DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3VWL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00717

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245511**
2.STATE VENDOR OR MEDICAID NO.
(L2) **865402000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRACARE HEALTH - MONTICELLO**
(L4) **1013 HART BOULEVARD**
(L5) **MONTICELLO, MN** (L6) **55362**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2013**

6. DATE OF SURVEY **8/9/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **89** (L18)

13.Total Certified Beds **89** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	89			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Karen Aldinger, Unit Supervisor 8/18/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/18/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 18, 2021

CMS Certification Number (CCN): 245511

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

Dear Administrator:

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

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

Effective July 27, 2021 the above facility is certified for:

89 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 89 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
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
August 18, 2021

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

RE: CCN: 245511
Cycle Start Date: June 17, 2021

Dear Administrator:

On July 9, 2021, we notified you a remedy was imposed. On August 9, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 27, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 17, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 9, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 17, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 27, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3VWL

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(L3) **CENTRACARE HEALTH - MONTICELLO**
(L4) **1013 HART BOULEVARD**
(L5) **MONTICELLO, MN** (L6) **55362**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2013**

6. DATE OF SURVEY **06/17/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

12.Total Facility Beds **89** (L18)
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10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	89			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Austin Fry, HFE NE II 07/26/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/06/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
July 9, 2021

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

RE: CCN: 245511
Cycle Start Date: June 17, 2021

Dear Administrator:

On June 17, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 17, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 17, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 17, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 17, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Centracare Health - Monticello will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 17, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor

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

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 17, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@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 06/17/2021

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 6/14/21 to 6/17/21, a survey for compliance with CMS Appendix Z Emergency Preparedness Requirements was completed during a recertification survey. CentraCare Health - Monticello was found in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 6/14/21 to 6/17/21, a standard recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were completed at the time of the recertification survey. CentraCare Health - Monticello was found not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint(s) were found to be substantiated; however, no deficiencies were cited due to actions taken by the facility prior to the recertification survey: H5511080C (MN73295, MN73314) The following complaint(s) were found to be unsubstantiated: H5511075C (MN68621) H5511076C (MN70788) H5511077C (MN72234) H5511078C (MN72741, MN72804) H5511079C (MN73282) H5511081C (MN73735) 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 | 07/16/2021

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
	245511	A. BUILDING _____ B. WING _____	C 06/17/2021

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
F 000	Continued From page 1 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 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.	F 582		7/27/21

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 06/17/2021

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
F 582	Continued From page 2 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) to 3 of 3 residents (R58, R32, R30) reviewed whose Medicare Part A coverage ended and then remained in the facility. Findings include: R58's Notice of Medicare Non-Coverage (CMS-10123), dated 5/19/21, identified R58's last	F 582	Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS □ 10055) was issued to R58, R32, R30 and/or resident representative. All current residents of the facility will be audited to ensure they have received the correct SNF ABN; CMS 10055 document as applicable. Nurses, Social Worker and Household	

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	245511	A. BUILDING _____ B. WING _____	C 06/17/2021

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F 582	Continued From page 3 covered day of Medicare A would be 5/21/21. The form had dictation present which indicated it had been reviewed via telephone with R58's family member on 5/19/21 along with, "He is not choosing to file an appeal." R58's progress note, dated 5/19/21, identified the CMS-10123 was issued to R58 with a last covered day of 5/21/21. The note outlined, "Writer explained the reason for facility decision to end Skilled Nursing Facility therapy and nursing services on that date ... Planned discharge set for 5/24/21." In addition, R58's Advance Beneficiary Notice of Non-Coverage (ABN; CMS-R-131) had been provided which identified a potential cost of over $450.00 / day to R58 if paying privately for care and services at the facility. However, R58's medical record lacked evidence the required CMS-10055 had been reviewed and/or provided to R58 prior to their Medicare Part A coverage ending. R58's subsequent progress note, dated 5/24/21, identified R58 discharged home on 5/24/21 (three days after coverage ended). R32's Notice of Medicare Non-Coverage (CMS-10123), dated 4/30/21, identified R32's last covered day of Medicare A would be 5/6/21. The form had dictation present which indicated it had been reviewed via telephone with R32's family member on 4/30/21. R32's progress note, dated 4/30/21, identified the CMS-10123 was issued to R32 with a last covered day of 5/6/21. The note outlined, "Writer explained the reason for facility decision to end Skilled Nursing Facility therapy and nursing services on that date ... No planned discharge at	F 582	Coordinators will be re-educated regarding issuing Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS □ 10055) to residents and/or resident representatives. Director of Nursing, or designee, will audit charts of residents required to receive Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS □ 10055) to ensure proper notification is complete. Audits will be completed weekly for the first four weeks, monthly for three months and as determined by QA thereafter.	

