

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER Frazee Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 219 West Maple Avenue Frazee, MN 56544	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905</p> <p>Based on observation, interview and document review, the facility failed to accurately code the oral/dental section of the Minimum Data Set (MDS) for identified dental issues for 1 of 1 residents (R13) reviewed for dental services.</p> <p>Findings include:</p> <p>R13's quarterly MDS dated [DATE], identified R13 had severe cognitive impairment, and diagnoses which included: Alzheimer's disease, anxiety, and depression.</p> <p>R13's significant change MDS dated [DATE], identified R13 had no natural teeth or fragments.</p> <p>R13's significant change Care Area Assessment (CAA), dated 2/15/24, identified R13 lacked natural teeth, did not report complications and denied need for dental check-up at that time. Identified R13 wore upper dentures and staff were to assist with cleaning and placement as needed and R13 refused lower dentures.</p> <p>R13's Dental/Oral Data Collection Tool dated 5/6/24, identified R13 only wore upper dentures, no teeth lower jaw, and did not wish dental visit as nothing had worked in the past and was fine.</p> <p>R13's Dental/Oral Data Collection Tool dated 8/5/24, identified R13 only wore upper dentures, no teeth lower jaw, and did not wish dental visit as nothing had worked in the past and was fine.</p> <p>R13's Dental/Oral Data Collection Tool dated 8/22/24, identified R13 had own teeth and upper partial. R13 was seen by ATD hygienist, likely root tips in upper right (UR) and decay in upper left (UL). R13 mandible (lower jaw) was edentulous (toothless) with minimal ridge remaining.</p> <p>R13's Dental/Oral Data Collection Tool dated 11/4/24, identified R13 only wore upper dentures, no teeth lower jaw, and did not wish dental visit as nothing had worked in the past and was fine.</p> <p>R13's care plan revised 8/20/24, identified R13 was at risk for complications with deficits with activities of daily living (ADL)s related to current medical/physical status. R13's interventions included set up, assist of one as needed for hygiene and oral care completed. R13's care plan identified at risk for complications with dental status, and upper dentures and no teeth on bottom. Interventions included to coordinate arrangements for dental care, transportation as needed/as ordered. provide dental care as needed.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R13's Apple Tree Dental Oral/Dental Assessment Form dated 8/22/24, identified likely root tips in upper right UR and decay in upper left UL. Mandible was edentulous with minimal ridge remaining. R13 would like to see doctor of dental surgery (DDS) for broken teeth.</p> <p>During an observation on 11/4/24 at 11:40 a.m., R13 was sitting in recliner in room, eyes closed, dressed in street clothes. Partial was noted in water in dental cup by sink.</p> <p>During an interview on 11/6/24 at 9:30 a.m., registered nurse (RN)-A confirmed R13's Dental/Oral Data Collection Tool had been completed on 11/4/24. R13 stated R13 had upper dentures, did not want dental visit and staff assisted her to brush her dentures. RN-A reviewed R13's electronic medical record, verified R13 was seen by Apple Tree Dental in August and FM-A wanted R13 to be seen by DDS for root tips in UR and decay in UL. At 12:31 p.m., during follow up interview, RN-A verified had just assessed R13, and verified R13 had two upper natural teeth that needed some treatment and R13 wore a partial. RN-A stated MDS's were completed off site and RN-A confirmed her assessment completed on 11/4/24, was not accurate.</p> <p>During an interview on 11/6/24 at 12:06 p.m., director of nursing (DON) confirmed the above findings of R13's Dental/Oral Data Collection Tool dated 11/4/24, and MDS was not accurate. DON stated the expectation was assessments and MDS were to be completed accurately.</p> <p>The facility policy titled Nursing Documentation (General) revised 2/23, identified the facility would document in a standardized manner of the care and services provided to a resident. The policy identified MDS completion as per Centers for Medicare & Medicaid Services (CMS) and Medicare guidelines. Back-up documentation from nursing staff was also completed.