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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: UYKW
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 **03/02/2015** (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 03/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 03/11/2015 (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
02/23/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245511
Electronically Delivered
March 11, 2015

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 February 24, 2015 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
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 11, 2015

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

RE: Project Number S5511024

Dear Mr. Barrick:

On January 30, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 15, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 2, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 15, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 24, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 15, 2015, effective February 24, 2015 and therefore remedies outlined in our letter to you dated January 30, 2015, 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
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245511	A. Building B. Wing	3/2/2015

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).

(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	**02/24/2015**
ID Prefix **F0176** Reg. # **483.10(n)** LSC	**02/24/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**02/24/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	**02/24/2015**
ID Prefix **F0466** Reg. # **483.70(h)(1)** LSC	**02/24/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	03/11/2015	10562	3/2/2015
CMS RO				

Followup to Survey Completed on: 1/15/2015

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
245511	CENTRACARE HEALTH - MONTICELLO

Type of Survey (select all that apply)

I	D			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
M Other
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 10562			0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.25

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 3.25

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

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

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ID: UYKW
Facility ID: 00717

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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 **01/15/2015** (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:
X 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: **A1*** (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 :
Bruce Melchert, HFE NE II 02/11/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 02/20/2015 (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
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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
Posted 02/23/2015 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 30, 2015

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

RE: Project Number S5511024

Dear Mr. Barrick:

On January 15, 2015, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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:

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - 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;**
>
> **<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6**

months after the survey date; and

<u>Informal Dispute Resolution</u> **- 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:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

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 February 24, 2015, 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 April 15, 2015 (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 July 15, 2015 (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

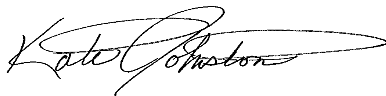
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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.

Feel free to contact me if you have questions.

Sincerely,



Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992   Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

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 ______	01/15/2015

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 A recertification survey was conducted and complaint investigation was also completed at the time of the standard survey. An investigation of complaint #H5511029 was completed. The complaint was not substantiated. 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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is	F 156		2/24/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 02/05/2015

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 ______	01/15/2015

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 156	Continued From page 1 entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; 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 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. 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 or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone	F 156		

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F 156	Continued From page 2 numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide appropriate liability notices or denial letter prior to discharge from Medicare services for 2 of 3 residents (R40, R43) reviewed for liability notices. Findings include: R40 was discharged from Medicare services on 10/10/14, according to R40's Notice of Medicare Non-Coverage, a Medicare liability notice. R40 remained in the facility. The facility failed to provide Skilled Nursing Facility Advance	F 156	Resident #40 and Resdient #43 remain in the facility and have had no change in coverage requiring a liability notice or denial letter. Staff that is responsbile to issue liability notices or denial letters has had training on the required forms and documentation. Audits wil be completed weekly for 4 weeks, and monthly for 2 months on	

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F 156	Continued From page 3 Beneficiary Notice, a Medicare liability notice that would allow R40 the choice to submit the facility bill to Medicare for review. During interview on 1/14/15, at 2:00 p.m., finance coordinator (FC) verified R40 did not receive the Skilled Nursing Facility Advance Beneficiary Notice or denial letter. R43 was discharged from Medicare services on 10/15/14, according to R43's Notice of Medicare Non-Coverage, a Medicare liability notice. R43 remained in the facility. The facility failed to provide Skilled Nursing Facility Advance Beneficiary Notice, a Medicare liability notice that would allow R43 the choice to submit the facility bill to Medicare for review. During interview on 1/14/15, at 2:00 p.m., finance coordinator (FC) verified R43 did not receive Skilled Nursing Facility Advance Beneficiary Notice or denial notice. During interview on 1/15/15, at 8:23 a.m., registered nurse-C (RN-C) stated R40 and R43 both received verbal and written notice to request an immediate appeal from the Quality Improvement Organization (QIO) (CMS 10123) but did not receive the Skilled Nursing Facility Advance Beneficiary Notice or denial letter, which allowed the choice to have the facility bill reviewed by Medicare. During interview at that time, RN-C confirmed R40 and R43 lacked decision to submit or not submit the bill to Medicare for review. Although RN-C stated she had received additional training on the Medicare denial process. Review of the Medicare information training for RN-C, identified that training occurred	F 156	residents who have received a liability notice or denial letter to monitor compliance iwth the required forms/documentation. Audit results will be reviewed by the QA Committee to determine further audit schedules. The Director of Nursing or designee is responsible to maintain compliance.	

