Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 27, 2023

Administrator
Centracare Willmar Care Center & Therapy Suites
1801 Willmar Avenue Southwest
Willmar, MN 56201

RE: CCN: 245410
Cycle Start Date: August 16, 2023

Dear Administrator:

On October 18, 2023, we notified you a remedy was imposed. On November 20, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 6, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 16, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 18, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 16, 2023, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 6, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 27, 2023

Administrator
Centracare Willmar Care Center & Therapy Suites
1801 Willmar Avenue Southwest
Willmar, MN 56201

Re: Reinspection Results
Event ID: NKHC12

Dear Administrator:

On November 20, 2023, survey staff of the Minnesota Department of Health - Health Regulation Division, completed a reinspection of your facility to determine correction of orders found on the survey completed on August 16, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building
HRD 3A 3rd Floor
PO Box 64900, 625 Robert St. N.
St. Paul, MN 55155
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 18, 2023

Administrator
Centracare Willmar Care Center & Therapy Suites
1801 Willmar Avenue Southwest
Willmar, MN 56201

RE: CCN: 245410
Cycle Start Date: August 16, 2023

Dear Administrator:

On September 7, 2023, we informed you that we may impose enforcement remedies.

On October 5, 2023, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 16, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 16, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 16, 2023.

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

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 16, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Centracare Willmar Care Center & Therapy Suites will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 16, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 16, 2024 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 On 10/3/23 through 10/5/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54105966C (MN97203), H54105921C (MN97207), H54105290C (MN96631), H54106105C (MN96414), H54106144C (MN97309), H54106242C (MN97387). As a result of the investigation, additional deficiencies were cited at F580, F684, F755. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		

