DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 22, 2023

Administrator
Centracare Health - Monticello
1013 Hart Boulevard
Monticello, MN 55362

RE: CCN: 245511
Cycle Start Date: January 6, 2023

Dear Administrator:

On February 15, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 22, 2023

Administrator
Centracare Health - Monticello
1013 Hart Boulevard
Monticello, MN 55362

Re: Reinspection Results
Event ID: 0C1U12

Dear Administrator:

On February 15, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 6, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 25, 2023

****PLEASE NOTE THAT HEALTH AND LIFE SAFETY CODE SURVEYS ARE BEING PROCESSED IN SEPERATE ENFORCEMENT CYCLES.****

Administrator
Centracare Health - Monticello
1013 Hart Boulevard
Monticello, MN 55362

RE: CCN: 245511
Cycle Start Date: January 6, 2023

Dear Administrator:

On January 6, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.

- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 April 6, 2023 (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 July 6, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245511	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH - MONTICELLO	1013 HART BOULEVARD MONTICELLO, MN 55362

(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
E 000	Initial Comments On 1/4/23 through 1/6/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. 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.	E 000		
F 000	INITIAL COMMENTS On 1/4/23 through 1/6/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. Complaint investigations were also completed. The following complaints were found to be UNSUBSTANTIATED: H55117127C/MN89101 H55117126C/MN86980 H55117123C/MN85921 H55117124C/MN84329 H5511095C/MN81876 H5511096C/MN81738 H5511098C/MN81473 H5511097C/MN78606 H55117319C/MN89841 The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed | 02/02/2023

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

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F 000	Continued From page 1 Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F 756		2/15/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH - MONTICELLO	1013 HART BOULEVARD MONTICELLO, MN 55362

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F 756	Continued From page 2 action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete a drug regimen review for residents ordered psychotropic drugs to receive gradual dose reductions for 1 of 5 residents (R9) who were reviewed for unnecessary medications. Findings include: R9's quarterly Minimum Data Set (MDS) dated 12/6/22, identified R9 had intact cognition, a Patient Health Questionnaire score of 1 suggesting minimal depression which may not require treatment, a diagnosis of depression and was receiving an antidepressant. R9's diagnosis list dated 1/6/23, indicated Major Depressive Disorder, single episode, unspecified. R9's order summary report dated 1/6/23, listed an order for Citalopram tablet 10 milligrams one time per day related to Major Depressive Disorder, Single episode, unspecified with a start date of 9/8/21.	F 756	Plan of Correction for F756 (D) DRUG REGIMEN REVIEW: Pharmacy Consultant provided recommendation regarding gradual dose reduction for R9's antidepressant on 1/12/2023 indicating that a trial reduction would not be appropriate. The Primary Provider reviewed, agreed and signed off on the recommendation. 40 out of 40 resident medical records have been audited to ensure residents who are receiving psychotropic medications have received gradual dose reduction recommendations as required by F756. A Minimum Effective Dose Assessment document has been implemented for completion, on a quarterly basis, for residents on psychotropic medications. The Minimum Effective Dose Assessment identifies the name of the psychotropic medication, date it was initiated, the last	

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F 756	Continued From page 3 R9's care plan dated 12/20/22, indicated a potential for drug interactions and adverse affects related to the use of multiple medications including the use of an antidepressant secondary to diagnosis of depression and directed staff that a monthly medication regimen review by the facility pharmacy consultant was to be completed and any recommendations were to be forwarded to the resident provider for review. R9 had documentation of pharmacy consultant reviews being completed every month over the past 13 months with no recommendation for a dose reduction of R9's Citalopram. When interviewed on 1/6/22, at 8:21 a.m. the director of nursing (DON) stated she was unable to identify a recommendation for a reduction in R9's Citalopram dose or a rationale as to why not. The DON also stated that there had been no attempts by the facility to reach out to the pharmacy consultant or R9's provider for a gradual dose reduction of her Citalopram dose or to obtain the rationale as to why not. When interviewed on 1/6/23, at 8:52 a.m. the facility Pharmacy Consultant (Pharm D) stated the recommendation for a dose reduction of R9's Citalopram was something they had missed in their monthly medication regimen reviews and they would have recommended R9's provider think about a reduction/discontinuation or provide rationale as to why not. The facility policy Psychotropic Medication Management dated February of 2022, identified that each resident's drug/medication regimen is managed and monitored which includes the implementation of gradual dose reductions (GDR)	F 756	attempt at reducing the dosage and if the prescriber feels a reduction is needed or clinically contraindicated. The Minimum Effective Dose Assessment will be initiated by RN Clinical Coordinators or designee. This assessment will be reviewed and signed by the Primary Provider. Primary Provider to provide new orders as clinically appropriate. Facility RN Clinical Coordinators, Pharmacy Consultant and Resident Primary Providers will be re-educated regarding the necessity to complete gradual dose reduction recommendations and will be educated on the implementation, and process for Provider review and signature, of the Minimum Effective Dose Assessment document. Director of Nursing, or designee, will audit completion of Minimum Effective Dose Assessments, for Residents having a quarterly assessment, for four weeks, then monthly for 11 months and as determined by QA thereafter. Director of Nursing, or designee, will audit for necessary dose reduction documentation by the Pharmacy Consultant and/or Primary Provider weekly for four weeks, then monthly for 11 months and as determined by QA thereafter. Date this will be corrected: Feb 15, 2023.	