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844</p> <p>Based on observation, interview and document review, the facility failed to implement interventions for 1 of 1 residents (R28) who had repeated falls in the facility and remained at high risk for falls. In addition, the facility failed to ensure an environment that was free of accident hazards, related to hot water temperatures in 4 of 6 resident rooms (R6, R10,R13, R185) tested for safe water temperatures. This deficient practice had the ability to affect all 4 residents who used water from the water faucets.</p> <p>Findings include:</p> <p>FALLS</p> <p>R28's quarterly Minimum Data Set (MDS) dated [DATE], identified R28 had moderate cognitive impairment and had diagnoses which included diabetes mellitus (DM), hypertension (elevated blood pressure), and anxiety disorder. Indicated R28 required supervision with toileting and transfers. Identified R28 had one fall since the last assessment.</p> <p>R28's annual Care Area Assessment (CAA) dated 8/2/24, identified R28 had reduced safety awareness and required staff assistance during transfers and ambulation. Identified staff would proceed with supportive care and functional status would be addressed in care plan.</p> <p>R28's Fall Risk Screening Tool dated 9/23/24, identified R28 had three or more falls in the past six months and was at high risk for falls.</p> <p>R28's care plan revised 10/2/24, identified R28 had a history of falls and was non compliant with therapy recommendations for ambulation and transfers. R28's interventions included: encourage resident to use Front wheeled walker when transferring in room, Call light positioned for easy access and staff to place w/c legs in wheelchair bag on back of w/c when resident in room to prevent from tripping on them. Identified R28 required assistance with dressing, toilet use, and transfers.</p> <p>R28's Kardex undated, identified staff were to place wheelchair legs (foot pedals) in wheelchair bag on back of wheelchair when resident was in her room to prevent from tripping on them.</p> <p>Review of R28's progress notes from 7/1/24 to 11/4/24, identified the following:</p> <p>-7/12/24 at 6:25 p.m., found sitting on the floor with legs out in front of her facing recliner. R28 stated she was transferring from wheelchair to the recliner and tripped and fell . R28 had several skin tears to right arm and elbow, no other injuries noted. Intervention: staff to place wheelchair legs in wheelchair bag when R28 was in her room.</p> <p>-8/4/24 at 8:00 p.m., found laying on left side with back towards the bed in room. R28 stated she was trying to turn oxygen concentrator on. two skin tears to left forearm, no other injuries noted. Intervention: oxygen concentrator moved next to bedside.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-10/1/24 at 4:50 p.m., found on floor next to nightstand. Skin tear to left forearm, no other injuries noted. R28 was self transferring. Intervention: anti roll backs on wheelchair.</p> <p>-10/11/24 at 9:00 a.m., Found on floor in room. R28 attempted to place clothes in hamper and fell on floor. Intervention: Therapy screen, lowered back of wheelchair seat.</p> <p>During an observation on 11/4/24 at 1:27 p.m., R28 was seated in her room in a recliner with a wheelchair on her right side which had two foot pedals applied and a large empty black bag on the back of the wheelchair.</p> <p>During an observation on 11/4/24 at 3:47 p.m., R28 was coming out of the bathroom in her room seated in a wheelchair which had two foot pedals applied and a large empty black bag on the back of the wheelchair.</p> <p>During an observation on 11/5/24 at 8:48 a.m., R28 was seated in her room in a recliner with a wheelchair on her left side which had two foot pedals applied and a large empty black bag on the back of the wheelchair.</p> <p>During an observation on 11/5/24 at 9:53 a.m., R28 remained seated as noted above in her recliner with a wheelchair on her left side which had two foot pedals applied and a large empty black bag on the back of the wheelchair.