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F 156	Continued From page 4 7/2014, even though R40 and R43 had notices occurring in 10/2014. Document review of facility Medicare Forms Summary Key Concepts Regarding Liability Notices and Resident Appeal Rights dated 1/2012, identified the skilled nursing facility provider may use either the Skilled Nursing Facility Advance Beneficiary Notice or one of the Denial Letters from the Centers for Medicare and Medicaid Services (CMS) website for Medicare skilled services, which did not occur.	F 156		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and care plan the self administration of nebulizers for 1 of 8 residents (R139) who was observed to receive medication during the course of the survey. Findings include: R139's admission Minimum Data Set (MDS), dated 12/29/14, identified R139 had intact cognition, and a diagnosis of heart failure. During observation of nebulizer medication administration on 1/15/15 at 8:45 a.m., registered	F 176	Resident 139 has discharged from the facility. The Medication Administration Policy/Procedure, including self-administration of medication criteria, has been reviewed and approved by the Medical Director. Upon admission, residents who choose to self-administer drugs will be assessed to ensure they are safe to do so. The Nursing Admission Assessment document will be completed to reflect this information. The physician order will	2/24/15

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F 176 Continued From page 5

nurse (RN)-D placed a liquid medication solution into a nebulizer machine, and handed the mouthpiece to R139 for her to hold while the medication was administered. R139 stated, "Am I supposed to hold on to this?" RN-D provided her instruction on how to hold the device, then left the room after turning the device on to deliver the medication. R139 remained in her room, holding the device until 8:54 a.m.. Nursing assistant (NA)-F entered the room, and turned the machine off and assisted R139 into the hallway to obtain her weight. NA-F returned R139 to her room, turned the machine on, and handed the mouthpiece back to R139 to continue with her nebulizer treatment, with the medication ceasing at 9:00 a.m.. R139 continued to hold the device after the medication ceased until RN-D returned to the room at 9:02 a.m. and turned off the machine.

R139's Care Center Standing House Orders, signed 1/7/15, indicated, "Resident may self administer nebulizer after initial set up by licensed nurse. Self administration of medications (SAM) assessment to be completed prior to self administration."

R139's Nursing Admission assessment, dated 12/29/14, identified a section for respiratory assessment which included nebulizer use. The following fields were able to be selected: self administer, monitor, or order. However, this section of the assessment was blank and not completed.

R139's care plan, dated 12/22/14, identified R139 was hospitalized in December 2014 for shortness of breath and weakness, however did not indicate if she was able to self administer her own

F 176

include the self-administration information.

Current residents who request to self administer drugs have been assessed to determine if they are safe to administer drugs. The assessments are reviewed by the IDT. Care plan are updated to reflect the resdient's ability to self-administer drugs.

Residents with current orders for nebulizer treatments have been re-assessed to ensure they are safe to self administer the nebulizer treatment after set-up. Their care plans have been updated to reflect the self-administration. Physician orders have been reviewed/updated to reflect the self-administration information.

Nurses have been educated on the process for assessing a resident's ability to self-administer medication, and expectation of physician orders and care plan documentation.

Audits will be completed weekly for 4 weeks, then monthly for 2 months, to monitor compliance on assessment and documentation required for residents who self-administer medications.

Audit results will be reviewed by the QA Committee to determine further auditing schedules.

The Director of Nursing or designee is responsible for monitoring compliance.

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F 176	Continued From page 6 medications or nebulizers. When interviewed on 1/15/15 at 9:08 a.m., RN-D stated R139 had a standing order for the self administration of her nebulizers, however no assessment had been completed prior to ensure she was safe to self administer her own nebulizer medications as directed by the physicians standing order. During interview on 1/15/15 at 9:16 a.m., RN-B stated R139 should have completed self administration of medication assessment before being left alone with her nebulizer treatments, "I would have liked to have seen that completed when she admitted." When interviewed on 1/15/15 at 12:48 p.m., the director of nursing (DON) stated R139 should not have been left alone with her nebulizer treatment without an assessment being completed to ensure she was able to perform the treatment safely. A facility Care Center - Medication Administration policy, dated 8/28/14, indicated a purpose, "To ensure the safe and effective administration of medications by qualified personnel." Further, the policy indicated, "Residents shall not be allowed to self-administer any medications unless an assessment is completed indicating self-administration is appropriate and specifically allowed by the provider, determined appropriate by the interdisciplinary team, and as indicated in the comprehensive care plan.	F 176		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		2/24/15