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F 756	Continued From page 4 and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medications in an effort to discontinue these drugs. The policy defined a gradual dose reduction as the "stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued." The policy also indicated that within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practioner has initiated a psychotropic medication, the facility must attempt a gradual dose reduction in two separate quarters (with at least one month between attempts), unless clinically contraindicated. After the first year, a gradual dose reduction must be attempted annually, unless clinically contraindicated.	F 756		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245511	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	DATE SURVEY COMPLETE: **1/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH - MONTICELLO	**1013 HART BOULEVARD MONTICELLO, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 324	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the kitchen hood system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1 and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/19/2023 between 09:15 AM and 12:45 PM, it was revealed by a review of available documentation that the facility was able to provide a kitchen hood inspection report dated 10/27/2022, but was unable to provide an inspection report that had been completed six months prior to that date. An interview with the Administrator and Facilities Manager verified this deficient finding at the time of discovery.

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

The above isolated deficiencies pose no actual harm to the residents

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/19/2023. At the time of this survey, Centracare Health - Monticello was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 02/07/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility is a 2-story building with a Sub-basement built in 1986 and was determined to be of Type II(222) construction. The facility is fully fire sprinkler protected and has a fire alarm system with smoke detection in corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 67 beds and had a census of 40 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 7.2.2 (3), 7.2.3, and 7.2.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/19/2023 between 09:15 AM and 12:45 PM, it was revealed by observation that the pressure gauge on the class K fire extinguisher in the kitchen was reading in the red non-operable range. An interview with the Administrator and Facilities Manager verified this deficient finding at the time of discovery.	K 355	The K fire extinguisher in the kitchen has been serviced by Summit Fire Protection and is in operable range. An audit of all Care Center fire extinguishers has been completed to ensure extinguishers are in operable range; no concerns identified. Monthly Preventative Maintenance of Care Center Fire Extinguishers will continue. Administrator, or designee, will audit Care Center fire extinguisher Preventative Maintenance completion and documentation monthly for six months and as determined by QA thereafter.	2/15/23
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested	K 761		2/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245511	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH - MONTICELLO	**1013 HART BOULEVARD** **MONTICELLO, MN 55362**

(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
K 761	Continued From page 3 annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code, section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/19/2023 between 09:15 AM and 12:45 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that the fire doors in the facility had been inspected. An interview with the Administrator and Facilities Manager verified this deficient finding at the time of discovery.	K 761	Facility has completed inspection of Care Center Fire Doors; no concerns identified. Annual Preventative Maintenance plan for Facility Fire Door Inspection was implemented and ensured to be in Facility preventative maintenance system (TMS) for annual completion. Facility will complete annual inspections of Care Center Fire Doors ongoing. Administrator, or designee, to audit annual completion of Fire Door Inspection for one year and as determined by QA thereafter.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		2/15/23

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K 918	Continued From page 4 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, observation, and staff interview, the facility failed to inspect the emergency generator per NFPA 99	K 918	Facility has documented the weekly generator inspections for the temporary generator.	

