne hand and his right elbow e harness on his right, towards I-Stopped before R7's d R7's pants and an nd pushed R7 and the athroom. NA-I then pushed R7 As R7's buttocks neared the aise R7 higher in the s buttocks over the arm rest of ned holding onto the machine	F 7	726	δ		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/27/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT COM	E SURVEY IPLETED
		245299	B. WING				C 19/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	with only his left ha harness. NA-I then left him attached to left the bathroom. A worked for a nursin the facility for two m he was done using R7's bathroom. NA- and raised R7 to a completed perineal EZ-Stand machine, bathroom. As NA-I towards a bath cha began sliding up his remained positione right hand pulled ch harness buckle had abdomen to his upp was positioned off on NA-I lowered R7 or seated in the bath of EZ-Stand harness with the upper bord upper neck. Near R wheelchair. In the s was a sling for the I transfer equipment) removed the rest of bath robe on R7 an R7's room to the tul On 10/17/18, at 2:5 bath chair, covered room after a bath. T again positioned in picked up the beigg placed it behind R7	nd and his elbow rested in the lowered R7 onto the toilet and the EZ-Stand machine and at 2:29 p.m. NA-I stated she g agency, and had worked at nonths. At 2:32 p.m. R7 stated the toilet and NA-I entered -I used the machine's controls semi-standing position. NA-I cares and pulled the with R7, out of R7's maneuvered the EZ-Stand ir, the harness around R7 s back. R7's right elbow d on the harness, with his osely to his chest. The I moved up from his lower ber chest and R7's right foot of the foot plate. At 2:34 p.m. to a bath chair. When R7 was chair, the lower border of the was around R7's upper back, er of the harness at R7's eat of the R7's wheelchair EZ-Lift (mechanical lifting machine. At 2:37 p.m. NA-I f R7's clothing and placed a d pushed the bath chair from	F 7	726			

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION	`́сом	E SURVEY IPLETED C
		245299	B. WING	í			19/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 726	harness onto R7's in the bathrobe's slee around R7's abdom strap tighter. NA-I p plate and applied th controls to raise the R7 stood up, while hand grips using hi was inside the bath assisted R7 to a sta buckle strap becam attempt to pull the b p.m. R7 was lowere edge of the bed. N/ harness and assiste R7 to dress. At 3:09 wheelchair near the NA-I then picks up the wheelchair's se stand near the bed. EZ-Stand machine the bed rail. NA-I tri edge of the bed, but the bed rail. NA-I tri edge of the bed, but the bed rail. NA-I tri edge of the bed, but the bed rail onto a stand near the side remained slumped NA-I placed the EZ back, while holding utilizing the transfer "I'm not sitting right the machine's harm attached the harnes and stated "you are	age 79 right elbow, which was inside ve. NA-I buckled the harness nen and pulled the buckle blaced R7's feet onto the foot ne calf strap, then used the e EZ-Stand's hydraulic arms. holding onto the machine's s left hand, as his right hand probe. As the machine anding position, the harness ne looser, and NA-I did not buckle's strap tighter. At 3:05 ed by the machine onto the A-I removed the machine's ed R7 to lay flat and assisted 9 p.m. NA-I pushed R7's e bed and locked the wheels. an EZ-Lift sling that was on that and placed the sling on a . At 3:10 p.m. NA-I moved the to the side of R7's bed near ied to assist R7 to sit up at the at R7 was unable to assist in A-I then placed a transfer belt the head of R7's bed. NA-I then the transfer belt with the left sist R7 to an upright seated of the bed. R7's right side back and leaned to the left. -Stand harness around R7's R7 in a seated position r belt. At 3:14 p.m. R7 stated " as NA-I struggled to place ess. At 3:16 p.m. NA-I ss to the EZ-Stand machine e not seated well", and gave hold onto the machines handle.	F	726			

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		AND HUMAN SERVICES				FORM	11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	`́СОМ	E SURVEY PLETED
		245299	B. WING				C 19/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 726	At 3:18 p.m. NA-I s mechanical arm, at straight in front of th NA-H knocked and stated to NA-I "we d hoyer [EZ-Lift], sind NA-H asked R7 if h nap and R7 answer removed the EZ-Sta to lay down, and the bed, lowered the be On 10/17/18, at 7:2 required extensive was a fall risk. NA-I something, like go to as he would try to d stated R7 transferre the EZ-Lift, but at ti stated she used the once a shift, as she transfer equipment NA-I stated R7 stru today, and if the tra the Stand we would was good for R7 to machine as he would in the air. NA-I indic instruct how to tran NA-I checked for th find one. At 7:36 p.I at the nurse's static transferred with two [EZ-Stand]. NA-I indic the facility other NA machines, and she	Ige 80 tarted to raise the EZ-Stands tempting to assist R7 to sit ne machine. At 3:20 p.m. entered R7's room. NA-H can lay him down and use the se he is tired". At 3:22 p.m. e preferred to lay in bed and red "yes". NA-I and NA-H and harness and assisted R7 e two staff boosted R7 up in ed and left the room. 7 p.m. NA-I stated R7 assistance with cares and stated when R7 wanted to do to bed, you have to be quick to things on his own. NA-I ed mostly with two staff and mes used the EZ-Stand. NA-I e Z-Stand with R7 at least e could use the standing with only one staff present. ggled with the EZ-Stand nsfer does not go well with d use the Lift. NA-I stated it use the standing transfer and get to exercise his legs, the Lift his legs just lay there cated R7's care plan would sfer R7, or the care guide. e care guide and could not m. NA-I found her care guide on and confirmed R7 was to be o staff and the hoyer dicated when she started at as showed her the EZ-Way had used the EZ-Way ty in the past. NA-I indicated	F 7	726			

