DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 15, 2019

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

RE: Project Number H5299016C

Dear Administrator:

On March 27, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Departments of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the March 27, 2019 standard survey the Minnesota Department of Health, completed an investigation of complaint number H5299016C.

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is May 6, 2019.

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.
- 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));

- 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 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 June 27, 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 September 27, 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 deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245299	A. BUILDING _____ B. WING _____	C 03/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/27/19 an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5299016C. Deficiency issued at F609 and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		5/6/19

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

Electronically Signed | 04/19/2019

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F 609	Continued From page 1 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State agency (SA) and immediately report to the administrator allegations of physical abuse for 1 of 1 resident (R1) who was dependent on staff for assistance with activities of daily living (ADL). In addition, the facility failed to ensure an alleged violation of resident to resident abuse was reported to the SA and the administrator immediately, no later than two hours, for 1 of 3 residents (R4) reviewed for allegations of abuse. Findings include: R1: R1's admission Minimum Data Set (MDS) dated 3/13/19, indicated R1 had moderate cognitive impairment and had diagnoses which included	F 609	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely	

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F 609	Continued From page 2 cerebrovascular accident (stroke) , hemiplegia or hemipariesis and acute respiratory distress. The MDS indicated R1 required extensive assistance of two staff with activities of daily living. Review of R1's Care Plan revised 3/6/19, indicated R1 was considered a vulnerable adult due to physically unable to provide own self preservation at time of admission due to immobility and weakness related to massive ischemic stroke, acute respiratory failure aspiration and pneumonia. The care plan listed several interventions which included: the facility will report any allegations of abuse or neglect to the appropriate SA and staff will report all concerns of abuse or neglect to their immediate supervisor. Review of R1's Progress Notes from 2/10/19 to 3/27/19, revealed the following: -2/9/19 at 8:37 p.m., R1 had bath this afternoon, skin was clear and intact. -2/11/19 at 2:30 p.m. observed bruising to left torso/rib cage. Bruising was yellowing in color and does not have any distinct pattern. Will have registered nurse (RN)-A question R1 later when family member (FM)-A not present. -2/11/19 at 2:37 p.m. staff and FM-A reported some faint gray discolored areas to lateral left ribcage and side of chest/abdomen. No complaints of pain, areas appear to be old and of unknown origin at this time. Clinical nurse manager, evening nurse and Administrator aware. -2/11/19 at 9:53 p.m. R1 had bruising on left side	F 609	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 participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. " R1 is no longer a resident at Frazee Care Center. R4 and R5 continue to reside at Frazee Care Center. " Residents who reside at Frazee Care Center could be affected by this practice. " Freedom from Abuse, Neglect, and Exploitation policy reviewed and revised as indicated. " Staff were re-educated on the Freedom from Abuse, Neglect, and Exploitation policy and reporting expectations. " DON/Designee will audit nursing staff use of the Freedom from Abuse, Neglect, and Exploitation Policy to ensure compliance by completing x2 audit weekly for 3 months. " DON/Designee will audit charts of current residents who reside at Frazee Care Center for the past 30 days to determine if any incidents were not reported, if applicable. VA reports will be filed for incidents found and not reported, as indicated. " DON/Designee will review nursing notes daily, 7 days a week for 30 days to monitor for reportable events, after 30 days, nursing notes will be reviewed Monday-Friday, and as indicated through accordance with the facility's Freedom from Abuse, Neglect, and Exploitation	

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F 609	Continued From page 3 of torso that was yellowing. "R1 states that he was grabbed hard and it hurt." This will be investigated. A review of the facility incident reports from 1/1/19 to 3/27/19, revealed there was no documentation that an incident report had been completed for the allegation of physical abuse for R1. A review of facility vulnerable adult reports from 1/1/19 to 3/27/19, revealed there was no documentation the SA had been notified immediately for an allegation of physical abuse for R1. On 3/27/19 at 12:37 p.m. social services (SS) confirmed FM-A filed a grievance on some suspicious bruising and thought she remembered an investigation being done, but was not sure. SS indicated she was not involved in the allegation of abuse with R1 and had no documentation in regards to it. The SS indicated she did not know what the director of nursing at the time did with the allegation of abuse. On 3/27/19 at 12:56 p.m. nursing supervisor (NS)-A indicated that she was not working over at the nursing home at the time of the incident regarding R1 and indicated the employees involved RN-A and RN-B no longer work at the facility. The NS-A indicated the two staff members involved in the incident left around the time of the incident and she was not aware of what happened. On 3/27/19 at 1:11 p.m. Interim director of nursing (IDON) indicated the incident with R1 was before she had come to the facility and knew	F 609	Policy. " Audit results will be reviewed at monthly QAPI meetings x3 months to ensure consistent implementation of the facility□s Freedom from Abuse, Neglect, and Exploitation policy. " Completion date: May 6, 2019	