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F 282	Continued From page 7 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement the care planed interventions for 2 of 10 residents (R16, and R23) in the sample reviewed for pressure ulcers and toileting. Findings include: R16's current physician orders dated 12/19/14, indicated she had unspecified disorder of skin and subcutaneous tissue and osteoporosis. R16's quarterly Minimum Data Set (MDS) dated 11/19/14, indicated she was moderately cognitively impaired, needed extensive assist of two with transfers, mobility, toileting and was at risk for pressure ulcers. A Care Area Assessment Worksheet (CAA) dated 8/27/14, identified she was at risk for pressure ulcer, was immobile and had pain. A Tissue Tolerance Observation dated 8/15/14, indicated R16 to be repositioned every two hours while lying or sitting. R16's care plan dated 10/15/14, indicated she was at risk for skin integrity impairment due to impaired mobility and risk for friction and sheer, long history of pressure ulcers. The care plan directed staff to reposition R16 according to her tissue tolerance. R16 also had a catheter and staff were to check and change her pad every two hours.	F 282	Resident 16 and Resident 23 have had new Tissue Tolerance forms completed to determine current lying and sitting repositioning needs. Their care plans have been updated to reflect current repositioning needs. The Tissue Tolerance Policy/Procedure has been reviewed and approved by the Medical Director. Residents who have not had a Tissue Tolerance form completed in the past 90 days have had a new Tissue Tolerance form completed and care plan updated. Residents who have had a Tissue Tolerance form completed in the past 90 days have had them reviewed to ensure it still meets the resident's needs. Care Plans have been reviewed/updated to reflect current repositioning needs. Staff has been educated on the expectation for following the individualized resident care plans. Audits will be completed daily for 2 weeks, weekly for 4 weeks, and monthly for 1 month to monitor compliance for repositioning residents as stated in their care plan. Audits will be conducted to	

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F 282	Continued From page 8 During continuous observation on 1/14/15 at 6:53 a.m. to 9:30 a.m. (2 hours and 37 minutes) R16 was observed to be lying in her bed watching television. At 7:27 a.m. nursing assistant (NA)-B entered R16's room and checked with her to see if she needed water. At 7:58 a.m. Licensed Practical Nurse (LPN)-A entered her room and gave her medications. At 8:01 a.m. R16 turned on her call light, NA-B entered room and R16 requested her breakfast. At 8:15 a.m. R16 was eating her breakfast and at 8:30 a.m. the resident continued to watch her television while lying in bed. During this time LPN-A and NA-B made no attempt to check/change or assist R16 with repositioning while in bed. During interview 1/14/15 at 9:30 a.m. NA-A stated R16 was changed and repositioned at 6:30 a.m. and stated they are to check/change and reposition her every two to three hours. NA-A then proceeded to change R16 at this time and her incontinent product was dry, with no red pressure areas noted. During interview 1/14/15, at 9:55 a.m. Registered Nurse (RN)-A stated according to R16's tissue tolerance and care plan she should have been repositioned and changed after two hours. R23's diagnoses, identified on current physician orders dated 12/10/14, included amputation, and venous insufficiency. R23's admission MDS dated 9/25/14, indicated impaired cognition, extensive assist of one with transfer, bed mobility and toileting. The MDS further indicated she was incontinent of urine and was at risk for pressure ulcers but has no pressure ulcers. A Tissue	F 282	cover all shifts. Audit results will be reviewed by the QA Committee to determine further auditing schedules. The Director of Nursing or designee is responsible for maintaining compliance.	

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F 282	Continued From page 9	F 282		

Tolerance Observation form dated 9/21/14, indicated R23 will be turned and repositioned every two hours lying and sitting. A Tissue Tolerance form dated 12/19/14, indicated R23 could tolerate two hour repositioning program lying. The form was not completed for sitting position.

R23's care plan dated 9/18/14, indicated she had potential for skin integrity impairment r/t frequent bladder incontinence and mobility impairment. The care plan interventions included air mattress, inspect skin with cares, licensed nurse to observe skin weekly, position body with pillows, pressure reduction cushion in wheelchair and "turn and reposition per tissue tolerance."

Review of R23's Weekly Skin Assessment Evaluation form, dated 1/14/15, indicated a skin concern on her right lower buttock 3.5 x 2.5 cm pink skin, bleachable, slightly rough.

During observation on 1/14/15, at 7:16 a.m., R23 was lying in bed with RN-A assessing R23's skin, and stated she (R23) had red area on her right buttock. At 7:45 a.m. R23 was wheeled to the dining room, returned at 8:55 a.m. and was then wheeled to the front of the day room facing the nurses station. At 9:20 a.m. the resident was wheeled to an activity and remained in the activity until 9:50 a.m.