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED C
l		245299	B. WING	i			_ 19/2018
NAME OF F	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	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	she was not aware completed on the facilit Way Stand Operato indicated "Transfern harness 1) Position upper body of the p harness are betwee resting 2-3 inches b the safety of the pa safety strap around the buckle and pull the patient 1) Positi outside of the harne hands on the padde control in-hand star the up button. As the simultaneously tigh around their torso." On 10/18/18, at 9:4 placement that was having one arm und a resident would no confirmed R7's last was 11/17, and ther be to continue to us transfers. Review of Pro Reha Therapy Screen, da was screened for sa falls and self transfe was now assist of the all transfers in room	if a competency check was acility's EZ-Way Lift or Stand. ty provided EZ-Way, Inc. EZ or's Instructions, undated, ring the patient: Attach in the harness around the patient so the sides of the en the patient's torso and arm, below the underarm. 20 For itient, securely fasten the d the patient's torso. 3) Secure the strap to tighten Raise ion patient's arms on the ess and have them place their ed handles. 2) With hand ind beside the patientPress he patient is being raised, iten the safety strap buckled d a.m. PT-A stated a harness is not under both arms, or der clothing while transferring of be safe. At 10:14 a.m. PT-A t safety screen with transfers rapy's recommendation would se EZ-Lift and two staff for all ab Nursing Referral For ated 11/27/17, indicated R7 afety on 11/13/17, due to two ers. The Screen indicated R7 wo staff with hoyer [EZ-Lift] for	F	726			

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		AND HUMAN SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245299	B. WING				C 19/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	(CM)-A stated R7 rewith all activities of transferred with two times. CM-A stated her expectation for care plan and the comechanical lift for a On 10/19/18, at 11: required assistance was at risk for falls staff and mechanical DON stated she wawith the EZ-Stand thad reviewed the pequipment with NA-transfer. The DON would be completing use. On 10/19/18, at 1:0 interview with EZ-W (EWPS)-A stated at placing the EZ-Stard always. She stated over the harness, os slipping out of the h stated staff should at the EZ-Stand's arm will become looser On 10/19/18, at 1:1 interview with the Dassumed training w completed on the flindicated the operation of the operation of the method.	equired maximum assistance daily living and was o staff and mechanical lift at all R7 was at risk for falls and staff would be to follow R7's care guides and to use the	F 7	226			

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED			
		245299	B. WING				C 19/2018			
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE					
FRAZEE	CARE CENTER			219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE			
F 726	classroom was com she was unaware w agency staff receive if the facility would in nursing agency stat training, she would complete competer the facility goes wit agency stated their On 10/19/18, at 1:2 completed the all st orientation and CM for nursing staff. Of training for EZ-Way On 10/19/18, at 1:2 new employee train infection control, pr Tuberculosis (a cor bacteria that mainly affect any other org are trained on the E are orientated to the completed by other work on the floor. Of checks were comple education received indicated the EZ-W the facility from time machines, but could representative was OM-A may have ne the EZ-Way instruc CM-A indicated new training was focuse surgical procedure	Appleted. The DON indicated what orientation the nursing ed. Her expectation would be, not have evidence of the ff member's competency expect the facility would ncy training. The DON stated h what areas the nursing staff were competent in. 20 p.m. OM-A stated she taff new employee general -A completed further training M-A stated she completed no	F 7	726						