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

Electronically Signed | 10/27/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		11/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 580	Continued From page 2 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify resident representative/physician timely following an incident where residents therapeutic dietary order was not followed with the potential for aspiration for 2 of 4 residents (R1, R2) reviewed. In addition, the facility failed to update the physician for 1 of 4 residents (R4), who had continuous low blood pressures. Findings include: R1's quarterly minimal data set (MDS) dated 9/11/23, indicated R1 had diagnoses which included stroke, dysphagia, hemiplegia/hemiparesis, and moderately impaired cognition. Further, R1's MDS identified R1 was independent with eating after setting up. R1's Physician Order Report, revealed R1's diet order dated 6/26/23, was mildly thick liquids. Review of facility report number 353673 to the State Agency (SA) dated 9/3/23, indicated R1 had reported choking on her old tea, and nursing assistant (NA) noted the tea was not thickened. Further, facility report lacked evidence R1's	F 580	Tag: F580 Corrective Action: On 10/5/2023 DON sent out email to all licensed with education, expectations, and policy for review when there is an incident reported or VA reported on resident. Staff were instructed to review all policies attached including “Incident Reporting “with specific expectations for monitoring of patient and notification of MD and patient representative after an incident. Staff instructed to sign an attached sign off sheet acknowledging review of education and policies before the start of their next shift. Plan of Correction: On 10/12/2023 Mandatory nursing meeting provided for all licensed staff. We had > 95% in attendance, any licensed staff that were unable to attend will have 1:1 review with Nurse Educator of DON before the start of their next shift. Education provided on utilizing policies per facility and review of how to locate policies via policy stat. Education provided for incident reporting and ensuring nursing intervention monitoring is implemented as appropriate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 580	Continued From page 3 representative/family was notified. Review of facility report number 353911 to the SA dated 9/25/23, indicated R1 reported she coughed on her tea and NA indicated the tea appeared to not be thickened. Further, facility report lacked evidence R1's representative/family was notified. R1's medical record lacked evidence R1's representative/family was notified. Review of R1's record lacked evidence R1's physician was notified of potential of aspiration after the two incidents occurred on 9/3/23 and 9/25/23. On 10/4/23 at 10:56 a.m. licensed practical nurse (LPN)-A indicated nursing staff were expected to notify the resident's representative/family/guardian right away if there was a possibility of aspiration following the incident. On 10/4/23 at 12:13 p.m., registered nurse (RN)-B indicated nursing staff were expected to notify resident's representative or emergency contact right away following an incident. On 10/4/23 at 5:12 p.m., RN-C confirmed R1's representative was not notified following the incidents that occurred on 9/3/23 or 9/25/23. On 10/5/23 at 8:48 a.m., director of nursing (DON) stated when an incident occurs or a vulnerable adult report had been submitted nursing staff have a thorough checklist to complete, and on the checklist, it directs staff to resident representative, but DON stated she	F 580	after incident. Reviewed Incident Reporting policy with discussion on timely notification of MD and patient representative after incident or VA report. Reviewed updated changes to VA reporting checklist with additions for initiating interventions, monitoring, notifying MD after all events, and notification of representative after incident. Corrective Action to Prevent Reoccurence: Updated Incident Reporting policy and VA checklist to include to notify DON within 24hrs for review and ensure appropriate assessment, notifications and monitoring is done. Audit process with length of time auditing will be completed: All incident reports and VA reports will be audited by DON to ensure monitoring, assessments and notifications are done as appropriate. This will be completed for 2 months. Report all results to QA Audits will be promptly discussed and review of findings at QA. Based on the findings, the QA committee will determine further frequency of ongoing monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 580	Continued From page 4 would revise the checklist to include family and/or guardian to make it clearer for staff. R2's quarterly MDS dated 8/21/23, indicated R2 had diagnoses which included intellectual disabilities, dysphasia, and moderately impaired cognition. Further, R2's MDS identified R2 was independent with eating after setting up. R2's Physician Order Report, revealed R2's diet order dated 6/20/23 was moderately thick liquids. R2's progress note dated 9/25/23, revealed R2 notified the nurse that evening shift gave him regular liquids and that he understood they were not thick liquids but drank it anyway. However, R2's record lacked evidence R2's physician was notified. On 10/4/23 at 10:56 a.m. licensed practical nurse (LPN)-A indicated nursing staff were expected to notify the resident's physician right away if there was a possibility of aspiration following the incident. On 10/4/23 at 12:13 p.m., registered nurse (RN)-B indicated nursing staff were expected to notify the resident's physician right away following an incident. On 10/4/23 at 5:12 p.m., RN-C confirmed R1's physician was not notified following the incidents that occurred on 8/26/23, 9/3/23, or 9/25/23. RN-C also confirmed R2's physician was not notified following the incident that was identified on 9/25/23. Further, RN-C indicated nursing staff were expected to complete a physician communication form as soon as they were able to ensure the physician was aware of the incident	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 580	Continued From page 5 and if there were any potential for an adverse outcome to the resident. On 10/5/23 at 8:48 a.m., director of nursing (DON) stated when an incident occurs or a vulnerable adult report had been submitted nursing staff have a thorough checklist to complete, and on the checklist, it directs staff to notify physician however it states notify if there is an injury. DON indicated staff are expected to notify physician whether there was an injury or no injury, and the checklist would be updated to be clearer for staff. AND R4's admission MDS dated 9/17/23, indicated R4 had diagnoses of atrial fibrillation, hypertension, wound infection and had moderately impaired cognition. R4 required extensive staff assistance with activities of daily living (ADLs) such as bed mobility, transfers, dressing and toileting. R4's medication administration record (MAR) dated 10/4/23, revealed R4 had orders for Losartan 25 mg once a day for essential hypertension start date of 9/22/23, Toprol X: extended release 100 mg twice a day for essential hypertension start date of 9/11/23, and Torsemide 10 mg once a day for essential hypertension start date of 9/12/23. Further review of R4's MAR revealed Losartan was not administered on 9/23/23, 9/24/23, 9/25/23, 10/1/23, 10/2/23, or 10/3/23 "due to