During interview 1/14/15 at 9:50 a.m. NA-B stated the last time they had repositioned R23 was when she was dressed for the day around 7:30 a.m., 2 hours and 20 minutes earlier.

During interview 1/14/15, at 9:55 a.m. RN-A stated the staff offered to toilet R23 at 9:15 a.m.

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F 282	Continued From page 10 and she refused but they should repositioned R23 according to tissue tolerance which was every two hours.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely repositioning for 2 of 2 residents (R16 and R23) reviewed at risk for pressure ulcers. Findings include: R16's current physician orders, dated 12/19/14, indicated she had unspecified disorder of skin, and subcutaneous tissue. R16's quarterly Minimum Data Set (MDS) dated 11/19/14, indicated she was moderately cognitively impaired, needed extensive assist of two with transfers, mobility, toileting and was at risk for pressure ulcers. A Care Area Assessment Worksheet (CAA) dated 8/27/14, indicated she was at risk for pressure ulcer, was immobile and had pain. A Tissue Tolerance Observation dated	F 314	Resident 16 and Resident 23 have had new Tissue Tolerance forms completed to determine current lying and sitting repositioning needs. Their care plans have been updated to reflect current repositioning needs. Residents who have not had a Tissue Tolerance form completed in the past 90 days have had a new Tissue Tolerance form completed and care plan updated. Residents who have had a Tissue Tolerance form completed in the past 90 days have had them reviewed to ensure it still meets the resident's needs. Care Plans have been reviewed/updated to reflect current repositioning needs. Staff has been educated on the	2/24/15

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F 314	Continued From page 11 8/15/14, indicated R16 to be repositioned every two hours while lying or sitting. R16's care plan dated 10/15/14, indicated she was at risk for skin integrity impairment due to impaired mobility and risk for friction and sheer, long history of pressure ulcers. The care plan indicated staff are to reposition her according to her tissue tolerance. During continuous observation on 1/14/15 at 6:53 a.m. to 9:30 a.m. (2 hours and 37 minutes) R16 was observed to be lying in her bed watching television. At 7:27 a.m. nursing assistant (NA)-B entered R16's room and checked with her to see if she needed water. At 7:58 a.m. Licensed Practical Nurse (LPN)-A entered her room and gave her medications. At 1/14/15, at 8:01 a.m. R16 turned on her call light. NA-B entered room and R16 requested her breakfast. At 8:15 a.m. R16 was eating her breakfast and at 8:30 a.m. resident continued to watch her television while still lying in bed. During this time LPN-A and NA-B made no attempt to assist R16 with repositioning while in bed. During interview 1/14/15 at 9:30 a.m. NA-A stated R16 was changed and repositioned at 6:30 a.m. They check/change and reposition her every two to three hours. NA-A then proceeded to change R16 incontinent product which was dry and no red area were noted on her buttocks. During interview 1/14/15, at 9:55 a.m. Registered Nurse (RN)-A stated according to R16's tissue tolerance she should have been repositioned after two hours.	F 314	expectation for following the individualized resident care plans. Audits will be completed daily for 2 weeks, weekly for 4 weeks, and monthly for 1 month to monitor compliance for repositioning residents as stated in their care plan. Audits will be conducted to cover all shifts. Audit results will be reviewed by the QA Committee to determine further auditing schedules. The Director of Nursing or designee is responsible for maintaining compliance.	

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F 314	Continued From page 12 R23's diagnoses, identified on her current physician orders dated 12/10/14, included amputation, and venous insufficiency. R23's admission Minimum Data Set (MDS) dated 9/25/14, indicated impaired cognition, extensive assist of one with transfer, bed mobility and toileting. The MDS further indicated she was incontinent of urine and is at risk for pressure ulcers but has no pressure ulcers. A CAA dated 10/01/14, indicated for extrinsic risk factors pressure, needs special mattress or seat cushion to reduce or relieve pressure and was incontinent of urine. A Tissue Tolerance Observation form dated 9/21/14, indicated R23 will be turned and repositioned every two hours lying and sitting. A Tissue Tolerance form dated 12/19/14, indicated R23 could tolerate two hour repositioning program while lying the form was not completed for sitting. R23's care plan dated 9/18/14, indicated she was at potential for skin integrity impairment r/t frequent bladder incontinence and mobility impairment. The car plan interventions included air mattress, inspect skin with cares, licensed nurse to observe skin weekly, position body with pillows, pressure reduction cushion in wheelchair and "turn and reposition per tissue tolerance." Review of R23's Weekly Skin Assessment Evaluation from dated 1/14/15, indicated on her right lower buttock 3.5 x 2.5 cm pink skin, bleachable, slightly rough. During observation on 1/14/15, at 7:16 a.m., R23 was lying in bed with RN-A assessing R23's skin, and stated she (R23) had red area on her right buttock. At 7:45 a.m. R23 was wheeled to the	F 314		