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F 582	Continued From page 4	F 582		

this time." However, R32's medical record lacked evidence the required CMS-10055 had been reviewed and/or provided to R32 prior to their Medicare Part A coverage ending.

R32's subsequent progress note(s), dated 5/6/21 to 6/17/21, identified R32 remained in the nursing home until 6/9/21.

R30's Notice of Medicare Non-Coverage (CMS-10123), dated 5/6/21, identified R30's last covered day of Medicare A would be 5/8/21. The form was signed R30 on 5/6/21.

R30's progress note, dated 5/6/21, identified the CMS-10123 was issued to R30 with a last covered date of 5/8/21. The note outlined, "Writer explained the reason for facility decision to end Skilled Nursing Facility therapy and nursing services on that date ... No planned discharge at this time." In addition, R30's Advance Beneficiary Notice of Non-Coverage (ABN; CMS-R-131) had been provided which identified a potential cost of over $340.00 / day to R30 if paying privately for care and services at the facility. However, R30's medical record lacked evidence the required CMS-10055 had been reviewed and/or provided to R30 prior to their Medicare Part A coverage ending.

R30's subsequent progress note(s), dated 5/8/21 to 6/17/21, identified R30 remained in the nursing home.

When interviewed on 6/17/21, at 9:22 a.m. licensed social worker (LSW)-A voiced herself and the care management team were responsible to ensure the CMS-10123 and subsequent appeal notices, including the SNFABN, were

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F 582	Continued From page 5 provided to residents. LSW-A reviewed R58, R32 and R30 and verified each resident had been covered with only Medicare Part A coverage and transitioned to private pay when their coverage was ended when the SNF determined they would no longer qualify for coverage. LSW-A verified the CMS-10055 was not provided to the residents reviewed, and expressed she provided the form(s) which she had been shown when orientated to her role several months prior. LSW-A acknowledged she was unaware of the requirement to provide the CMS-10055 to residents who would remain in the SNF after their coverage ended and voiced residents should be provided the required forms to ensure "they're fully aware" of their potential costs and "their right" to file appeal. A provided Advanced Beneficiary Notices (ABN), Advanced Recipient Notice (ARN) and Patient Waivers policy, dated 8/2020, identified a procedure which directed to provide the ABN when there was knowledge or reasonable doubt the services would be covered. The policy outlined, "The patient [resident] must be advised before the item(s) or service(s) are furnished," and, "When the patient [resident] has straight Medicare and Medicaid, both an ABN and a ARN are required." However, the policy lacked any information or directive to use the CMS-10055 (SNFABN) when providing such notice.	F 582		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		7/27/21

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F 656	Continued From page 6 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 656	Hospice Care Plan has been	

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F 656	Continued From page 7 review, the facility failed to ensure a comprehensive care plan was developed and available to help outline services and care provided while on hospice for 1 of 1 residents (R53) reviewed for hospice care and services. Findings include: R53's significant change Minimum Data Set (MDS), dated 6/1/21, identified R53 had severe cognitive impairment and required supervision to complete most of her activities of daily living (ADLs). Further, the MDS outlined R53 had several medical complications including non-traumatic brain dysfunction, renal disease and dementia, and received hospice care while a resident at the nursing home. On 6/14/21, at 9:52 a.m. R52 was observed seated on her bed in her room. R53 appeared comfortable and lacked any obvious physical signs of pain; however, merely responded with nonsensical conversation when questioned about her care and services she received at the nursing home. R53's medical record, including electronic and hard copies, were reviewed. R53's Initial Coordination Note (hospice), dated 5/24/21, identified R53 started hospice care on 5/24/21, and listed several initial visit frequencies for each respective discipline (i.e., registered nurse, home health aide). R53's (nursing home) care plan, revised 6/2/21, identified R53 was on hospice and "in the dying process" due to dementia with weight loss. A goal was listed which outlined, "Hospice team and SNF [nursing home] will coordinate care via	F 656	incorporated into the comprehensive plan of care for R53. Facility will ensure all current residents receiving hospice services have a comprehensive care plan incorporated into the facility medical record. Facility Nurses, Social Worker and Household Coordinators, and Hospice Agencies with current residents receiving hospice in the facility, will be reeducated regarding ensuring a comprehensive care plan is developed and available in the medical record. Director of Nursing, or designee, will audit all hospice resident medical records to ensure the hospice care plans are developed and available in the facility medical record. Audits will be completed weekly for the first four weeks, monthly for three months and as determined by QA thereafter.	

