December 1, 2021

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

CCN: 245511 RF:

Cycle Start Date: November 5, 2021

## Dear Administrator

On November 5, 2021, a survey was completed at your facility by the Minnesota Department of Health to investigate a complaint and a COVID-19 Focused Survey 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. The investigation resulted in no deficiencies being issued.

Also at the time of the investigation, the investigator also assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, found no violations of these rules promulgated under Minnesota Statute section 144.653 and/or Minnesota Statute section 144A.10.

The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction". This applies to federal deficiencies only. Electronically attached is your copy of the Federal Form CMS-2567 stating that no violations were noted at the time of this investigation.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 12/01/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245511	B. WING				C <b>05/2021</b>
	PROVIDER OR SUPPLIER			1	OTREET ADDRESS, CITY, STATE, ZIP CODE  1013 HART BOULEVARD  110 MONTICELLO, MN 55362	1170	03/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Control survey was the Minnesota Depa compliance with En regulations §483.73	COVID-19 Focused Infection conducted at your facility by artment of Health to determine nergency Preparedness 8(b)(6). The facility was found	E 0	000			
F 000	signature is not req page of the CMS-2 correction is require	nrolled in ePOC, your uired at the bottom of the first 567 form. Although no plan of ed, the facility must of the electronic documents.	F 0	000			
	Infection Control su facility by the Minne determine compliar	a COVID-19 Focused arvey was conducted at your esota Department of Health to not with §483.73 Infection was determined to be IN					
	was completed at y complaint investiga be IN compliance w	a standard abbreviated survey your facility to conduct a tion. Your facility was found to with 42 CFR Part 483, ong Term Care Facilities.					
	The following comp UNSUBSTANTIATE	plaints were found to be ED:					
	H5511082C (MN78 H5511083C (MN75						
	signature is not req	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, the facility must					

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.

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		245511	B. WING			C <b>11/05/2021</b>
NAME OF PROVIDER OR SUPPLIER  CENTRACARE HEALTH - MONTICELLO				STREET ADDRESS, CITY, STATE, ZIP CODE 1013 HART BOULEVARD MONTICELLO, MN 55362	I	11/00/2021
(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 CORRE ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	Continued From pa acknowledge receip	ge 1 ot of the electronic documents.	F 0	00		

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,			ATE SURVEY OMPLETED	
			A. BOILDING.			<u> </u>	
		00717	B. WING			5/2021	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
CENTRA	CARE HEALTH - MO	NTICELLO	T BOULEVA LLO, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 000	2 000 Initial Comments						
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correpursuant to a surve found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Deputermination of worrected requires requirements of the number and MN Ruwhen a rule contain comply with any of lack of compliance re-inspection with a result in the assess	hether a violation has been					
	that may result from orders provided that the Department wit	hearing on any assessments in non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.					
	conducted at your t Minnesota Departn facility was found II State Licensure.	a complaint survey was facility by surveyors from the nent of Health (MDH). Your N compliance with the MN					
	The following comp	plaints were found to be					

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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		00717	B. WING		11/0	5/2021	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STATE, ZIP CODE	1 1170	3/2021	
CENTRACARE HEALTH - MONTICELLO 1013 HART BOULEVARD							
	MONTICELLO, MN 55362						
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	UNSUBSTANTIATE	ED:					
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Minnesota Department of Health STATE FORM