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 ______	01/15/2015

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 314	Continued From page 13 dining room, returned at 8:55 a.m. and was then wheeled to the front of the day room facing the nurses station. At 9:20 a.m. the resident was wheeled to an activity and remained in the activity until 9:50 a.m. During interview 1/14/15 at 9:50 a.m. NA-B stated the last time they had repositioned R23 was when she was dressed for the day around 7:30 a.m., 2 hours and 20 minutes earlier. During interview 1/14/15, at 9:55 a.m. RN-A stated the staff offered to toilet R23 at 9:15 a.m. and she refused but they should repositioned R23 according to tissue tolerance which was every two hours. Although resident was assessed to be a risk for skin breakdown, had a red buttocks the facility repositioned R23 after sitting for 2 hours and 20 minutes. Although R23 was assessed to be a risk for skin breakdown, and had a red buttocks, the facility repositioned R23 after sitting for 2 hours and 20 minutes. The facilities Care Center Treatment and Prevention of Skin Breakdown and Pressure Ulcers reviewed on January 2015, indicated "It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for ulcers according industry standards of care."	F 314		
F 466 SS=C	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY	F 466		2/24/15

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 ______	01/15/2015

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 466	Continued From page 14 The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure potable and non-potable water needs for the facility were estimated, and a plan for allocation and distribution was made, should loss of normal water supply occur. This had the potential to affect all 82 current residents of the facility, as well as staff and visitors. Findings include: The facility's emergency water procedure, dated 4/29/2014, included information about the sources of the facility's water supply from the city. The document did not include any specific information about procurement of an alternative water supply, nor did it present any procedure for calculating the estimated amount of emergency water required, to meet the needs of the residents and staff in the facility. Further, the document lacked any direction or arrangement for distribution of water in the facility to residents, staff and departments, should there be a loss of water supply. During an interview on 1/15/2015 at 1:43 p.m., the facility administrator said he had "no additional information or calculations" regarding an emergency water supply for the facility. The administrator said it was his understanding "we	F 466	The policy/procedure to ensure water availability has been updated to include estimated needs of potable and non-potable water needs for the facility, and a plan for allocation and distribution should loss of normal water supply occur. The policy/procedure will be reviewed by the QA Committee. The Care Center Administrator is responsible for maintaining compliance.	

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 ______	01/15/2015

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 466	Continued From page 15 would always have the water available to us from the city." The administrator also said "I understand if we need to update this policy", and determine "where would get water, and estimate how much potable and non-potable water we need, and how to store and divide it up." "I understand we can make that change," the administrator said. A facility policy regarding water supply and/or emergency preparedness was requested, but none provided.	F 466		

Printed: 01/22/2015
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES F5511023
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245511	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	01/20/2015

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	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 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. 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 84 beds at the time of the survey.	K 000		

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

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.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
January 30, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5511024

Dear Mr. Barrick:

The above facility was surveyed on January 12, 2015 through January 15, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

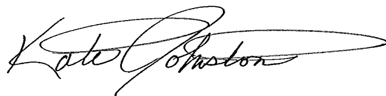
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please 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.

Please feel free to call me with any questions.

Sincerely,



Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00717	A. BUILDING: ______ B. WING ______	01/15/2015

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On January 12th, 13th, 14th and 15th, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement the care planed interventions for 2 of 10 residents (R16, and R23) in the sample reviewed for pressure ulcers and toileting. Findings include: R16's current physician orders dated 12/19/14, indicated she had unspecified disorder of skin and subcutaneous tissue and osteoporosis. R16's quarterly Minimum Data Set (MDS) dated 11/19/14, indicated she was moderately cognitively impaired, needed extensive assist of two with transfers, mobility, toileting and was at risk for pressure ulcers. A Care Area Assessment Worksheet (CAA) dated 8/27/14, identified she was at risk for pressure ulcer, was immobile and had pain. A Tissue Tolerance Observation dated 8/15/14, indicated R16 to be repositioned every two hours while lying or	2 565	corrected	2/24/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 3	2 565		

sitting.

R16's care plan dated 10/15/14, indicated she was at risk for skin integrity impairment due to impaired mobility and risk for friction and sheer, long history of pressure ulcers. The care plan directed staff to reposition R16 according to her tissue tolerance. R16 also had a catheter and staff were to check and change her pad every two hours.