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F 609	Continued From page 4	F 609		

nothing about the situation. The IDON indicated that any type of abuse they would protect the resident, suspend the perpetrator if it was a staff member, do body assessment and report to the SA immediately within 2 hours of the incident. The IDON indicated she would start an investigation once the incident had been reported to the SA and indicated she had 5 days to submit the investigation to the SA. The IDON indicated she could not find any evidence that a incident report, a report to the SA or an investigation had been completed in regards to the allegation of abuse for R1. The IDON indicated her expectation of staff would be to report the incident to her and the administrator and follow the facility policy to report to the SA.

On 3/27/19 at 2:36 p.m. FM-A indicated that R1 had reported to her that a staff member was rough with him during cares and caused the bruising. R1 confirmed this by nodding his head yes and showed with gestures of his hands of rolling him back and forth in the bed. When R1 was asked if the bruising was caused by staff rolling him back and forth in bed he nodded his head yes.

R4:
R4's annual MDS dated 1/15/19, indicated R4 had moderate cognitive impairment and had diagnoses which included developmental disorder, anxiety and depression. The MDS indicated R1 required supervision of one staff for transfers, limited assistance of one staff for bed mobility and toileting, and extensive assistance of one staff with dressing and personal hygiene. The MDS further indicated R4 had no behaviors exhibited.

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F 609	Continued From page 5 Review of R4's Care Plan revised 11/2/19, indicated R4 was considered a vulnerable adult due to age, placement, and diagnosis of systemic lupus atheromatosis, mild cognitive impairment, anxiety disorder, hypertension, and chronic gout. R4 at moderate risk, of harm by other due to outbursts and inappropriate reactions to stressful situations. The care plan listed several interventions which included: executive director, DON, social worker will report all incidents of abuse to the appropriate SA and staff will report all concerns of abuse or neglect to their immediate supervisor. Review of R4's Progress Notes from 1/1/19 to 3/27/19, revealed the following: - on 1/2/19 at 10:02 p.m. R4 spazzed out on another resident in the dining room. She also hit resident a couple of times in the shoulder. A review of the facility incident reports from 1/1/19 to 3/27/19, revealed there was no documentation an incident report had been completed for the allegation of resident to resident abuse involving R4. A review of the facility vulnerable adult reports from 1/1/19 to 3/27/19, revealed there was no documentation the Administrator or the SA had been notified immediately of the allegation of resident to resident abuse. In a follow up interview on 3/27/19 at 4:24 p.m. the IDON and NS-A confirmed finding for R4 and the facility had no incident report competed on the resident to resident altercation involving R4 and R5. The IDON and NS-A indicated they were	F 609		

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F 609	Continued From page 6	F 609		

not working at the nursing home when the incident took place and could not find any documentation as to when the SA or if the SA had been notified of the resident to resident altercation.

On 3/27/19 at 1:24 p.m. interim Administrator indicated he had started about a week ago and was unable to provide any further information regarding R1. The interim Administrator indicated with any type of abuse, they would protect the resident involved, suspend the perpetrator if it was a staff member pending investigation, report it to him and the SA immediately within 2 hours and start an investigation. The interim Administrator indicated his expectations of staff to protect the resident and follow the facility policy.

Review of facility policy titled, Freedom From Abuse, Neglect and Exploitation revised on 11/16, indicated it is also the policy of this community to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property (alleged violations) are reported immediately to the administrator of the community, but no later that two hours after the allegation is made, if the events that caused the allegation involve abuse or serious bodily injury, or no later that 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury. Such violations are also reported immediately to state agencies in accordance with existing state law. The community investigates each such alleged violation thoroughly and reports the results of all investigations to the administrator, as well as to state agencies and Adult Protective Services as required by state and

