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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QN96

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 **05/10/2016** (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:
X 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 :
Brenda Fischer, Unit Supervisor 05/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 05/16/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
__X__ 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
05/09/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245511
May 16, 2016

Mr. Troy Barrick, Administrator
Centracare Health - Monticello
1013 Hart Boulevard
Monticello, Minnesota 55362

Dear Mr. Barrick:

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 April 26, 2016 the above facility is certified for or recommended 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 16, 2016

Mr. Troy Barrick, Administrator
Centracare Health - Monticello
1013 Hart Boulevard
Monticello, Minnesota 55362

RE: Project Number S5511025

Dear Mr. Barrick:

On April 12, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 17, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On May 10, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 27, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 17, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 26, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 17, 2016, effective April 26, 2016 and therefore remedies outlined in our letter to you dated April 12, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245511 Y1	A. Building B. Wing Y2	5/10/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 04/26/2016	ID Prefix F0322 Reg. # 483.25(g)(2) LSC	Correction Completed 04/26/2016	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 04/26/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 05/16/2016	SIGNATURE OF SURVEYOR 10562	DATE 05/10/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/17/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245511	A. Building 01 - MAIN BUILDING 01 B. Wing	4/27/2016

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0054	Correction Completed 04/26/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** TL/KJ	**DATE** 05/16/2016	**SIGNATURE OF SURVEYOR** 34764	**DATE** 04/27/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/15/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QN96

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00717

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(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: **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 **03/17/2016** (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

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 — 04/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/04/2016 (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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 30, 2016

Mr. Troy Barrick, Administrator
Centracare Health - Monticello
1013 Hart Boulevard
Monticello, Minnesota 55362

RE: Project Number S5511025

Dear Mr. Barrick:

On March 17, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Minnesota Department of Health
Telephone:
Fax:

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 26, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved

and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 17, 2016 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 September 17, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

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

Feel free to contact me if you have questions.

Sincerely,

, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: Fax:

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245511	A. BUILDING _____ B. WING _____	03/17/2016

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	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the dignity of private space was maintained for 2 of 3 residents (R200, R39) reviewed for dignity. Findings include: R200's Brief Interview for Mental Status (BIMS), a tool used to determine cognition, dated 3/3/16, identified R200 had intact cognition. On 3/14/16, at 8:26 a.m. R200 was being interviewed by the surveyor for stage I of the	F 241	It is the policy of the facility to ensure the dignity and private space for all residents. It is also the policy and procedure for Monticello Care Center staff to knock on all resident doors and await for acknowledgement prior to entering a resident room. Staff education was provided to all staff on 04/05/16 and on 04/07/16 regarding the expectation for knocking on the resident door prior to entering. Physician (MD-A)	4/26/16

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

Electronically Signed | 04/22/2016

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 _____	03/17/2016

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 241	Continued From page 1 quality indicator survey (QIS) in her room with the door closed. At 8:36 a.m. medical doctor (MD)-A suddenly opened R200's room door and entered without knocking or allowing R200 to invite him inside. MD-A discussed several medical concerns with R200, and left the room closing the door behind him, while the surveyor was present. When interviewed on 3/14/16, at 8:41 a.m. R200 stated she didn't like when staff just opened her closed door and entered without being invited, "That I didn't like." R200 stated she had been in the bathroom with the door open a couple days prior, and staff just opened the room door and came in then as well which also was upsetting to her, "Things like that, I don't approve of." Further, R200 stated there was, "Quite a few" staff members who don't knock before they come into her room, and she wished they would. R39's 5-day Prospective Payment System (PPS) Minimum Data Set (MDS) dated 2/7/16, identified R39 had intact cognition. During interview on 3/14/16, at 9:41 a.m. R39 stated staff will consistently knock on her door, but will open it up right away after knocking and not wait for her to answer which she did not like. R39 stated she had been using the bathroom before and had staff come in without being invited, and it makes her feel like she has no privacy. Further, R39 stated she now locks the bathroom door to prevent staff from opening it without being invited to do so. When interviewed on 3/15/16, at 1:16 p.m. nursing assistant (NA)-A stated all staff should, "Knock on the door" before entering a resident's	F 241	was also educated and informed of this expectation during the time of the survey. A dignity policy and procedure was in draft form at the time of survey and was approved at the Quality Assurance Meeting on 04/21/16. Audits will be conducted weekly for (4) weeks, then monthly for (2) months and randomly throughout the year to monitor compliance with the policy and procedure for knocking on a resident door, and waiting for acknowledgement to enter when a resident is able to do so. Audits will be reviewed quarterly by the Quality Assurance Committee. Responsible Persons: Director of Nursing Director of Social Services	