condition" or low blood pressure (BP); Toprol was not administered 9/23/23, 9/24/23 AM or PM, 9/25/23, 10/1/23 AM or PM, 10/2/23, and 10/3/23 "due to condition" or low BP; and Torsemide was	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 580	Continued From page 6 not administered on 9/23/23, 9/24/23, 10/1/23, 10/2/23, or 10/3/23 "due to condition" and low BP. R4's physician orders lacked perimeters for BPs and when to notify the physician and/or not administer blood pressure medications. Review of R4's BP record revealed R4 was noted to have low BP on 9/23/23, 9/24/23, 9/25/23, 9/26/23, 9/28/23, 10/1/23, and 10/2/23. R4's record lacked evidence R4 physician was notified of R4's continued low BP's or staff not administering blood pressure medications as ordered due to R4's low BP and condition from 9/22/23 until 10/2/23. Review of facility document titled Physician Communication dated 10/2/23, indicated R4 slipped down from the EZ stand while transferring from bed to bathroom. R4 became dizzy and was unable to hold on to EZ stand. R4 had been noted to not be feeling well, complaints of dizziness with standing, nausea, dry heaves and has frequent loose stools. However, document did not address R4's low BPs. On 10/5/23 at 9:42 a.m., registered nurse (RN)-D indicated since R4 admitted to the facility she continued to have hypotensive episodes. RN-D indicated since 9/13/23, R4 was noted to have low blood pressures and since have stayed low. RN-D confirmed there had been no further communication with R4's physician between 9/22/23 through 10/3/23, when R4 was discharged to the hospital. RN-D stated staff would be expected to notify and communicate with the resident's physician regarding changes with resident's condition.	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 580	Continued From page 7 On 10/5/23 at 11:37 a.m. attempt to contact and interview medical doctor (MD)-A but unsuccessful. On 10/5/23 at 12:09 p.m., director of nursing (DON) nursing staff was expected to update the physician if they are holding any medications and reasoning as well as asking the physician for perimeters on blood pressure medications. Review of facility policy titled Incident Reports dated 10/23, defines incident as any adverse occurrence or allegation of an occurrence regardless of the presence of adverse outcomes. Occurrence may include by was not limited to choking episode, elopement, fall, abrasion, skin tear, bruise, burn, allegation of abuse of neglect. Further, policy revealed the resident's provider and/or their designee would be notified of incidents which have occurred as well as resident's representative was also to be notified. Review of facility policy titled Vital Signs dated 3/23, directs staff if vital signs are abnormal based on resident baseline, update provider as necessary.	F 580		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		11/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 684	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor for signs and symptoms of aspiration for 2 of 4 residents (R1, R2) reviewed who were not provided thickened liquid as ordered. Findings include: R1's quarterly minimal data set (MDS) dated 9/11/23, indicated R1 had diagnoses which included stroke, dysphagia, hemiplegia/hemiparesis, and moderately impaired cognition. Further, R1's MDS identified R1 was independent with eating after setting up. R1's Physician Order Report, revealed R1's diet order dated 6/26/23, was mildly thick liquids. Review of facility report number 353673 to the State Agency (SA) dated 9/3/23, indicated R1 had reported choking on her old tea, and nursing assistant (NA) noted the tea was not thickened. R1 was immediately assessed by floor nurse and vital signs were within normal limits and lung sounds were clear in all lobes. Review of facility report number 353911 to the SA dated 9/25/23, indicated R1 reported she coughed on her tea and NA indicated the tea appeared to not be thickened. Review of R1's Medication Administration History dated 10/5/23, revealed there was no additional monitoring for signs and symptoms of aspiration following the incidents that occurred on 9/3/23 and 9/25/23.	F 684	Tag: F684 Corrective Action: On 10/5/2023 DON sent out email to all licensed with education, expectations, and policy for review when there is an incident reported or VA reported on resident. Staff were instructed to review All policies attached including “Incident Reporting “with specific expectations for monitoring after an incident Staff instructed to sign an attached sign off sheet acknowledging review of education and policies before the start of their next shift. Plan of Correction: On 10/12/2023 Mandatory nursing meeting provided for all licensed staff. We had > 95% in attendance, any licensed staff that were unable to attend will have 1:1 review with Nurse Educator of DON before the start of their next shift. Education provided on utilizing policies per facility and review of how to locate policies via policy stat. Education provided for incident reporting and ensuring nursing intervention monitoring is implemented as appropriate after incident. Reviewed updated changes to VA reporting checklist with additions for initiating interventions and monitoring after incident. Corrective Action to Prevent Reoccurence: Updated Incident Reporting policy and VA checklist to include to notify DON within 24hrs for review and ensure appropriate assessment, notifications and monitoring is done.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 684	Continued From page 9 Review of R1's progress notes lacked evidence of assessment following 9/25/23 incident. R2's quarterly MDS dated 8/21/23, indicated R2 had diagnoses which included intellectual disabilities, dysphasia, and moderately impaired cognition. Further, R2's MDS identified R2 was independent with eating after setting up. R2's Physician Order Report, revealed R2's diet order dated 6/20/23 was moderately thick liquids. Review of facility report number 353907 to the SA dated 9/25/23, indicated R2 had reported to the nurse he was given the wrong liquids on 9/24/23. R2's progress note dated 9/25/23, revealed R2 notified the nurse that evening shift gave him regular liquids and that he understood they were not thick liquids but drank it anyway. Lung sounds were clear bilaterally. R2's medical record lacked evidence of any additional monitoring for signs or symptoms of aspiration. On 10/4/23 at 10:56 a.m. licensed practical nurse (LPN)-A indicated nursing staff were expected to monitor for signs and symptoms of aspiration by listening to the resident's lung sounds for 24 hours and place an order in the resident's treatments for oncoming shifts to continue. On 10/4/23 at 12:13 p.m., registered nurse (RN)-B indicated nursing staff were expected to assess the resident right away by listening to lung sounds taking vitals and initiating a treatment in the resident's orders for oncoming shifts to continue to monitor for signs or symptoms of	F 684	Audit process with length of time auditing will be completed: All incident reports and VA reports will be audited by DON to ensure monitoring and assessments are in place as appropriate. This will be completed for 2 months. Report all results to QA Audits will be promptly discussed and review of findings at QA. Based on the findings, the QA committee will determine further frequency of ongoing monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 684	