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F 609	Continued From page 7 federal law.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate an allegation of abuse for 1 of 1 resident (R1) who required staff assistance with activities of daily living. Findings include: R1's admission Minimum Data Set (MDS) dated 3/13/19, indicated R1 had moderate cognitive impairment and had diagnoses which included cerebrovascular accident (stroke) , hemiplegia or hemiparesis and acute respiratory distress. The MDS indicated R1 required extensive assistance	F 610	" R1 is no longer a resident at Frazee Care Center. R4 and R5 continue to reside at Frazee Care Center. " Residents who reside at Frazee Care Center could be affected by this practice. " Freedom from Abuse, Neglect, and Exploitation policy reviewed and revised as indicated. " Staff were re-educated on the Freedom from Abuse, Neglect, and Exploitation policy and reporting expectations. " DON/Designee will audit nursing staff use of the Freedom from Abuse, Neglect,	5/6/19

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F 610	Continued From page 8 of two staff with activities of daily living. Review of R1's Care Plan revised 3/6/19, indicated R1 was considered a vulnerable adult due to physically unable to provide own self preservation at time of admission due to immobility and weakness related to massive ischemic stroke, acute respiratory failure aspiration and pneumonia. The care plan listed several interventions which included: the facility will report any allegations of abuse or neglect to the appropriate SA and staff will report all concerns of abuse or neglect to their immediate supervisor. Review of R1's Progress Notes from 2/10/19 to 3/27/19, revealed the following: -2/9/19 at 8:37 p.m., R1 had bath this afternoon, skin was clear and intact. -2/11/19 at 2:30 p.m. observed bruising to left torso/rib cage. Bruising was yellowing in color and does not have any distinct pattern. Will have registered nurse (RN)-A question R1 later when family member (FM)-A not present. -2/11/19 at 2:37 p.m. staff and FM-A reported some faint gray discolored areas to lateral left ribcage and side of chest/abdomen. No complaints of pain, areas appear to be old and of unknown origin at this time. Clinical nurse manager, evening nurse and Administrator aware. -2/11/19 at 9:53 p.m. R1 had bruising on left side of torso that was yellowing. "R1 states that he was grabbed hard and it hurt." This will be investigated.	F 610	and Exploitation Policy to ensure compliance by completing x2 audit weekly for 3 months. " DON/Designee will audit charts of current residents who reside at Frazee Care Center for the past 30 days to determine if any incidents were not reported, if applicable. VA reports will be filed for incidents found and not reported, as indicated. " DON/Designee will review nursing notes daily, 7 days a week for 30 days to monitor for reportable events, after 30 days, nursing notes will be reviewed Monday-Friday, and as indicated through accordance with the facility's Freedom from Abuse, Neglect, and Exploitation Policy. " Audit results will be reviewed at monthly QAPI meetings x3 months to ensure consistent implementation of the facility s Freedom from Abuse, Neglect, and Exploitation policy. " Completion date: May 6, 2019	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 9	F 610		

A review of the facility incident reports from 1/1/19 to 3/27/19, revealed there was no documentation that an incident report had been completed and an invesitgation of the allegation of physical abuse for R1.

A review of facility vulnerable adult reports from 1/1/19 to 3/27/19, revealed there was no documentation the SA had been notified immediately for an allegation of physical abuse for R1.

On 3/27/19 at 12:37 p.m. social services (SS) confirmed FM-A filed a grievance on some suspicious bruising and thought she remembered an investigation being done, but was not sure. SS indicated she was not involved in the allegation of abuse with R1 and had no documentation in regards to it. The SS indicated she did not know what the director of nursing at the time did with the allegation of abuse.

On 3/27/19 at 12:56 p.m. nursing supervisor (NS)-A indicated that she was not working over at the nursing home at the time of the incident regarding R1 and indicated the employees involved RN-A and RN-B no longer work at the facility. The NS-A indicated the two staff members involved in the incident left around the time of the incident and she was not aware of what happened.

On 3/27/19 at 1:11 p.m. Interim director of nursing (IDON) indicated the incident with R1 was before she had come to the facility and was unable to provide any further information regarding the allegation of abuse for R1. The

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	245299	A. BUILDING _____ B. WING _____	C 03/27/2019

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F 610	Continued From page 10	F 610		

IDON indicated she would start an investigation once the incident had been reported to the SA. The IDON indicated she could not find any evidence that a incident report, a report to the SA or an investigation had been completed in regards to the allegation of abuse for R1. The IDON indicated her expectation of staff would be to report the incident to her and the administrator and follow the facility policy to report to the SA.

On 3/27/19 at 2:36 p.m. FM-A indicated that R1 had reported to her that a staff member was rough with him during cares and caused the bruising. R1 confirmed this by nodding his head yes and showed with gestures of his hands of rolling him back and forth in the bed. When R1 was asked if the bruising was caused by staff rolling him back and forth in bed he nodded his head yes.