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	245511	A. BUILDING _____ B. WING _____	03/17/2016

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F 241	Continued From page 2 room to respect their privacy. NA-A stated she had noticed some staff not knocking or waiting for a response before entering resident rooms before, but added staff, "Try to" do it when they remember. Further, NA-A stated staff are trained to knock on resident room doors and wait for a response during their annual in-service. During interview on 3/15/16, at 1:29 p.m. registered nurse (RN)-D stated staff should be knocking on a resident door and waiting for a response before entering the room to provide, "Polite dignity" to the resident. When interviewed on 3/15/16, at 1:41 p.m. RN-E stated all staff, including the physicians working at the facility, should knock on the door and wait to be welcomed by the residents before going into their room because, "This is their home." A facility policy on dignity was requested, but none was provided.	F 241		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration,	F 322		4/26/16

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	245511	A. BUILDING _____ B. WING _____	03/17/2016

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 322	Continued From page 3 metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure feeding tube placement was appropriately checked prior to instillation of medications for 1 of 2 residents (R11) observed to receive medication through their feeding tube during the survey. Findings include: R11's quarterly Minimum Data Set (MDS) dated 2/3/16, identified R11 received no nutrition by mouth (NPO) and used a tube feeding while a resident in the facility. R11's Nutritional Status Care Area Assessment (CAA) dated 11/23/15, identified R23 was NPO and, "All nutritional needs for calories, protein and fluid are met via tube feedings and flushes." Further, the CAA directed staff to, "Proceed to nutritional plan of care to maintain stable weights with tube feeding while avoiding complications [i.e. GI [gastrointestinal] distress, aspiration [inhalation of liquid or gastric contents into lungs], s/sx [signs and symptoms] intolerance.]" R11's care plan dated 11/24/15, identified R11 used a tube feeding and directed staff to, "Check placement of tube feeding prior to medication administration, tube feeding, flushes and PRN [as	F 322	It is the Policy and Procedure of the facility to verify feeding tube placement prior to the instillation of medications. Resident R11 did not have any complications related to the instillation of medications and water prior to checking placement. Registered Nurse (RN-A) did complete a Tube Feeding Audit for Administration on 02/02/16. Staff re-education was provided to Licensed Nurses on 04/05/16 and 04/07/16. Competency check off audits will be conducted in addition to written education by 04/26/16. Audits will be performed monthly for three months and then randomly thereafter. Results of the audits will be reviewed quarterly by the Quality Assurance Committee. Responsible Person for compliance: Director of Nursing	

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CENTRACARE HEALTH - MONTICELLO	1013 HART BOULEVARD MONTICELLO, MN 55362

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F 322	Continued From page 4	F 322		

needed]."

R11's physician orders dated 1/18/16, identified R11 had a J/G tube (which is a single tube with multiple ports- the jejunostomy enters the small intestine and the gastrostomy enters the stomach), placed and directed staff to, "Check placement [of gastrostomy tube] prior to administration of any medications, water flushes, or tube feeding product. Auscultate [listen with a stethoscope] with 15-30 cc's [cubic centimeters] of air. Stop once placement is verified."