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family/resident wishes ..." along with several interventions to help R53 meet this goal. These included, "Hospice HHA [home health aide] to assist with ADL and socialization per hospice care plan. Check hospice calendar for anticipated date of visit," and, "Hospice skilled nursing to visit per hospice care plan for resident assessment, chart review, pain assessment ... Check hospice calendar for anticipated date of visit." However, R53's medical record lacked any current hospice calendar for June 2021, nor was there any hospice care plan located to help determine what or when services would be provided to R53 to ensure the highest level of well-being was achieved.

On 6/16/21, at 9:50 a.m. nursing assistant (NA)-A stated R53 would often refuse cares and yell at them to "get out" of her room. NA-A voiced she was aware R53 had started hospice care, and had "seen them" present in the nursing home but expressed she was "not sure what they do" for R53.

When interviewed on 6/16/21, at 12:07 p.m. registered nurse manager (RN)-C stated R53 had "pretty severe" cognitive impairment and qualified for hospice care after having a noticeable weight loss. RN-C reviewed R53's medical record and expressed they completed R53's significant change in status (SCSA) MDS on 6/1/21, and signed the corresponding Care Area Assessments (CAAs) on 6/8/21 when they held her care conference. RN-C acknowledged R53's medical record lacked a hospice care plan or current calendar of their scheduled visits, and expressed she contacted hospice who reported they had failed to leave it in the record. RN-C added she was unaware "they [hospice] had a

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F 656	Continued From page 9 separate care plan" which needed to be in the medical record and expressed it was important to ensure care plans were updated and present in the medical record so staff were able to "provide the best care" for the resident. A provided Comprehensive Care Plans - Long Term Care policy, dated 6/2021, identified the facility must develop and implement a comprehensive person-centered care plan for each resident. These care plans must describe the services to be furnished to the resident to "attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being" and were to be developed with seven (7) days of the completion of the comprehensive assessment.	F 656		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		7/27/21

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F 755	Continued From page 10 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were properly documenting shift to shift narcotic count for 14/14 residents to prevent drug diversion. Findings include: During observation of narcotic count books, it was noted that approximately 25 signatures were missing for May 2021 and 22 missing for June 2021. During an interview on 06/16/21, at 01:43 p.m. registered nurse (RN)-A stated narcotics are signed off by two nurses for at administration, for shift count and disposal and then goes into the steri-cycle (box for safely destroying medications) for secure storage, DON reviews disposition. During interview on 6/16/21, at 2:30 p.m. RN-C stated all narcotics are counted at the change of each shift by the two staff members and then signed in the narcotic book. They do this to	F 755	Narcotic reconciliation process was reviewed, and deficient practices will be corrected with an identified process. Nursing staff will be re-educated regarding regulation and narcotic reconciliation documentation process. Director of Nursing, or designee, will audit to ensure compliance with narcotic reconciliation. Audits will be completed weekly for the first four weeks, monthly for three months and as determined by QA thereafter.	