Continued From page 10 aspiration following an incident of wrong diet given, however RN-B was unsure how long to monitor for aspiration. On 10/4/23 at 5:12 p.m. RN-C indicated nursing staff were expected to monitor for signs and symptoms of aspiration on each shift for 3 days following an incident of the wrong diet given. RN-C stated the nursing staff would implement an order in the resident's MAR for oncoming shifts to continue to monitor. Further, RN-C confirmed there were no additional monitoring treatments/orders in either R1 or R2's orders following the incidents and in addition no adverse outcomes. On 10/5/23 at 8:48 a.m., director of nursing (DON) stated nursing staff were expected to assess the resident immediately following an incident of the wrong diet and then plan a nursing treatment order into Matrix (electronic medical record system). Further, DON stated nursing should be assessing lung sounds, temperature, choking or coughing episodes every shift and when there are any changes identified, and closely monitoring the resident for 48-72 hours typically aspiration symptoms would be noted by then. Review of facility policy titled Vitals Signs dated 3/23, directed staff to obtain vitals signs at least weekly unless ordered more frequently by the provider or per nursing discretion. Further, unusual or irregular readings are brought to the attention of the charge nurse for further follow up, and if the vital signs are abnormal based on resident baseline, update the provider as necessary.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 755	Continued From page 11	F 755		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to administer blood pressure medications in accordance to physician's orders	F 755	Tag: F755 Corrective Action: On 10/5/2023 DON	11/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 755	Continued From page 12 for 1 of 4 residents (R4) reviewed. Findings include: R4's admission MDS dated 9/17/23, indicated R4 had diagnoses of atrial fibrillation, hypertension, wound infection and had moderately impaired cognition. R4 required extensive staff assistance with activities of daily living (ADLs) such as bed mobility, transfers, dressing and toileting. R4's medication administration record (MAR) dated 10/4/23, revealed R4 had orders for Losartan 25 milligram (mg) once a day for essential hypertension start date of 9/22/23, Toprol X: extended release 100 mg twice a day for essential hypertension start date of 9/11/23, and Torsemide 10 mg once a day for essential hypertension start date of 9/12/23. Further review of R4's MAR revealed Losartan was not administered on 9/23/23, 9/24/23, 9/25/23, 10/1/23, 10/2/23, or 10/3/23 "due to condition" or low blood pressure (BP); Toprol was not administered 9/23/23, 9/24/23 AM or PM, 9/25/23, 10/1/23 AM or PM, 10/2/23, and 10/3/23 "due to condition" or low BP; and Torsemide was not administered on 9/23/23, 9/24/23, 10/1/23, 10/2/23, or 10/3/23 "due to condition" and low BP. R4's physician orders lacked perimeters for BPs and when to notify the physician and/or not administer blood pressure medications. On 10/5/23 at 9:42 a.m., registered nurse (RN)-D indicated since R4 admitted to the facility she continued to have hypotensive episodes. RN-D indicated since 9/13/23, R4 was noted to have low blood pressures and since have stayed low. Further, RN-D stated there were no perimeters given on R4's blood pressure medications or	F 755	conducted a compliance review for "Held" medication in the EMAR for all residents in house. No other incidents of "Held" medications without notification to MD or parameters were identified. On 10/5/2023 DON sent out email with education, expectations for holding medications and policy review of "Change in Condition "for all licensed staff. Staff were instructed to review and sign an attached sign off sheet acknowledging review of education before the start of their next shift. Plan of Correction: On 10/12/2023 Mandatory nursing meeting provided for all licensed staff. We had > 95% in attendance, any licensed staff that were unable to attend will have 1:1 review with Nurse Educator of DON before the start of their next shift. Education provided on utilizing policies per facility and review of how to locate policies in policy stat. Education on required documentation with expectations for progress notes, review, and education of policies for Change in Condition, Incident reporting, and Medication error. Education provided on acceptable vital sign ranges and to notify MD if persistent change in vitals is noted with request for parameters to hold medication. 10/20 DON updated daily huddle sheet for staff huddles to include changes in condition and medication issues -education provided via email and at morning huddle for leadership to discuss any residents with changes in condition from previous shift and any medication concern (ie: held, missing medication, adverse effect etc) with discussion for actions taken. Clinical	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 755	Continued From page 13 when to notify the physician. RN-D stated nursing staff were holding R4's blood pressure medications based on "nursing driven those are standard perimeters on medications in the drug book". RN-D stated nursing staff were expected to notify the physician if any medications were being held and the reasoning. On 10/5/23 at 11:37 a.m. attempt to contact and interview medical doctor (MD)-A but unsuccessful. On 10/5/23 at 12:09 p.m., director of nursing (DON) nursing staff was expected to update the physician if they are holding any medications and should be asking the physician for perimeters on blood pressure medications. Review of facility policy titled Medication Error Reporting Process dated 6/23, defines medication error as when a dose of medication administered to resident deviates from the physician's order in the resident's chart or from the nursing home's policy and procedures. Further, the facility policy did not give staff direction related to when a medication was not administered per physician orders.	F 755	Coordinators are to discuss changes at individual morning huddles in each household respectively. Corrective Action to Prevent Reoccurence: Every day in morning huddle with Leadership all residents are reviewed and discussed for any change in condition (includes vital signs) from previous shift, any medication issues and with discussion on actions taken/needed. Documentation of this is on a “Huddle Sheet” with listed categories as above. Clinical Coordinators will review huddle sheet from morning leadership huddle and discuss all residents on individual household addressing all areas listed on huddle sheet. Clinical Coordinators will review “24hr report” progress notes in Matrix daily for continued review of residents within individual household this will help identify changes in conditions for residents, medication needs etc. Audit process with length of time auditing will be completed: DON will do weekly audits for compliance with “huddle sheet” completion within each household in facility for one month. DON will do weekly audits for Clinical Coordinators report and review of Matrix “24hr report” for one month. Report all results to QA . Both audits will be promptly discussed and review of findings at QA. Based on the findings, the QA committee will determine further frequency of ongoing monitoring.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 18, 2023