On 3/27/19 at 1:24 p.m. interim Administrator indicated he had started about a week ago and was unable to provide any further information regarding R1. The interim Administrator indicated with any type of abuse, they would protect the resident involved, suspend the perpetrator if it was a staff member pending investigation, report it to him and the SA immediately within 2 hours and start an investigation. The interim Administrator indicated his expectations of staff to protect the resident and follow the facility policy.

Review of facility policy titled, Freedom From Abuse, Neglect and Exploitation revised on 11/16, indicated it is also the policy of this community to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property

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F 610	Continued From page 11 (alleged violations) are reported immediately to the administrator of the community, but no later that two hours after the allegation is made, if the events that caused the allegation involve abuse or serious bodily injury, or no later that 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury. Such violations are also reported immediately to state agencies in accordance with existing state law. The community investigates each such alleged violation thoroughly and reports the results of all investigations to the administrator, as well as to state agencies and Adult Protective Services as required by state and federal law.	F 610		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 15, 2019

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

Re: State Nursing Home Licensing Orders - Complaint Number H5299016C

Dear Administrator:

A complaint investigation was completed on March 27, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. Please remember that this provision is only a suggestion 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 violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

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.

When all licensing orders are corrected, the form should be signed and returned electronically 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

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00730	A. BUILDING: _____ B. WING _____	C 03/27/2019

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On March 27th, 2019 surveyors of this Department's staff visited the above provider for a complaint investigation to investigate complaints H5299016C and was found to be substantiated. The complaint was substantiated at 1980 and the following correction orders are issued.	2 000		

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2 000	Continued From page 1 Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of	21980		5/6/19

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21980	Continued From page 2 known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State agency (SA) and immediately report to the administrator allegations of physical abuse for 1 of 1 resident (R1) who was dependent on staff for assistance with activities of daily living (ADL). In addition, the facility failed to ensure an alleged violation of resident to resident abuse was reported to the SA and the administrator immediately, no later than two hours, for 1 of 3 residents (R4) reviewed for allegations of abuse. Findings include:	21980	Completion date 5/6/19	

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21980	Continued From page 3 R1: R1's admission Minimum Data Set (MDS) dated 3/13/19, indicated R1 had moderate cognitive impairment and had diagnoses which included cerebrovascular accident (stroke) , hemiplegia or hemipariesis and acute respiratory distress. The MDS indicated R1 required extensive assistance of two staff with activities of daily living. Review of R1's Care Plan revised 3/6/19, indicated R1 was considered a vulnerable adult due to physically unable to provide own self preservation at time of admission due to immobility and weakness related to massive ischemic stroke, acute respiratory failure aspiration and pneumonia. The care plan listed several interventions which included: the facility will report any allegations of abuse or neglect to the appropriate SA and staff will report all concerns of abuse or neglect to their immediate supervisor. Review of R1's Progress Notes from 2/10/19 to 3/27/19, revealed the following: -2/9/19 at 8:37 p.m., R1 had bath this afternoon, skin was clear and intact. -2/11/19 at 2:30 p.m. observed bruising to left torso/rib cage. Bruising was yellowing in color and does not have any distinct pattern. Will have registered nurse (RN)-A question R1 later when family member (FM)-A not present. -2/11/19 at 2:37 p.m. staff and FM-A reported some faint gray discolored areas to lateral left ribcage and side of chest/abdomen. No complaints of pain, areas appear to be old and of unknown origin at this time. Clinical nurse	21980		

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21980	Continued From page 4 manager, evening nurse and Administrator aware. -2/11/19 at 9:53 p.m. R1 had bruising on left side of torso that was yellowing. "R1 states that he was grabbed hard and it hurt." This will be investigated. A review of the facility incident reports from 1/1/19 to 3/27/19, revealed there was no documentation that an incident report had been completed for the allegation of physical abuse for R1. A review of facility vulnerable adult reports from 1/1/19 to 3/27/19, revealed there was no documentation the SA had been notified immediately for an allegation of physical abuse for R1. On 3/27/19 at 12:37 p.m. social services (SS) confirmed FM-A filed a grievance on some suspicious bruising and thought she remembered an investigation being done, but was not sure. SS indicated she was not involved in the allegation of abuse with R1 and had no documentation in regards to it. The SS indicated she did not know what the director of nursing at the time did with the allegation of abuse. On 3/27/19 at 12:56 p.m. nursing supervisor (NS)-A indicated that she was not working over at the nursing home at the time of the incident regarding R1 and indicated the employees involved RN-A and RN-B no longer work at the facility. The NS-A indicated the two staff members involved in the incident left around the time of the incident and she was not aware of what happened.	21980		