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F 755	Continued From page 11 assure all medications are accounted for at shift change. During interview on 06/17/21, at 9:26 a.m. RN-D stated the facility used a book to count narcotics at the end of each shift and they were always counted with two people and signed when completed. RN-D further stated counting narcotics was important as it holds people accountable. During interview on 06/17/21, at 9:49 a.m. the director of nursing (DON) confirmed that the Narcotic Count should be completed by two people and signed for accountability and that it is unacceptable to have missing signatures. During interview on 06/17/21, at 10:49 a.m. the consulting pharmacist (CP), stated two people sign- duo signature verification that meds are all accounted for. Review of policy Medication Disposition (1/2021) indicated "all narcotics should have two signatures".	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		7/27/21

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F 758	Continued From page 12 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 758	R24, who was on hospice at the time of	

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F 758	Continued From page 13 facility failed to ensure non-pharmacological interventions were consistently attempted and/or documented prior to the administration of as-needed (PRN) psychotropic medication for 1 of 5 residents (R24) reviewed for unnecessary medication use. Findings include: R24's significant change Minimum Data Set (MDS), dated 4/23/21, identified R24 had severe cognitive impairment and demonstrated delusions and hallucinations. Further, the MDS outlined R24 required extensive assistance to complete most of her activities of daily living (ADLs), and she received antipsychotic and antianxiety medication on a daily basis. R24's Order Summary Report, signed 5/6/21, identified R24's current physician ordered medications. This included an order for lorazepam (an anti-anxiety medication) 0.5 milligrams (mg) by mouth every day; along with an additional order for lorazepam 0.5 mg by mouth every four (4) hours as-needed for anxiety and restlessness. R24's Medication Administration Record (MAR), dated 06/2021, identified R24's provided medications for the month, including as-needed medications. This identified R24 received the as-needed lorazepam a total of a nine (9) times so far in June 2021, with two of the nine episodes being recorded as ineffective in reducing the behavior R24 displayed. Further, R24's corresponding progress note(s) for the administrations identified a total of 10 entries had been completed in the record related to R24's as-needed lorazepam administration. However, of	F 758	survey, has since passed away. An audit will be done for all current residents receiving PRN psychotropic medications to evaluate the ongoing need of the PRN psychotropic medication. Nursing staff will attempt, and document, non-pharmacological interventions provided prior to PRN psychotropic medication administration. Nursing staff, Social Worker and Household Coordinators will be re-educated regarding attempting, and documenting attempts of, non-pharmacological interventions prior to administering PRN psychotropic medications. Director of Nursing, or designee, will audit current resident medical records with PRN psychotropic orders. Audits will be completed weekly for the first four weeks, monthly for three months and as determined by QA thereafter.	

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F 758	Continued From page 14	F 758		

the completed note(s) only two had any recorded non-pharmacological interventions recorded as being attempted prior to administration of the as-needed lorazepam. The remainder of the notes outlined:

On 6/2/21, at 4:27 p.m. R24 was recorded as being restless, reaching out towards the air and trying to stand up. R24 was administered the as-needed lorazepam; however, the note lacked any evidence non-pharmacological interventions had been attempted, and/or their effect, prior to the administration of the as-needed lorazepam. On 6/4/21, at 11:57 p.m. R24 was recorded as restless and attempting to self transfer. R24 was administered the as-needed lorazepam; however, the note lacked any evidence non-pharmacological interventions had been attempted, and/or their effect, prior to the administration of the as-needed lorazepam.

On 6/6/21, at 12:09 a.m., an administration was record without any recorded behaviors being displayed by R24, nor if any non-pharmacological interventions had been attempted, and/or their effect, prior to the administration of the as-needed lorazepam. An additional note, recorded on 6/6/21 at 4:11 a.m. outlined the as-needed lorazepam had again been administered but lacked any recorded behaviors being displayed by R24, nor if any non-pharmacological interventions had been attempted, and/or their effect, prior to the administration

On 6/12/21, at 1:59 a.m. R24 was recorded as restless and as-needed lorazepam was given. R24 was administered the as-needed lorazepam; however, the note lacked any evidence

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	245511	A. BUILDING _____ B. WING _____	C 06/17/2021

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 758	Continued From page 15	F 758		

non-pharmacological interventions had been attempted, and/or their effect, prior to the administration of the as-needed lorazepam. On 6/13/21, at 1:48 a.m. R24 was recorded as being restless and swinging her legs out of bed. R24 was administered the as-needed lorazepam; however, the note lacked any evidence non-pharmacological interventions had been attempted, and/or their effect, prior to the administration of the as-needed lorazepam.