During observation of medication instillation into R11's gastrostomy tube on 3/15/16, at 3:46 p.m. registered nurse (RN)-A entered R11's room with medications to be given. RN-A turned off the running tube feeding which was infusing into R11's jejunostomy tube and flushed the jejunostomy tube with approximately 30 cc's of water while using a stethoscope to auscultate R11's stomach, where the gastrostomy tube was located to check placement of the jejunostomy tube, and not the gastrostomy tube. RN-A poured 30 cc's of water into an open syringe attached to R11's gastrostomy tube followed by medications then additional water. RN-A did not check for correct placement of the gastrostomy tube to prevent aspiration.

When interviewed on 3/16/16, at 7:50 p.m. RN-A stated she could not recall how she checked placement for R11's medication administration using the gastrostomy tube when observed on 3/15/16. RN-A stated she was unsure why she would have flushed the jejunostomy tube instead of the gastrostomy tube, but added the gastrostomy tube should be checked for

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CENTRACARE HEALTH - MONTICELLO	1013 HART BOULEVARD MONTICELLO, MN 55362

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F 322	Continued From page 5 placement when giving water or medications, "I really don't remember." Further, RN-A stated she was unsure of the facility policy for checking jejunostomy tube placement. When interviewed on 3/17/16, at 9:23 a.m. RN-C stated the facility policy was to check placement of any feeding tubes with air instead of water, and RN-A should have checked R11's gastrostomy tube for placement instead of the jejunostomy tube prior to infusing water and medications. A facility Feeding Tube Instilling Medications policy dated 1/14/14, directed staff to, "Check placement and patency of all feeding tubes," and, "Tubes that are sutured into place, such as an abdominal PEG tube [type of G-tube], must be checked for proper placement by auscultation air injected in the tube over the epigastric region." However, the policy did not identify any instructions of the care or checking of a jejunostomy tube.	F 322		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 323	It is the Policy of the facility to complete	4/26/16

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	245511	A. BUILDING _____ B. WING _____	03/17/2016

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 323	Continued From page 6 facility failed to comprehensively assess safety with smoking for 1 of 1 residents (R27) identified to be smoking while residing at the facility. Findings include: R27's admission Minimum Data Set (MDS) dated 2/26/16, identified R27 had intact cognition, used a wheelchair for mobility and required limited assistance with off-unit locomotion. R27's Diagnosis Report dated 3/2/16, identified R27 had a diagnosis on admission to the facility of, "Personal history of nicotine dependence." On 3/14/16, at 9:37 a.m. R27 was being interviewed about her bathing choices, she asked the surveyor if they had some matches. R27 stated she had cigarettes left and wanted matches so she could smoke them. When questioned about missing personal items, R27 responded, "Just my matches." R27's progress notes were reviewed and identified the following entries by staff into R27's medical record: On 3/13/16, R27 offered staff money to purchase cigarettes for her. The staff reported it to the nurse who identified R27 was, "Reminded that she has cigarettes in the Med [medication] room/ Told writer later that she forgot. Was given one cigarette at this time." On 3/7/16, R27 stated to staff she, "Had one cigarette yesterday in the parking lot..." The staff, "Informed resident on CentraCare's non-smoking policy and [R27] stated, 'I know, I know."	F 323	all required Assessments for all residents. Resident R-27 was identified as a resident who had a history of smoking prior to admission and upon admission was not smoking while participating in rehab on the TCU. Resident R-27 did begin to smoke on 03/05/16 and had again ceased smoking on 03/14/16. During the actual survey from 03/14/16-03/17/16, Resident R-27 was not participating in smoking, and had agreed to wear the Nicotine patch as part of her smoking cessation program. A smoking assessment was completed on 03/22/16 that indicated that Resident R-27 was safe to participate in smoking independently if she elected to smoke again. Although CentraCare Health Monticello is a non-smoking facility, the facility will comprehensively assess and Care Plan a resident who indicates that they may wish to smoke while residing in the Care Center to maintain safety. Resident R-27 has discharged to home, and currently there are no residents who are currently smoking in the facility. The facility will comprehensively assess and care plan all residents who indicate that they may wish to smoke. Audits will be conducted and presented to the Quality Assurance Committee if a resident has been assessed for smoking. Responsible Person:	