During continuous observation on 1/14/15 at 6:53 a.m. to 9:30 a.m. (2 hours and 37 minutes) R16 was observed to be lying in her bed watching television. At 7:27 a.m. nursing assistant (NA)-B entered R16's room and checked with her to see if she needed water. At 7:58 a.m. Licensed Practical Nurse (LPN)-A entered her room and gave her medications. At 8:01 a.m. R16 turned on her call light, NA-B entered room and R16 requested her breakfast. At 8:15 a.m. R16 was eating her breakfast and at 8:30 a.m. the resident continued to watch her television while lying in bed. During this time LPN-A and NA-B made no attempt to check/change or assist R16 with repositioning while in bed.

During interview 1/14/15 at 9:30 a.m. NA-A stated R16 was changed and repositioned at 6:30 a.m. and stated they are to check/change and reposition her every two to three hours. NA-A then proceeded to change R16 at this time and her incontinent product was dry, with no red pressure areas noted.

During interview 1/14/15, at 9:55 a.m. Registered Nurse (RN)-A stated according to R16's tissue tolerance and care plan she should have been repositioned and changed after two hours.

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2 565	Continued From page 4	2 565		

Continued From page 4

R23's diagnoses, identified on current physician orders dated 12/10/14, included amputation, and venous insufficiency. R23's admission MDS dated 9/25/14, indicated impaired cognition, extensive assist of one with transfer, bed mobility and toileting. The MDS further indicated she was incontinent of urine and was at risk for pressure ulcers but has no pressure ulcers. A Tissue Tolerance Observation form dated 9/21/14, indicated R23 will be turned and repositioned every two hours lying and sitting. A Tissue Tolerance form dated 12/19/14, indicated R23 could tolerate two hour repositioning program lying. The form was not completed for sitting position.

R23's care plan dated 9/18/14, indicated she had potential for skin integrity impairment r/t frequent bladder incontinence and mobility impairment. The care plan interventions included air mattress, inspect skin with cares, licensed nurse to observe skin weekly, position body with pillows, pressure reduction cushion in wheelchair and "turn and reposition per tissue tolerance."

Review of R23's Weekly Skin Assessment Evaluation form, dated 1/14/15, indicated a skin concern on her right lower buttock 3.5 x 2.5 cm pink skin, bleachable, slightly rough.

During observation on 1/14/15, at 7:16 a.m., R23 was lying in bed with RN-A assessing R23's skin, and stated she (R23) had red area on her right buttock. At 7:45 a.m. R23 was wheeled to the dining room, returned at 8:55 a.m. and was then wheeled to the front of the day room facing the nurses station. At 9:20 a.m. the resident was wheeled to an activity and remained in the activity until 9:50 a.m.

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2 565	Continued From page 5 During interview 1/14/15 at 9:50 a.m. NA-B stated the last time they had repositioned R23 was when she was dressed for the day around 7:30 a.m., 2 hours and 20 minutes earlier. During interview 1/14/15, at 9:55 a.m. RN-A stated the staff offered to toilet R23 at 9:15 a.m. and she refused but they should repositioned R23 according to tissue tolerance which was every two hours. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that resident care plans are implement; provide staff education; develop monitoring systems or audit to ensure ongoing compliance. Report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and	2 900		2/24/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 900	Continued From page 6	2 900		

B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review the facility failed to provide timely repositioning for 2 of 2 residents (R16 and R23) reviewed at risk for pressure ulcers.

corrected

Findings include:

R16's current physician orders, dated 12/19/14, indicated she had unspecified disorder of skin, and subcutaneous tissue. R16's quarterly Minimum Data Set (MDS) dated 11/19/14, indicated she was moderately cognitively impaired, needed extensive assist of two with transfers, mobility, toileting and was at risk for pressure ulcers. A Care Area Assessment Worksheet (CAA) dated 8/27/14, indicated she was at risk for pressure ulcer, was immobile and had pain. A Tissue Tolerance Observation dated 8/15/14, indicated R16 to be repositioned every two hours while lying or sitting.

R16's care plan dated 10/15/14, indicated she was at risk for skin integrity impairment due to impaired mobility and risk for friction and sheer, long history of pressure ulcers. The care plan indicated staff are to reposition her according to her tissue tolerance.