</p> <p>During a joint interview on 11/5/24 at 9:55 a.m., nursing assistant (NA)-A and registered nurse (RN) -C verified R28 was seated in a recliner in her room with a wheelchair next to her which had two foot pedals applied. NA-A stated the foot pedals should not have been on R28's wheelchair because she had tripped on the wheelchair pedals and fell in the past. RN-C stated her expectation was that R28's wheelchair foot pedals would have been placed in the black bag behind R28's wheelchair anytime R28 was in her room.</p> <p>During an interview on 11/5/24 at 10:05 a.m., RN manager (RN-M) verified R28 had several falls in the facility. RN-C stated one of R28's falls had been related to R28 tripping over her wheelchair pedals while in her room therefore R28's wheelchair pedals were to be placed in the bag on the back of R28's wheelchair anytime R28 was not being transported by staff. RN-M indicated her expectation was that care planned interventions would have been followed.</p> <p>During an interview on 11/5/24 at 1:19 p.m., director of nursing (DON) verified R28 had several falls in the facility. Verified R28's wheelchair pedals were to be placed in a bag in the back of the wheelchair anytime R28 was in her room as a fall intervention. DON indicated her expectation was that care planned interventions would have been followed.</p> <p>HOT WATER</p> <p>On 11/4/24 at 12:02 p.m., during resident screening the water temperature in R6, R10, R13, and R185, felt very warm to the touch after running water for only a few minutes.</p> <p>On 11/4/24 at 12:32 p.m., maintenance director (MD) verified the water in R6, R10, R13, and R185's room felt too hot and used a thermometer to measure the water temperatures using the facility thermometer in resident rooms registered as follows:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-R6's room [ROOM NUMBER] water was 122.2 degrees F.</p> <p>-R10's room [ROOM NUMBER] water was 122 degrees F.</p> <p>-R13 room [ROOM NUMBER] water was 122.2 degrees F.</p> <p>-R185 room [ROOM NUMBER] water was 122 degrees F.</p> <p>During an interview on 11/4/24 at 2:40 p.m., registered nurse (RN)-C verified all four residents were at risk for potential burns when the water was too hot.</p> <p>During an interview on 11/5/24 at 8:00 a.m. MD verified the above rooms were too hot according to State and Federal guidelines. MD stated he had completed random audits of water temps in the past month. MD stated at some point in the last month, the aerators (a device that screws into a faucet to control the amount of water that comes out of the faucet) had been adjusted so there was more hot water coming from the faucets than should have been which could affect the temperature of the water coming from the above faucets. MD stated his expectation was that the water temperatures in all resident rooms would not exceed federal guidelines as water over 120 degrees F. had the potential to burn someone.</p> <p>During an interview on 11/5/24 at 1:16 p.m., administrator stated his expectations were that the water temperatures would remain within the Federal guidelines.</p> <p>Review of a facility policy titled Accidents/Falls-HDGR reviewed 11/23, identified the facility strived to promote safety, dignity, and overall quality of life for its residents by providing an environment that was free from any hazards for which the facility had control and by providing appropriate supervision and interventions to prevent avoidable accidents. Identified, resident care plans should be evaluated and updated with each fall with a new and applicable intervention based on root cause. The focus was to be on prevention and maintaining a safe environment. further identified the resident's individualized care plan was to be updated with any changes or new interventions post fall/incident/accident, communicated to appropriate staff, and implemented.</p> <p>The facility policy Water Temperatures dated 1/22, identified [NAME] Care Center would check hot water temperatures at least once a week randomly to ensure water temperatures were between 105-120 degrees F. (or as specified by State requirements). Indicated staff were to check resident rooms at the end of each wing on a rotating basis per facility policy.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905</p> <p>Based on interview and document review, the facility failed to provide arrangements for follow-up care with a dentist for 1 of 1 residents (R13) reviewed for dental care.