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	245511	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/19/2023**

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K 918	Continued From page 5 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/19/2023 between 09:15 AM and 12:45 PM, it was revealed by a review of available documentation that on 12/20/2022 the facility found that their generator had a bad fuel pump and was not operating correctly, so they brought in a temporary generator on 12/21/2022. The facility did not have documentation showing that they have been conducting weekly inspections of the temporary generator that is currently onsite. While talking with the maintenance employee that conducts their generator inspections, he told me that he has been doing weekly inspections on their temporary generator, but was not logging them. An interview with the Administrator and Facilities Manager verified this deficient finding at the time of discovery.	K 918	Facility will continue to document weekly generator inspections. Administrator, or designee, to audit weekly generator inspection completion and documentation weekly for the first four weeks, then monthly for three months and as determined by QA thereafter.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 25, 2023

Administrator
Centracare Health - Monticello
1013 Hart Boulevard
Monticello, MN 55362

Re: State Nursing Home Licensing Orders
Event ID: 0C1U11

Dear Administrator:

The above facility was surveyed on January 4, 2023 through January 6, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 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 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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.

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:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00717	A. BUILDING: _____ B. WING _____	C 01/06/2023

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CENTRACARE HEALTH - MONTICELLO	1013 HART BOULEVARD MONTICELLO, MN 55362

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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 1/4/23 through 1/6/23, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following licensing orders were issued: 1530 Please indicate in your electronic plan of	2 000		

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2 000	Continued From page 1 correction that you have reviewed these orders, and identify the date when they will be completed. The following complaints were found to be UNSUBSTANTIATED: H55117127C/MN89101 H55117126C/MN86980 H55117123C/MN85921 H55117124C/MN84329 H5511095C/MN81876 H5511096C/MN81738 H5511098C/MN81473 H5511097C/MN78606 H55117319C/MN89841 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction	2 000		

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2 000	Continued From page 2 is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director	21530		2/15/23

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21530	Continued From page 3 of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to complete a drug regimen review for residents ordered psychotropic drugs to receive gradual dose reductions for 1 of 5 residents (R9) who were reviewed for unnecessary medications. Findings include: R9's quarterly Minimum Data Set (MDS) dated 12/6/22, identified R9 had intact cognition, a Patient Health Questionnaire score of 1 suggesting minimal depression which may not require treatment, a diagnosis of depression and was receiving an antidepressant. R9's diagnosis list dated 1/6/23, indicated Major Depressive Disorder, single episode, unspecified.	21530	Corrected	

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21530	Continued From page 4 R9's order summary report dated 1/6/23, listed an order for Citalopram tablet 10 milligrams one time per day related to Major Depressive Disorder, Single episode, unspecified with a start date of 9/8/21. R9's care plan dated 12/20/22, indicated a potential for drug interactions and adverse affects related to the use of multiple medications including the use of an antidepressant secondary to diagnosis of depression and directed staff that a monthly medication regimen review by the facility pharmacy consultant was to be completed and any recommendations were to be forwarded to the resident provider for review. R9 had documentation of pharmacy consultant reviews being completed every month over the past 13 months with no recommendation for a dose reduction of R9's Citalopram. When interviewed on 1/6/22, at 8:21 a.m. the director of nursing (DON) stated she was unable to identify a recommendation for a reduction in R9's Citalopram dose or a rationale as to why not. The DON also stated that there had been no attempts by the facility to reach out to the pharmacy consultant or R9's provider for a gradual dose reduction of her Citalopram dose or to obtain the rationale as to why not. When interviewed on 1/6/23, at 8:52 a.m. the facility Pharmacy Consultant (Pharm D) stated the recommendation for a dose reduction of R9's Citalopram was something they had missed in their monthly medication regimen reviews and they would have recommended R9's provider think about a reduction/discontinuation or provide rationale as to why not.	21530		

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21530	Continued From page 5 The facility policy Psychotropic Medication Management dated February of 2022, identified that each resident's drug/medication regimen is managed and monitored which includes the implementation of gradual dose reductions (GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medications in an effort to discontinue these drugs. The policy defined a gradual dose reduction as the "stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued." The policy also indicated that within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practioner has initiated a psychotropic medication, the facility must attempt a gradual dose reduction in two separate quarters (with at least one month between attempts), unless clinically contraindicated. After the first year, a gradual dose reduction must be attempted annually, unless clinically contraindicated. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure pharmacy reviews are timely and irregularities are being acted upon. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21530		