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	`́СОМ	E SURVEY PLETED C
		245299	B. WING				_ 19/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 726 F 791 SS=D	an airway and to re lungs) and ventilator mechanically move the lungs, to provid for a patient who is or breathing insuffic nursing agency stat EZ-Way machines CM-A stated the fac trainer (a training st subject-matter expe- but no longer have Review of the facilit Orientation Checkli NA-I was oriented t included: Human R including competen On-Boarding, Safet On 10/19/18, at 1:2 Competencies and however was not pu Review of the faciliti Stand, last revised refer to instructions be used. Staff must safety precautions. Obtain correct lift a to manufacture dire Routine/Emergency CFR(s): 483.55(b)(hrough this opening to provide move secretions from the ors (a machine designed to breathable air into and out of e the mechanism of breathing physically unable to breathe, ciently). CM-A indicated new ff would be trained on the by their peers on the floor. cility used to utilize train the trategy were the trainer, a ert, trained other employees), that process in place. ty provided Agency Employee st, dated 8/21/18, indicated to various topics which esources and Pre-Arrival ncies and skills testing, ty, and Scheduling. t2 p.m. NA-I's Agency Skills testing was requested, rovided. ty policy titled, Lift-Sit to 3/1/14, indicated staff would for the facility equipment to t be trained in lift use and The policy further indicated 1. nd sling. 8. Transfer according tection guidelines. y Dental Srvcs in NFs 1)-(5)	F 7				11/28/18
	§483.55 Dental Ser The facility must as						

Facility ID: 00730

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY IPLETED
		245299	B. WING				C 19/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 791	Continued From pa	ge 85	F	791			
	§483.55(b) Nursing The facility-	Facilities.					
	outside resource, ir of this part, the follo the needs of each r	ervices (to the extent covered n); and					
	assist the resident- (i) In making appoir	transportation to and from the					
	residents with lost of dental services. If a 3 days, the facility r what they did to en- and drink adequate	promptly, within 3 days, refer or damaged dentures for referral does not occur within must provide documentation of sure the resident could still eat ly while awaiting dental ttenuating circumstances that					
	those circumstance dentures is the faci not charge a reside dentures determine	have a policy identifying s when the loss or damage of lity's responsibility and may ent for the loss or damage of ed in accordance with facility lity's responsibility; and					
	eligible and wish to reimbursement of d	assist residents who are participate to apply for lental services as an incurred nder the State plan.					

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		AND HUMAN SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMI	E SURVEY PLETED
		245299	B. WING				C 19/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 791	This REQUIREMEN by: Based on interview facility failed to prov care for 1 of 1 resid dental services. Findings include: R28's quarterly Min 9/19/18, identified F had diagnoses whic (impairment in moto lower extremities), f limitations of activiti identified R28 requi hygiene. R28's MD concerns. R28's care plan rev had an activities of performance deficit balance and limited further indicated sh independent with ou On 10/15/18, at 9:1 needed to see a de spoken to her about facility, and once no bathroom the dentis had not been seen R28's admission as identified R28 had I	NT is not met as evidenced v and document review, the vide arrangements for dental lents (R28) reviewed for imum Data Set (MDS) dated R28 was cognitively intact and ch included paraplegia or or sensory function of the muscle weakness and ies due to disability. The MDS ired assistance with personal OS further identified no dental rised 9/25/18, indicated R28 daily living (ADL) self care related to her impaired I mobility. R28's care plan e had her own teeth and was ral cares after set up. 9 a.m. R28 indicated she intist. R28 indicated they had t seeing a dentist at the otified her while she was in the st had come to the facility, but by the dentist. assessment dated 3/26/18,	F 7	791	 o R28 has been offered dental appointment 10/19/2018 and decline She was offered again on 10/31/20 declined. o All other residents reviewed to determine dental needs and follow completed as indicated. o Education provided to nursing and IDT on reporting and following assistance needed to facilitate demappointments. o Audit will be conducted two tim weekly for four weeks on 2 residen then weekly for one month and more for two months to monitor compliant with dental appointments. o DON/ Designee will report result rends of all audits to QAPI Commit 3 months to review and follow-up an needed. o Compliance date. 11/28/2018 	18 and up staff up on tal es ts and nthly ice ilts and ttee for	

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES			C	FORM MB NO.	: 11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	`́сом	E SURVEY IPLETED C
		245299	B. WING				
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 791	Continued From pa	ge 87	F	791			
	cleaning, has partia Form indicated R28	: teeth/dental- due for al plate, does not always wear. 3 attended the meeting.					
	indicated R28 atten	teeth/dental-blank, form ided the meeting. No appointment included.					
		tation indicated R28 was but refused. No reference to included.					
		ation R28 had seen a dentist, 10/18 note identified R28 was					
	nurse (LPN)-B indi intact and could info	3 a.m. licensed practical cated R28 was cognitively orm you if she wanted indicated R28 had never ontal appointments.					
	she arrived she info due for a dental cle still like to see a de	7 a.m. R28 indicated when ormed the facility staff she was aning. R28 stated she would ntist, and no one had spoken up a dental appointment or					
	(CM)-A indicated sh requested to see a dental exams were conferences. CM-A practice was for the appointments and t	56 a.m. clinical manager ne was not aware R28 dentist. CM-A confirmed discussed at resident care A indicated the usual facility e facility to set up dental ransportation. CM-A indicated dents or responsible parties if					