</p> <p>Findings include:</p> <p>R13's quarterly Minimum Data Set (MDS) dated [DATE], identified R13 had severe cognitive impairment, and diagnoses which included: Alzheimer's disease, anxiety, and depression.</p> <p>R13's significant change MDS dated [DATE], identified R13 had no natural teeth or fragments.</p> <p>R13's significant change Care Area Assessment (CAA), dated 2/15/24, identified R13 lacked natural teeth, and did not report complications and denied need for dental check-up at that time. Identified R13 wore upper dentures and staff were to assist with cleaning and placement as needed and R13 refused lower dentures.</p> <p>R13's Dental/Oral Data Collection Tool dated 8/22/24, identified R13 had own teeth and upper partial. R13 was seen by ATD hygienist, likely root tips in UR and decay in UL. R13 mandible (lower jaw) was edentulous (toothless) with minimal ridge remaining.</p> <p>R13's Dental/Oral Data Collection Tool dated 11/4/24, identified R13 only wore upper dentures, no teeth lower jaw, and did not wish dental visit as nothing had worked in the past, and was fine.</p> <p>R13's care plan revised 8/20/24, identified R13 was at risk for complications with deficits with activities of daily living (ADL)s related to current medical/physical status. R13's interventions included set up, assist of one as needed for hygiene and oral care completed. Identified at risk for complications with dental status, and upper dentures and no teeth on bottom. Interventions included to coordinate arrangements for dental care, transportation as needed/as ordered. Provide dental care as needed.</p> <p>R13's Apple Tree Dental Oral/Dental Assessment Form dated 8/22/24, identified likely root tips in upper right (UR) and decay in upper left (UL). Mandible was edentulous with minimal ridge remaining. R13 would like to see doctor of dental surgery (DDS) for broken teeth.</p> <p>R13's progress notes reviewed from 8/1/24 to 11/6/24, identified the following;</p> <p>-8/22/24 at 11:31 a.m., R13 seen today by ATD hygienist. Likely root tips in upper right UR and decay in UL. R13 would like to see DDS for broken teeth.</p> <p>-9/24/24 at 4:34 p.m., writer followed up with family member (FM)-A regarding resident dental hygienist review. FM-A suggested to follow through with R13 to be seen by DDS for evaluation.</p> <p>R13's progress notes lacked follow up for DDS evaluation was scheduled or completed.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 11/04/24 at 12:39 p.m., family member (FM)-A indicated the facility had spoken to her about having R13 seen by a dentist and she had stated she wanted the appointment to be scheduled. FM-A was not aware if an appointment had been scheduled.</p> <p>During an interview on 11/6/24 at 9:30 a.m., registered nurse (RN)-A stated R13 had upper dentures, did not want a dental visit and staff assisted her to brush her dentures. RN-A reviewed R13's electronic medical record, verified R13 was seen by Apple Tree Dental in August and FM-A wanted R13 to be seen by DDS.</p> <p>During an interview on 11/6/24 at 10:10 a.m., social services director (SSD)-A confirmed a call had been placed to FM-A and had agreed R13 was to be seen by DDS. SSD-A stated it was tied up in paper work, and stated she had not yet finished faxing the request for R13 to be scheduled to be seen by DDS. SSD-A confirmed an appointment had not been scheduled.</p> <p>During an interview on 11/6/24 at 12:06 p.m., director of nursing (DON) stated SSD scheduled follow up appointments and transportation. DON confirmed R13 and FM-A had wanted a follow up appointment with DDS to be scheduled. DON stated if there were no sores or concerns noted, she would expect dental appointment requests be followed up on within a couple of weeks. DON indicated if the family or resident gave the approval to be seen by DDS, DON would expect the appointment to be scheduled within a couple of weeks. DON confirmed an appointment for R13 had not been completed.</p> <p>The facility policy titled Dental Services, revised 8/22, identified the community provided or obtained, from an outside resource, routine and emergency dental services to meet the needs of each resident. The community would assist the resident in making appointments by arranging transportation to and from the dentist's office.</p>