On 6/14/21, at 7:32 a.m. R24 was recorded as being restless in the morning. R24 was administered the as-needed lorazepam; however, the note lacked any evidence non-pharmacological interventions had been attempted, and/or their effect, prior to the administration of the as-needed lorazepam. On 6/16/21, at 1:54 p.m. R24 was recored as attempting to remove her clothing, yelling out and grabbing at things. R24 was administered the as-needed lorazepam; however, the note lacked any evidence non-pharmacological interventions had been attempted, and/or their effect, prior to the administration of the as-needed lorazepam.

R24's medical record was reviewed and lacked evidence the staff had attempted any non-pharmacological intervention to reduce R24's behavior (i.e., toileting, repositioning) prior to administering the as-needed psychotropic medication.

When interviewed on 6/16/21, at 9:47 a.m. nursing assistant (NA)-A stated R24 had cognitive impairment and her communication was "just kind of random talking." R24, at times, did get agitated and the staff would often try to use a weighted blanket or have the nurses provide her with

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F 758	Continued From page 16	F 758		

medication to help her calm down. NA-A voiced she felt R24's behaviors were "about the same" in the past few months and expressed just visiting with R24 seems to help calm her down the best when she gets upset or seems restless.

On 6/16/21, at 1:41 p.m. registered nurse (RN)-D was interviewed. She expressed non-pharmacological interventions should be attempted and recorded in the progress notes prior to administering any as-needed medication. This was important to do as staff did not "want to medicate all the time" to control or reduce behaviors. Further, RN-D expressed she had "sometimes" noticed issues with other nurses not recording their non-pharmacological interventions in the record adding it seemed to struggle more on the long-term care unit(s).

When interviewed on 6/16/21, at 2:13 p.m. registered nurse manager (RN)-C stated she reviewed R24's medical record and verified it lacked evidence any non-pharmacological interventions were attempted prior to the as-needed lorazepam being provided. RN-C voiced the staff should be recording such interventions in their notes to ensure the resident was not provided "too much medication" and because the care team "needs to know what options we are trying" to reduce behaviors. Further, RN-C stated they had not been auditing or monitoring medical records to ensure staff were recording their non-pharmacological interventions prior to the standard survey.

A provided Psychotropic Medication Management - Long Term Care policy, dated 1/2021, identified each resident's medication regimen would be managed and monitored which included the use

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F 758	Continued From page 17 of gradual dose reductions and non-pharmacological interventions prior to starting or continuing psychotropic medication.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review the facility failed to ensure expired medications were removed from use on 2 of 4 medication carts reviewed for medication storage.	F 761	Expired Medications identified during survey were immediately removed from the med carts. Medications will be labeled with date open	7/27/21

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F 761	Continued From page 18 Findings include: During observation on 6/16/21, 1:43 p.m. 2 of 4 medication carts were reviewed and expired medications were found. -Lantus- no open date noted on vial, dose: 12 Units /HS- almost full pen -Unlabeled Beneprotein- Exp March 27, 2020 -Stock Tylenol 325mg- 1000 tablets opened 12/13/20- exp 3/21 -Lidocaine 1% vial- Mix 2.1ml in Rocephin (1g) -Ondansetron 4mg- Filled 3/17/20 and refill as needed through 3/17/21 During an interview with the consulting pharmacist (CP) on 06/17/21, 10:49 a.m. CP stated that it was important to use medications prior to their expiration date so that the medication was safe and effective during administered. The CP was then asked about expired Insulin Pens and stated, they should be writing the open date and expiration date on it and dates should be placed on the packaging right away, adding, there may be different expiration dates based on the manufacturer, a "cheat sheet" should be in the medication cart or available in the policy and procedure manual that we give staff. Typically, it's 28 but can be 18 or 14, as it depends on the insulin. During an interview on 06/17/21, at 09:49 a.m. with DON she stated Lidocaine Vials are mostly one time use and the night nurse does checks routinely as well as the pharmacy puts expiration dates on with a monthly cycle except TCU is two weeks. Staff should be writing the open date and expiration date after opening. A facility policy Medication Guidelines 6/2021	F 761	and expiration date. Staff will be re-educated regarding appropriate medication labeling. Director of Nursing, or designee, will audit each med cart and each med room weekly for four months for appropriate medication labeling and to ensure medications in med carts and med rooms are not expired.	