During continuous observation on 1/14/15 at 6:53 a.m. to 9:30 a.m. (2 hours and 37 minutes) R16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00717	A. BUILDING: ______ B. WING ______	01/15/2015

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) COMPLETE DATE
2 900	Continued From page 7	2 900		

was observed to be lying in her bed watching television. At 7:27 a.m. nursing assistant (NA)-B entered R16's room and checked with her to see if she needed water. At 7:58 a.m. Licensed Practical Nurse (LPN)-A entered her room and gave her medications. At 1/14/15, at 8:01 a.m. R16 turned on her call light. NA-B entered room and R16 requested her breakfast. At 8:15 a.m. R16 was eating her breakfast and at 8:30 a.m. resident continued to watch her television while still lying in bed. During this time LPN-A and NA-B made no attempt to assist R16 with repositioning while in bed.

During interview 1/14/15 at 9:30 a.m. NA-A stated R16 was changed and repositioned at 6:30 a.m. They check/change and reposition her every two to three hours. NA-A then proceeded to change R16 incontinent product which was dry and no red area were noted on her buttocks.

During interview 1/14/15, at 9:55 a.m. Registered Nurse (RN)-A stated according to R16's tissue tolerance she should have been repositioned after two hours.

R23's diagnoses, identified on her current physician orders dated 12/10/14, included amputation, and venous insufficiency. R23's admission Minimum Data Set (MDS) dated 9/25/14, indicated impaired cognition, extensive assist of one with transfer, bed mobility and toileting. The MDS further indicated she was incontinent of urine and is at risk for pressure ulcers but has no pressure ulcers. A CAA dated 10/01/14, indicated for extrinsic risk factors pressure, needs special mattress or seat cushion to reduce or relieve pressure and was incontinent

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of urine. A Tissue Tolerance Observation form dated 9/21/14, indicated R23 will be turned and repositioned every two hours lying and sitting. A Tissue Tolerance form dated 12/19/14, indicated R23 could tolerate two hour repositioning program while lying the form was not completed for sitting.

R23's care plan dated 9/18/14, indicated she was at potential for skin integrity impairment r/t frequent bladder incontinence and mobility impairment. The car plan interventions included air mattress, inspect skin with cares, licensed nurse to observe skin weekly, position body with pillows, pressure reduction cushion in wheelchair and "turn and reposition per tissue tolerance."

Review of R23's Weekly Skin Assessment Evaluation from dated 1/14/15, indicated on her right lower buttock 3.5 x 2.5 cm pink skin, bleachable, slightly rough.

During observation on 1/14/15, at 7:16 a.m., R23 was lying in bed with RN-A assessing R23's skin, and stated she (R23) had red area on her right buttock. At 7:45 a.m. R23 was wheeled to the dining room, returned at 8:55 a.m. and was then wheeled to the front of the day room facing the nurses station. At 9:20 a.m. the resident was wheeled to an activity and remained in the activity until 9:50 a.m.

During interview 1/14/15 at 9:50 a.m. NA-B stated the last time they had repositioned R23 was when she was dressed for the day around 7:30 a.m., 2 hours and 20 minutes earlier.

During interview 1/14/15, at 9:55 a.m. RN-A stated the staff offered to toilet R23 at 9:15 a.m. and she refused but they should repositioned R23

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2 900	Continued From page 9 according to tissue tolerance which was every two hours. Although resident was assessed to be a risk for skin breakdown, had a red buttocks the facility repositioned R23 after sitting for 2 hours and 20 minutes. Although R23 was assessed to be a risk for skin breakdown, and had a red buttocks, the facility repositioned R23 after sitting for 2 hours and 20 minutes. The facilities Care Center Treatment and Prevention of Skin Breakdown and Pressure Ulcers reviewed on January 2015, indicated "It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for ulcers according industry standards of care." A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents with or at risk for pressure ulcers receive timely services; educate staff as appropriate; then develop monitoring systems or audit to ensure ongoing compliance. Report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 900		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin	21565		2/24/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00717	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 01/15/2015

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21565	Continued From page 10 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and care plan the self administration of nebulizers for 1 of 8 residents (R139) who was observed to receive medication during the course of the survey. Findings include: R139's admission Minimum Data Set (MDS), dated 12/29/14, identified R139 had intact cognition, and a diagnosis of heart failure. During observation of nebulizer medication administration on 1/15/15 at 8:45 a.m., registered nurse (RN)-D placed a liquid medication solution into a nebulizer machine, and handed the mouthpiece to R139 for her to hold while the medication was administered. R139 stated, "Am I supposed to hold on to this?" RN-D provided her instruction on how to hold the device, then left the room after turning the device on to deliver the medication. R139 remained in her room, holding the device until 8:54 a.m.. Nursing assistant (NA)-F entered the room, and turned the machine off and assisted R139 into the hallway to obtain her weight. NA-F returned R139 to her room, turned the machine on, and handed the mouthpiece back to R139 to continue with her nebulizer treatment, with the medication ceasing	21565	corrected	

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21565	Continued From page 11	21565		

at 9:00 a.m.. R139 continued to hold the device after the medication ceased until RN-D returned to the room at 9:02 a.m. and turned off the machine.