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		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245299	B. WING				C 19/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 791	a dental exam was arrange the appoint needed. On 10/19/18, at 10: (DON) indicated th dental exams was t admission if they wa any concerns. DOR assist the resident had a regular denta Apple Tree Dental a Apple Tree Dental a Apple Tree Dental a Apple Tree Dental a Apple Tree Dental a and would screen re floor staff could ass transportation, or th CM-A who could as appointments and t her expectations we added to the Apple a dental appointme On 10/19/18, at 12: had just followed up exam. CM-A confir appointment. CM-A she would arrange she felt better, and for transportation. The facility policy tif -HDGR (Health Din 9/22/17, identified th provide or obtain ro services to meet the policy further indica assist the resident i	age 88 needed or wanted and try to tment and transportation if :42 a.m. director of nursing he facility's usual practice for the residents were asked on vanted to see a dentist, or had N indicated they would then to schedule the exam if they st, or could be screened by at the facility. DON indicated came into the facility routinely residents. DON indicated the sist in scheduling exams and hey could inform herself or ssist in arranging the dental transportation. DON indicated ould be for a resident to to Tree Dental list or assisted in ent if requested or needed. :36 p.m. CM-A indicated she p with R28 regarding a dental med R28 still wanted a dental A indicated R28 informed her her appointment herself after asked the facility to arrange tled Dental Services (General) mensions Group) revised the community (facility) would butine and emergency dental e needs of each resident. The ated the community would in making appointments by fation to and from the dentist's	F 7	91			

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		AND HUMAN SERVICES			FO	ORM A	11/27/2018 PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			COMP	SURVEY LETED
		245299	B. WING	i		C 10/1	9/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E	(X5) COMPLETION DATE
F 791	Continued From pa office.	ge 89	F	791			
F 812 SS=F	Food Procurement, CFR(s): 483.60(i)(1	Store/Prepare/Serve-Sanitary)(2)	F٤	812			11/28/18
	§483.60(i) Food sat The facility must -	ⁱ ety requirements.					
	approved or consid state or local author (i) This may include from local producer and local laws or re (ii) This provision do facilities from using gardens, subject to safe growing and fo (iii) This provision do	e food items obtained directly s, subject to applicable State					
	serve food in accorn standards for food s This REQUIREMEN by: Based on observat review, the facility fa sanitary kitchen env food were properly walk in cooler/freez failed to prepare foo 1 kitchens observed hairnets when walk area. This had the p	e, prepare, distribute and dance with professional service safety. NT is not met as evidenced tion, interview, and document ailed to ensure a clean and vironment and failed to ensure stored and dated for 1 of 1 er. Furthermore, the facility od in a sanitary manner in 1 of d when staff did not utilize ing through the preparation potential to affect 39 of the 39 ved food from the kitchen.			 o Coffee maker cleaned and descale o Food in walk-in cooler and dessert freezer found to not be dated or covere have been disposed of o Kitchen staff have been wearing hanets o White fan has been cleaned and debris moved o Sink next to juice machine, three compartment sink, and ice machine has been cleaned and de-limed o All food has been reviewed and date 	t ed air ave	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (COM	E SURVEY PLETED
		245299	B. WING) 10/1	_ 19/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 812	On 10/15/18 at 7:07 the facility kitchen a following concerns - the coffee maker i encrusted hard wat small flakes under t Walk in cooler: - a large bag of shro opened and three of - a large bag of shro opened and three of - a large block of Ar opened and half us - a large block of will opened and half us - a large loaf a bana and over half used - a half of a pan of of dated. Dessert freezer: - a large loaf of ban - a package of strav and noted dated. - a package of coold dated. C-A confirmed the a food items should b and that this was no On 10/15/18 at 7:19 food preparation for dietary manager (D from the back door wearing her coat, p	I a.m. during an initial tour of area with cook (C)-A the were identified: In the kitchen area, had er lime scale build up with he three coffee dispensers. edded lettuce, which was uarter full was not dated. edded cheese, which was uarter full was not dated. nerican cheese, which was ed was not dated. nite cheese, which was ed was not dated. ana bread, which was opened was not dated. coffee cake not covered and ana bread that was not dated. wherry strudel was opened the doe was opened and not above finding and indicated all re properly covered, dated	F 8	312	if unopened o Deep clean of food storage and area has been completed o Education given to dietary staff of following cleaning schedule o Educated on use of hair nets in kitchen area o Audits of dates on food will occu- times weekly for 4 weeks then week one month and then monthly for 2 m to ensure compliance with this pract o Audits of cleaning schedule occ times weekly for 4 weeks then week one month and then monthly for 2 months to ensure compliance with th practice. o Audits of use of hair nets will be two times weekly for four weeks and weekly for one month and then mon for two months o DON/ Designee will report result trends of all audits to QAPI Committ 3 months to review and follow-up as needed. o Compliance date. 11/28/2018	on entire ur two dy for nonths tice. ur two dy for his done d then thly ts and tee for	