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	245511	A. BUILDING _____ B. WING _____	03/17/2016

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CENTRACARE HEALTH - MONTICELLO	1013 HART BOULEVARD MONTICELLO, MN 55362

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F 323	Continued From page 7 On 3/5/16, R27 was, "Noted to be outside smoking this shift," and the staff found cigarettes in her room when they searched it. R27's care plan dated 3/2/16, identified R27 was at risk for falls and, "May be unable to summon help in an emergency due to physical or mental disabilities," adding R27, "May be unable to identify and/or escape a hazardous situation." However, R27's care plan lacked any indication R27 was currently smoking, or any indication of how much assistance she needed to safely smoke while at the facility. Review of R27's medical record, and progress notes identified a comprehensive smoking assessment had not been completed to determine if R27 was safe to smoke while at the facility, either with or without assistance from the staff. During interview on 3/15/16, at 1:16 p.m. nursing assistant (NA)-A stated R27 had asked staff, visitors and the care cab driver before for cigarettes, at times offering them money to go purchase them for her. NA-A stated R27 had been found to have cigarettes in her room before, but NA-A added she had never personally observed her to be smoking. NA-A stated R27 was independent with her locomotion in her wheelchair and at times will go outside on her own. Further, NA-A stated R27 had stayed at the facility before, and R27's smoking had, "Kinda been an issue before," but NA-A was unable to recall why it had been of concern on her past admissions to the facility. When interviewed on 3/15/16, at 1:41 p.m. registered nurse (RN)-E stated all residents who	F 323	Director of Nursing	

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CENTRACARE HEALTH - MONTICELLO	1013 HART BOULEVARD MONTICELLO, MN 55362

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F 323	Continued From page 8 wished to smoke had to leave the grounds to do so. The facility currently had a resident, R27, who still smokes, "Maybe once a week," and leaves the premises to do so when staff provide her cigarettes from the medication room. RN-E stated the facility had not assessed her ability to smoke, including lighting the cigarette and safety with ashing or extinguishing the cigarette adding when R27 left the grounds to smoke, R27 was responsible for her own safety. Further, RN-E stated there was, "Probably a whole lot of tings that could happen" to a resident if they were smoking and not safe to do so, including, "[R27] could burn herself." During interview on 3/15/16, at 3:32 p.m. the director of nursing (DON) stated the facility had no formal policy on how to complete a smoking assessment, and added R27 had not been comprehensively assessed for safety with smoking, despite staff keeping cigarettes for her in the medication room, "There was not a formal assessment done, no." Further, the DON stated the facility was responsible for R27's safety and should have comprehensively assessed her ability to smoke, "We have to make that assessment."	F 323		

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

F5511024

PRINTED: 04/25/2016
FORM APPROVED
OMB NO. 0938-0391

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 _____	**03/15/2016**

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CENTRACARE HEALTH - MONTICELLO	**1013 HART BOULEVARD** **MONTICELLO, MN 55362**

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K 000	INITIAL COMMENTS 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 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/22/2016

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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	245511	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/15/2016**

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K 000	Continued From page 1 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency 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 76 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 054 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 Findings include: On facility tour between 9:30 AM and 1 00PM on 03/15/2016, records review revealed the facility did not have the required documentation for the smoke detector sensitivity testing. This deficient practice was confirmed by the Maintenance Supervisor.	K 054	All required smoke detectors for the nursing home, including those activating door hold-open devices, will have required documentation for the smoke detector sensitivity testing.	4/26/16