R139's Care Center Standing House Orders, signed 1/7/15, indicated, "Resident may self administer nebulizer after initial set up by licensed nurse. Self administration of medications (SAM) assessment to be completed prior to self administration."

R139's Nursing Admission assessment, dated 12/29/14, identified a section for respiratory assessment which included nebulizer use. The following fields were able to be selected: self administer, monitor, or order. However, this section of the assessment was blank and not completed.

R139's care plan, dated 12/22/14, identified R139 was hospitalized in December 2014 for shortness of breath and weakness, however did not indicate if she was able to self administer her own medications or nebulizers.

When interviewed on 1/15/15 at 9:08 a.m., RN-D stated R139 had a standing order for the self administration of her nebulizers, however no assessment had been completed prior to ensure she was safe to self administer her own nebulizer medications as directed by the physicians standing order.

During interview on 1/15/15 at 9:16 a.m., RN-B stated R139 should have completed self administration of medication assessment before being left alone with her nebulizer treatments, "I would have liked to have seen that completed when she admitted."

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21565	Continued From page 12 When interviewed on 1/15/15 at 12:48 p.m., the director of nursing (DON) stated R139 should not have been left alone with her nebulizer treatment without an assessment being completed to ensure she was able to perform the treatment safely. A facility Care Center - Medication Administration policy, dated 8/28/14, indicated a purpose, "To ensure the safe and effective administration of medications by qualified personnel." Further, the policy indicated, "Residents shall not be allowed to self-administer any medications unless an assessment is completed indicating self-administration is appropriate and specifically allowed by the provider, determined appropriate by the interdisciplinary team, and as indicated in the comprehensive care plan. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents, who request self-administration of medications, are appropriately assessed and have a physician's order to do so; educate staff as needed; then develop monitoring systems and audit to ensure ongoing compliance. Report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21565		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and	21800		2/24/15

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21800	Continued From page 13 residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.	21800		
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide appropriate liability notices or denial letter prior to discharge from Medicare services for 2 of 3 residents (R40, R43) reviewed for liability notices. Findings include: R40 was discharged from Medicare services on		corrected	

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21800	Continued From page 14	21800		

Continued From page 14

10/10/14, according to R40's Notice of Medicare Non-Coverage, a Medicare liability notice. R40 remained in the facility. The facility failed to provide Skilled Nursing Facility Advance Beneficiary Notice, a Medicare liability notice that would allow R40 the choice to submit the facility bill to Medicare for review. During interview on 1/14/15, at 2:00 p.m., finance coordinator (FC) verified R40 did not receive the Skilled Nursing Facility Advance Beneficiary Notice or denial letter.

R43 was discharged from Medicare services on 10/15/14, according to R43's Notice of Medicare Non-Coverage, a Medicare liability notice. R43 remained in the facility. The facility failed to provide Skilled Nursing Facility Advance Beneficiary Notice, a Medicare liability notice that would allow R43 the choice to submit the facility bill to Medicare for review. During interview on 1/14/15, at 2:00 p.m., finance coordinator (FC) verified R43 did not receive Skilled Nursing Facility Advance Beneficiary Notice or denial notice.

During interview on 1/15/15, at 8:23 a.m., registered nurse-C (RN-C) stated R40 and R43 both received verbal and written notice to request an immediate appeal from the Quality Improvement Organization (QIO) (CMS 10123) but did not receive the Skilled Nursing Facility Advance Beneficiary Notice or denial letter, which allowed the choice to have the facility bill reviewed by Medicare. During interview at that time, RN-C confirmed R40 and R43 lacked decision to submit or not submit the bill to Medicare for review.

Although RN-C stated she had received

Minnesota Department of Health

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additional training on the Medicare denial process. Review of the Medicare information training for RN-C, identified that training occurred 7/2014, even though R40 and R43 had notices occurring in 10/2014.

Document review of facility Medicare Forms Summary Key Concepts Regarding Liability Notices and Resident Appeal Rights dated 1/2012, identified the skilled nursing facility provider may use either the Skilled Nursing Facility Advance Beneficiary Notice or one of the Denial Letters from the Centers for Medicare and Medicaid Services (CMS) website for Medicare skilled services, which did not occur.

A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents receive the required Medicare denial and appeal rights notices; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee.

TIME PERIOD FOR CORRECTION: Twenty one (21) days.