		AND HUMAN SERVICES				FORM): 11/27/2018 1 APPROVED . 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	CON	TE SURVEY MPLETED
		245299	B. WING	i			C / 19/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 812	where C-A was pre breakfast meal and prepping desserts f brown hair and was she entered the kitc being prepped for th was not wearing a l the kitchen area wh for the day and indi put a hair net on rig DM proceeded to a brown hair while sh and off to the side of confirmed staff sho when in the kitchen At 8:09 a.m. during temperatures of foo blowing above the of clean dish area. Th on the entire front of blowing away from -at 8:34 a.m. the litt machine in the dinin had encrusted hard flakes around the fa and around the entite On 10/19/18 at 9:15 kitchen with the DM were identified: - the little sink next dining room area of hard water lime sca the faucet, the hand the entire outer edg indicated all staff us	pping sausage for the other dietary staff was for lunch. DM-A had long s not wearing a hair net when chen area where food was he day. DM-A confirmed she hair net while walking through nile food was being prepped icated that she usually does ght away when she gets here. upply a hair net to her long the stood in the kitchen area of the kitchen area. The DM uld wear hair nets at all times	F	812			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245299	B. WING				C 19/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	cleaning and de-lim - a white fan was b and above the clean dust particles on the of long lint/dirt blow the air. - three compartment encrusted hard wat flakes around the fat the sink compartment outer edge of the si - the ice machine loc encrusted hard wat upper lip on the out - dessert freezer has bread that was not strawberry strudel w - a large tub of brow storage bin was ope - a large tub of pow storage bin was ope - a large tub of pow storage bin was ope - the air conditioner prepping area was particles on the entil long lint/dirt blowing and into the air. - the coffee maker i encrusted hard wat small flakes under to The DM-A confirme indicated everything when opened. The dispensers of the co-	ing the sink. lowing above the dishwasher in dish area. The fan had black e entire front of it with pieces ing away from the fan and into at sink in the kitchen are had er lime scale build up with aucet, the handles of the sink, ents and around the entire nk. incated in the kitchen area had er lime scale build up on the side of the ice machine lid. Id a large loaf of banana dated and a package of vas opened and noted dated. Ven sugar half full in a dry ened and not dated. der sugar half full in a dry ened and not dated. dered milk half full in a dry ened and not dated. in the window near the blowing and had black dust ire front of it with pieces of g away from the air conditioner n the kitchen area, had er lime scale build up with he three coffee dispensers. d the above findings and g should be labeled and dated	F	312			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245299 B. WING 10/19/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE CARE CENTER FRAZEE, MN 56544 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 812 Continued From page 93 F 812 indicated they needed to do a better job with de-liming the sinks and ice machine. On 10/19/18 at 10:01 a.m. the maintenance supervisor (MS) confirmed the kitchen and housekeeping staff were responsible for de-liming the the sinks in the dining room and kitchen area. The MS indicated he did not have any cleaning logs for these areas. Review of facility policy titled, Cleaning and Sanitation of Dining and Food Services undated, indicated the food service staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. 10/19/18 requested policy in regards to labeling and dating food items, one was not provided. F 880 **Infection Prevention & Control** F 880 11/28/18 CFR(s): 483.80(a)(1)(2)(4)(e)(f) SS=F §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245299	B. WING	i			C 19/2018
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	controlling infection diseases for all resi visitors, and other i under a contractual facility assessment §483.70(e) and foll standards; §483.80(a)(2) Writt procedures for the but are not limited t (i) A system of surv possible communic infections before th persons in the facilit (ii) When and to wh communicable dise reported; (iii) Standard and tr precautions to be for infections; (iv)When and how i resident; including I (A) The type and du depending upon the involved, and (B) A requirement ti least restrictive pos the circumstances. (v) The circumstances (v) The circumstances (vi) The hand hygier by staff involved in	s and communicable dents, staff, volunteers, ndividuals providing services arrangement based upon the conducted according to owing accepted national en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other ty; om possible incidents of ase or infections should be ansmission-based ollowed to prevent spread of solation should be used for a out not limited to: uration of the isolation, e infectious agent or organism hat the isolation should be the sible for the resident under ces under which the facility oyees with a communicable skin lesions from direct nts or their food, if direct	F٤	380			