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21980	Continued From page 5 On 3/27/19 at 1:11 p.m. Interim director of nursing (IDON) indicated the incident with R1 was before she had come to the facility and knew nothing about the situation. The IDON indicated that any type of abuse they would protect the resident, suspend the perpetrator if it was a staff member, do body assessment and report to the SA immediately within 2 hours of the incident. The IDON indicated she would start an investigation once the incident had been reported to the SA and indicated she had 5 days to submit the investigation to the SA. The IDON indicated she could not find any evidence that a incident report, a report to the SA or an investigation had been completed in regards to the allegation of abuse for R1. The IDON indicated her expectation of staff would be to report the incident to her and the administrator and follow the facility policy to report to the SA. On 3/27/19 at 2:36 p.m. FM-A indicated that R1 had reported to her that a staff member was rough with him during cares and caused the bruising. R1 confirmed this by nodding his head yes and showed with gestures of his hands of rolling him back and forth in the bed. When R1 was asked if the bruising was caused by staff rolling him back and forth in bed he nodded his head yes. R4: R4's annual MDS dated 1/15/19, indicated R4 had moderate cognitive impairment and had diagnoses which included developmental disorder, anxiety and depression. The MDS indicated R1 required supervision of one staff for transfers, limited assistance of one staff for bed mobility and toileting, and extensive assistance of one staff with dressing and personal hygiene. The	21980		

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21980	Continued From page 6 MDS further indicated R4 had no behaviors exhibited. Review of R4's Care Plan revised 11/2/19, indicated R4 was considered a vulnerable adult due to age, placement, and diagnosis of systemic lupus atheromatosis, mild cognitive impairment, anxiety disorder, hypertension, and chronic gout. R4 at moderate risk, of harm by other due to outbursts and inappropriate reactions to stressful situations. The care plan listed several interventions which included: executive director, DON, social worker will report all incidents of abuse to the appropriate SA and staff will report all concerns of abuse or neglect to their immediate supervisor. Review of R4's Progress Notes from 1/1/19 to 3/27/19, revealed the following: - on 1/2/19 at 10:02 p.m. R4 spazzed out on another resident in the dining room. She also hit resident a couple of times in the shoulder. A review of the facility incident reports from 1/1/19 to 3/27/19, revealed there was no documentation an incident report had been completed for the allegation of resident to resident abuse involving R4. A review of the facility vulnerable adult reports from 1/1/19 to 3/27/19, revealed there was no documentation the Administrator or the SA had been notified immediately of the allegation of resident to resident abuse. In a follow up interview on 3/27/19 at 4:24 p.m. the IDON and NS-A confirmed finding for R4 and the facility had no incident report competed on the resident to resident altercation involving R4	21980		

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21980	Continued From page 7	21980		

and R5. The IDON and NS-A indicated they were not working at the nursing home when the incident took place and could not find any documentation as to when the SA or if the SA had been notified of the resident to resident altercation.

On 3/27/19 at 1:24 p.m. interim Administrator indicated he had started about a week ago and was unable to provide any further information regarding R1. The interim Administrator indicated with any type of abuse, they would protect the resident involved, suspend the perpetrator if it was a staff member pending investigation, report it to him and the SA immediately within 2 hours and start an investigation. The interim Administrator indicated his expectations of staff to protect the resident and follow the facility policy.

Review of facility policy titled, Freedom From Abuse, Neglect and Exploitation revised on 11/16, indicated it is also the policy of this community to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property (alleged violations) are reported immediately to the administrator of the community, but no later that two hours after the allegation is made, if the events that caused the allegation involve abuse or serious bodily injury, or no later that 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury. Such violations are also reported immediately to state agencies in accordance with existing state law. The community investigates each such alleged violation thoroughly and reports the results of all investigations to the administrator, as well as to state agencies and Adult Protective Services as required by state and

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21980	Continued From page 8 federal law. Suggested Method of Correction: The adminstrator and/or designee could review the facility polices in regards to reporting of allegations of mistreatment to the State Agency. The administrator and/or designee could educate staff on ensuring reports are submitted in a timely manner. The administrator or designee could routinely monitor to ensure reports are submitted in a timely manner. Suggested Date of Correction: Fourteen (14) days	21980		