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F 761	Continued From page 19 states that "No discontinued, outdated, or deteriorated medications are available for use in this facility and that licensed staff will check expiration date/beyond use date on package/container."	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 842		7/27/21

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F 842	Continued From page 20 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain an accurate, complete and readily accessible medical record related to code status for 1 of 1 residents (R20)	F 842	POLST Form placed in Advance Directive section of medical record for R45. All current resident charts audited to	

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F 842	Continued From page 21 identified to not have Physician's Orders for Life Sustaining Treatment (POLST) in the designated area of the medical record. Findings include: R20's admission record dated 2/5/2018, indicated diagnoses included Amyotrophic lateral sclerosis (ALS), severe protein-calorie malnutrition, dysphagia, chronic pain syndrome, functional quadriplegia, major depressive disorder, and anxiety disorder. R20's quarterly minimum data set (MDS) dated 4/21/21, indicated cognition was intact. R20's care plan indicated "speech is slurred/mumbled-voice is soft. Depend on TOBII (mechanical device used to type or speak words). A review of R20's electronic medical record included orders for DNR/DNI (allow natural death). A review of R20's paper medical record revealed no POLST form or any other advanced care directives located directly behind the designated tab. During an interview on 6/15/21, at 12:48 p.m. registered nurse (RN)-A stated "I know she (R20) is a DNR/DNI but I don't see it in her advanced directives." "If someone coded and it is not clear what their wisher were, we would have to initiate CPR. Further, RN-A stated the source of truth was the paper chart. During an interview on 6/15/21, at 3:09 p.m. RN-B stated the process was to check the paper chart for a resident's code status behind the advanced directives tab, If it was not there it could delay action or create confusion.	F 842	ensure Advanced Directive documents are in correct location of medical records. Staff will be re-educated regarding proper location for advance directive documents in medical record. Director of Nursing, or designee, will audit resident charts to ensure advanced directive forms are in the proper location of the medical record. Audits will be completed weekly for the first four weeks, monthly for three months and as determined by QA thereafter.	

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F 842	Continued From page 22 During an interview on 6/17/21, at 11:31 a.m. the director of nursing (DON) stated it was her expectation the POLST form was located behind the advanced directives tab in the paper chart. Further, there needed to be quick and consistent access during emergent situations. The Advance Directive/POLST policy, last approved 6/2021 directed residents health care wishes would be documented and respected, however, the policy lacked direction where the form was located in the paper chart.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		7/23/21

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F 880	Continued From page 23 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 24 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was performed during medication administration for 1 of 1 residents (R45) reviewed for infection control. Findings include: During observation on 6/15/21, at 7:04 p.m. registered nurse (RN)-D was observed preparing Ampicillan for R45. Proper hand hygiene was completed while preparing the solution and upon entering the room. RN-D set up the IV pump, programming the rate and the dose. RN-D proceeded to clean the PICC line with the alcohol swab and flush with saline without donning gloves. During interview on 6/15/21, at 7:05 p.m. RN-D stated that gloves did not need to be worn when providing PICC antibiotic as she was not taught this in nursing school. However, upon orientation competency review, it was noted that RN-D was trained on proper facility protocol on administering IV (intravenous) antibiotics. During interview on 6/15/21, at 7:25 p.m. RN-E stated she does not work with central lines often however, the steps included checking the site, assuring the line was patent, check the dressing and gloves should be worn. RN-E further stated that it was important to wear gloves to prevent infections.	F 880	Re-education completed with the nurse observed during survey resulting in this deficiency. No impact to R45 due to the deficient practice. Root Cause Analysis has been completed to identify the problem that resulted in this deficiency and interventions for corrective action will be implemented to prevent recurrence. Nursing staff re-education and competency to be completed regarding proper hand hygiene and hand hygiene with Vascular Access. Hand Hygiene re-education and competency will be completed by Care Center staff. Hand hygiene policies and procedure have been reviewed to ensure they meet CDC guidance and CMS requirements and will be reviewed as needed. Competencies for Hand Hygiene and Vascular Access will be included in our new hire Competency Based Orientation program. Director of Nursing, or designee, will complete hand hygiene audits. Audits will	