		AND HUMAN SERVICES & MEDICAID SERVICES			FOF	ED: 11/27/2018 M APPROVED O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED
		245299	B. WING		1	C 0/19/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	identified under the corrective actions ta §483.80(e) Linens. Personnel must har transport linens so infection. §483.80(f) Annual r The facility will cond IPCP and update th This REQUIREMEN by: Based on interview facility failed to impli infection control pro- surveillance data, ir illnesses not treated the spread of comm- infections. This defi potential to affect al resided in the facilit ensure the commor machines were disi manufacture's reco use on 2 of 2 units, R27, R144, R26, R2 who received blood the facility failed to prior to sterile glove (R10) observed whi suctioning procedur Findings include: INFECTION CONT Review of the facility	facility's IPCP and the aken by the facility. Indle, store, process, and as to prevent the spread of eview. duct an annual review of its leir program, as necessary. NT is not met as evidenced or and document review, the ement a comprehensive logram to include timely including viral infections and d with antibiotics to prevent hunicable disease and cient practice had the I 41 residents who currently y. Further, the facility failed to in use blood glucose meter infected according to current mmendation after resident for 11 residents (R41, R42, 24, R23, R30, R11, R33, R19) glucose testing. In addition, perform proper hand hygiene e use for 1 of 1 residents le completing tracheostomy re.	F	380	 R27, R26, R11, R33, R19 have had blood glucose monitoring in accordance with proper manufacturers recommendation for disinfection of the blood glucose machine R41, R42, R144, R24, R23, R30 ha not been identified on the survey reside sample list provided by MDH R10 has had tracheostomy care wit proper infection control process pertaini to hand hygiene. All residents who use glucometer could be affected, none show ill affect All residents with procedures requiring sterile glove use could be affected, none show ill affect Surveillance for infection is ongoing for all residents Education and competency provide to licensed nurses on disinfection of glucometers in accordance with manufacturers recommendation Education and competency provide to licensed nurses on procedure for steril gloves 	ve nt ng d

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			COM	E SURVEY PLETED
		245299	B. WING) 10/1) 19/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	The forms included also included colum room number, signs results, UA (urine a precautions, presen and date resolved. forms for the entries -January 2018, one wheezing, rhonchi, and fever, treatmen illnesses or viral inf -February 2018, four with various symptoms. antibiotics. No furth were listed. -March 2018, two re- various symptoms. antibiotics. No furth were listed. -April 2018, four res- various symptoms. antibiotics. No furth were listed. -May 2018, eight re- various symptoms. antibiotics. No furth were listed. -May 2018, eight re- various symptoms. antibiotics. No furth were listed. -June 2018, fourtee with various symptom	018 revealed the following: the month and year. They not of date, name of resident, and symptoms, X-Ray nalysis) results, medications, and on admit, acquired in house All areas were completed on a listed below. e resident was identified with diminished breath sounds at with Augmentin. No further	Fδ	380	 o Education has been provided to nursing staff on infection control surveillance, monitoring and trendir infections to include viral infections illness not treated with antibiotic o Audits will occur weekly for 2 residents for 4 weeks then monthly months to ensure infection control surveillance is accurate and ongoin o DON/ Designee will report resu trends of all audits to QAPI Commit 3 months to review and follow-up as needed. o Compliance date. 11/28/2018 	ng of and for 2 g. Its and tee for	
	antipiotics. No furth	ier illnesses or viral infections					

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	`́сом	E SURVEY PLETED C
		245299	B. WING				_ 19/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
FRAZEE	CARE CENTER				19 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From pa were listed.	ge 97	F٤	380			
	various symptoms. antibiotics. First pa sequence from 7/3/ included two reside	dents were identified with All were treated with ge identified eight residents in 18, to 7/20/18. Second page nts identified on 7/10/18, then illnesses or viral infections					
	various symptoms.	residents were identified with All were treated with her illnesses or viral infections					
	identified with vario	ourteen residents were us symptoms. All were treated further illnesses or viral ed.					
	various symptoms.	residents were identified with All were treated with her illnesses or viral infections					
	(DON) indicated sh control surveillance facility only tracked antibiotic treatment on weekends. DON progress notes daily checked for any new	41 a.m. director of nursing e completed the infection forms. DON confirmed the those residents who received and did not complete tracking N indicated she read resident y when she was present and w infections and orders. DON wed the weekend notes for ays.					
		led Infection Prevention and evised 11/2016, specified a					

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		AND HUMAN SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245299	B. WING	i			C 19/2018
NAME OF F	ROVIDER 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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	reports, investigater communicable dise volunteers, visitors providing service un arrangement and fo standards. The pol was in place for sur possible communic before they could b the facility. DISINFECTION BL R26 was observed seated in a recliner positioned to her rig entered R26's room container, which he glucose testing met multiple lancets, an were individually we and picked up the g plastic container an then cleansed R26' wipe, obtained a sa finger, and obtained from the glucose m used test strip from meter back into the test strips bottle, lar then left R26's room the white container medication cart, and medication cart, and medication cart. RN	e that prevents, identifies, s, and controls infections and ases for all residents, staff, and other individuals	F	880			
	On 10/17/18, at 7:5	7 p.m. RN-B stated the Even					