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F 880	Continued From page 25 During interview on 6/16/21, at 8:30 a.m. RN-F stated when completing the 5 medication administration checks (a standard of practice to reduce errors while administrating medications), applying gloves for infection control would be very important when working with PICC lines. During interview on 6/16/21, at 8:33 a.m. RN-G reviewed the steps for administering medication through a picc line and stated wearing gloves would be important because it is a direct line to the resident's vein. During interview on 06/17/21, 9:49 a.m. the director of nursing (DON) stated gloves should always be worn while administering IV medications or while working with a PICC line for infection control purposes. It was taught in orientation and staff should be aware of this. Reviewed RN-D competency and according to the record she was educated on proper protocol and policy/procedure on administration of medication through a picc line. Peripheral IV Catheter- Long Term Care policy 5/2020 reviewed and states "midline catheter maintenance- Midline catheters will be considered a type of peripheral catheter" in that hand hygiene and donning gloves is an expectation.	F 880	be completed weekly for the first four weeks, monthly for three months and as determined by QA thereafter. DPOC Documents submitted via email to Susie Haben on 7/23/2021.	

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	245511	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/17/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey the Centracare Health - Monticello Nursing Home 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/16/2021

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
	245511	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/17/2021**

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 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail 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 89 beds and had a census of 61 beds 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.	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was	K 321	Storage room door A112 on the 2nd floor	7/27/21

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K 321	Continued From page 3 revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect 10 of 89 residents. Findings include: On 06/17/2021, at 10:53 a.m. during the facility tour observations revealed that the doors to the storage room A112 on the 2nd floor of the facility did not a self-closing device to ensure that the door positively latch into the frame. This deficient condition was verified by the Maintenance Supervisor.	K 321	of the facility has had self-closing device installed to ensure the door positively latches to the frame. Care Center hazardous areas will be audited to ensure doors for hazardous areas shall be self-closing or automatic closing. Administrator or designee will complete annual audit of hazardous areas to ensure self-closing or automatic closing door requirements are met.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of all	K 345	Facility has completed a semi-annual	7/27/21

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K 345	Continued From page 4 available documentation, the facility has not maintained the fire alarm system testing and maintenance documentation in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 9.6.1.3, and .NFPA 72 National Fire Alarm Code 2010 edition, section 14.3.1. This deficient practice could affect 89 of 89 residents. Findings include: On 06/17/2021, at 9:30 a.m., during the review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor it was revealed that the facility did not conduct a semi-annual visual inspection of the fire alarm initiating devices. This deficient condition was verified by the Maintenance Supervisor.	K 345	visual inspection of the fire alarm initiating devices. Facility will continue with ongoing semi-annual visual inspections of the fire alarm initiating devices. Administrator or designee to audit semi-annual visual inspections of the fire alarm initiating devices.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced	K 712		7/27/21

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K 712	Continued From page 5 by: Based on staff interview and a review of the available documentation, it was determined that the facility failed to conduct 1 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition, sections 19.7.1.2 and 19.7.1.6, during the last 12 months. Thess deficient conditions could affect 89 of 89 residents. Findings include: On 06/17/2021, at 10:00 a.m., during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility did not conduct a 1st shift (day) fire drill in the 3rd quarter within the last 12 month period. This deficient condition was verified by the Maintenance Supervisor.	K 712	Facility to complete drills at least quarterly on each shift at expected and at unexpected times under varying conditions. Administrator or designee to audit fire drill completion quarterly for six months and thereafter as determined by QA.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced	K 901		7/27/21

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K 901	Continued From page 6 by: Based on staff interview and a review of all available documentation, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient condition could affect 89 of 89 residents. Findings include: On 06/17/2021, at 10:20 a.m. during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility could not provide a completed utility risk assessment document at the time of the inspection. The utility risk assessment that was provided at the time of the inspection did not cover patient care equipment as detailed in NFPA 99 "Health Care Facilities Code" 2012 edition Chapter 10 - Electrical Equipment, and Chapter 11 - Gas Equipment. This deficient condition was verified by the Maintenance Supervisor.	K 901	Facility has completed the Facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. BioMed will ensure Facility Risk Assessment is reviewed annually. Administrator or designee to audit annual completion of Facility Risk Assessment	