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		AND HUMAN SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245299	B. WING				_ 19/2018
NAME OF F	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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Care G3 glucose m glucose meter and the A wing with order RN-B stated staff us disinfecting wipe to done once per sift. On 10/19/18, at 8:5 EvenCare G3 gluco in the building and of that had an order for DON indicated her the glucose meter v using the Micro-Kill resident use. She s the meter back into sanitized, as all the would then be conta- sanitized prior. On 10/19/18, at 9:0 EvenCare G3 User guide's Table of Co Meter, was reviewed instructed the user and disinfected betw instructions listed s been approved for EvenCare G3 mete Mirco-Kill+ (plus) ar However, the list di The guide indicated may be used for dis system, however, the validated and could meter.	ge 99 Neter was a common use was used for any resident on ers for blood glucose testing. sed a Micro-Kill One clean the meter, and this was 3 a.m. the DON confirmed the ose meters were common use could be used for any resident or blood glucose testing. The expectation for disinfecting would be to disinfect the meter One wipes, between each tated, staff should not place the carrying container until supplies in the container aminated if the meter was not 0 a.m. the DON provided the 's Guide, undated. The ntents, 6. Caring For the ed. 6. Caring for the Meter the meter should be cleaned ween each patient. The everal products which had cleaning and disinfecting the r, which included: Medline hd Medline Mirco-Kill Bleach. d not include Micro-Kill One. d other EPA registered wipes sinfecting the EvenCare G3 hese wipes had not been affect the performance of the 08 a.m. licensed practical	F	380			

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		AND HUMAN SERVICES			FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		245299	B. WING			C 19/2018
NAME OF F	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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	and stated she san between each resid wipe. On 10/19/18, at 10: was working on Win on Wing B was a co She stated she san between each resid wipe. On 10/19/18, at 10: service representat Micro-Kill One was Micro-Kill One was Micro-Kill+ or Micro difference in each p ingredient of the wi One had not been t meter. MCSR-A sta would be to follow t Guide's instructions On 10/19/18, at 10: interview with the D expect the facility w G3's manufacturer's disinfecting the met residents (R41, R42 R30, R11, R33, R19 machine. Review of the facilit Infection Control Ga glucometers which than one resident we	cated she worked on Wing A, itized the EvenCare G3 meter dent utilizing the Micro-Kill One 13 a.m. LPN-B indicated she ng B and the glucose meter ommon use glucose meter. itized the EvenCare G3 meter dent utilizing the Micro-Kill One 24 a.m. Medline customer tive (MCSR)-A stated not the same product as o-Kill Bleach, and stated the product was the main pe. MCSR-A stated, Micro-Kill tested on the EvenCare G3 ated the recommendation the EvenCare G3's User	F 880			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
		• •			(X3) DATE SURVEY COMPLETED		
		245299	B. WING	i		C 10/19/2018	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE CARE CENTER					19 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	(EPA)-Registered d hepatitis B virus (HI and human immund use the products as manufacturer. HAND HYGIENE R10's quarterly Min 8/2/18, identified R required total assist living (ADL) and wa wheelchair indepen R10's MDS also ide included cerebral p disorder that usually anxiety and respirat further identified he suctioning, tracheos R10's care plan las ventilator depender chronic respiratory which the body or ro of oxygen). R10's of suction tracheostory least 1 time per shift On 10/17/18, at 2:3 with the head of his Registered nurse (F supplies ready for s looking for the sucti her the supplies we bed side table. RN from the bed side ta the suction kit on the removed the packa	isinfectant effective against BV), hepatitis C virus (HCV), odeficiency virus (HIV), and to a directed by the imum Data Set (MDS) dated 10 was cognitively intact, tance with activities of daily is able to use his electric dently with supervision. entified diagnoses which alsy (permanent movement y appeared in early childhood) tory failure. R10's MDS used oxygen, required stomy care and ventilation. t reviewed 8/7/18, identified and tracheostomy due to failure with hypoxia (condition egion of the body is deprived care plan further indicated to my PRN (as needed) and at	F	380			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245299	B. WING			C 10/19/2018	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE CARE CENTER					19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	would stop soundin RN-A walked to the the doorknob, react alarm, which was lo his door, then she r used the door knob walked back to the the sterile gloves w hygiene. RN-A the through his tracheo wearing the sterile g On 10/17/18, at 6:5 had sanitized her h the room, but forgo after touching the b opening the kit, tou and turning off the v door. RN-A indicate hand hygiene prior and indicated this w On 10/18/18, at 11: would absolutely ex preformed prior to a suctioning. DON in not preformed prior could pass germs a infection. On 10/19/18, at 9:5 (CM)-A indicated sh training, and the lice training during orier washing for infection	nd. R10 indicated the alarm g once he was suctioned. door, opened the door with hed up and turned off the bocated outside his room near e-entered R10's room and to close the door. RN-A bedside table, then applied ithout performing hand in began to suction R10 stomy ventilator tubing while gloves. 59 p.m. RN-A indicated she ands when she first entered t to perform hand hygiene edside table drawer handle, ching R10's door knob twice ventilator alarm outside his ed she should have preformed to putting on the sterile gloves	F	380			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 11/27/2018 MAPPROVED D. 0938-0391			
		· ·		E CONSTRUCTION (X3) DA	(X3) DATE SURVEY COMPLETED				
		245299	B. WING		10	C 10/19/2018			
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE				
FRAZEE CARE CENTER				219 WEST MAPLE AVENUE, PO BOX 96 FRAZEE, MN 56544					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 880 F 881 SS=F	after each direct res hand-washing was professional practic conducted per reco (Centers for Diseas guidelines. The pol washing prior to ste Antibiotic Stewards CFR(s): 483.80(a)(3) §483.80(a) Infection program. The facility must es and control program a minimum, the follo §483.80(a)(3) An ar that includes antibio system to monitor a This REQUIREMEN by: Based on interview facility failed to deve comprehensive anti- with established pro- unnecessary antibio drug resistance. Th documentation of a documentation of a cocumentation of a documentation of a documentation of a fresidents on antibio practice had the por residents who curres	aff were to wash their hands sident contact for which indicated by accepted ee. Hand-washing was also mmendations from the CDC ee Control and Prevention) licy lacked direction for hand erile glove application. hip Program 3) n prevention and control tablish an infection prevention n (IPCP) that must include, at owing elements: ntibiotic stewardship program otic use protocols and a	F 8		 An antibiotic Stewardship policy has been developed with protocols to help reduce unnecessary antibiotic use and reduce potential drug resistance All current antibiotics reviewed for appropriate use and follow up if indicated o Education provided to nursing administration and nurse managers on antibiotic stewardship policy and procedures Education provided to clinicians and residents on antibiotic resistance and opportunities for improvement Audit of antibiotic stewardship reviews will be conducted two times 	11/28/18			
		Stewardship Program dated			weekly for four weeks and then weekly for	r			

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		AND HUMAN SERVICES				FORM	11/27/2018 APPROVED 0938-0391
		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
245299		B. WING			C 10/19/2018		
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRAZEE CARE CENTER					19 WEST MAPLE AVENUE, PO BOX 96 RAZEE, MN 56544		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 881	10/14/17, identified (HDG) communities Antibiotic Stewards promote appropriat optimizing the treat the possible advers antibiotic use. The ASP would include nursing staff, reside antibiotic resistance improvement. The ASP team would in- of residents on anti- criteria for active int- included improving communication of c when a resident is f infection and optimi The policy further ic infection criteria to prescribing. The po- include DON or IP (collect data which in ordered, type of orc physician or on-call tests such as cultur antibiotic ordered a during the course of did not include the a- program or protoco initiation of the antil Review of the faciliti Community Infection 2018, to October 20	COVIDER OR SUPPLIER CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 104 10/14/17, identified the Health Dimensions Group (HDG) communities would implement an Antibiotic Stewardship Program (ASP) to promote appropriate antibiotic use while optimizing the treatment of infections and reduce the possible adverse events associated with antibiotic use. The policy further indicated the ASP would include education for clinicians, nursing staff, residents and families about antibiotic resistance and opportunities for improvement. The policy indicated the facility ASP team would include a report for the number of residents on antibiotics that did not meet criteria for active infection. Actions listed included improving the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection and optimize us of diagnostic testing. The policy further identified tracking to include DON or IP (infection preventionist) to collect data which included type of antibiotic ordered, type of order received, if attending physician or on-call doctor, when appropriate tests such as cultures were obtained before antibiotic ordered and if antibiotic twas changed during the course of the treatment. The policy did not include the antibiotic stewardship program or protocols to be reviewed prior to the initiation of the antibiotic. Review of the facility forms titled Frazee Care Community Infection Control Log from January 2018, to October 2018 indicated the facility identified the individual resident, the date an		381	one month and then monthly for two months o DON/ Designee will report result trends of all audits to QAPI Commit 3 months to review and follow-up a needed. o Compliance date. 11/28/2018	ilts and ttee for	

		AND HUMAN SERVICES			FORM	: 11/27/2018 APPROVED . 0938-0391
			TIPLE CONSTRUCTION	(X3) DAT COM	(X3) DATE SURVEY COMPLETED C	
245299		B. WING _		10/19/2018		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
FRAZEE	CARE CENTER			219 WEST MAPLE AVENUE, PO BO FRAZEE, MN 56544	X 96	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 881	stewardship protoc the initiation of the On 10/18/18, at 11: (DON) reviewed fac program with surve facility did not not h regarding the use of confirmed since the protocols, no educa	ol had been reviewed prior to	F 88			

Facility ID: 00730

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