Administrator
Centracare Willmar Care Center & Therapy Suites
1801 Willmar Avenue Southwest
Willmar, MN 56201

Re: State Nursing Home Licensing Orders
Event ID: NKHC11

Dear Administrator:

The above facility was surveyed on October 3, 2023 through October 5, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to contact me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00313	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & TH	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/3/23 through 10/5/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00313	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & TH	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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
2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H54105966C (MN97203), H54105921C (MN97207), H54105290C (MN96631), H54106105C (MN96414), H54106144C (MN97309), H54106242C (MN97387). As a result of the investigation, an additional licensing order was issued at 1830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00313	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & TH	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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
2 000	Continued From page 2 Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such	21830		11/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00313	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & TH	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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
21830	Continued From page 3 conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00313	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & TH	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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
21830	Continued From page 4 accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify resident representative/physician timely following an incident where residents therapeutic dietary order	21830	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00313	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & TH	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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
21830	Continued From page 5 was not followed with the potential for aspiration for 2 of 4 residents (R1, R2) reviewed. In addition, the facility failed to update the physician for 1 of 4 residents (R4), who had continuous low blood pressures. Findings include: R1's quarterly minimal data set (MDS) dated 9/11/23, indicated R1 had diagnoses which included stroke, dysphagia, hemiplegia/hemiparesis, and moderately impaired cognition. Further, R1's MDS identified R1 was independent with eating after setting up. R1's Physician Order Report, revealed R1's diet order dated 6/26/23, was mildly thick liquids. Review of facility report number 353673 to the State Agency (SA) dated 9/3/23, indicated R1 had reported choking on her old tea, and nursing assistant (NA) noted the tea was not thickened. Further, facility report lacked evidence R1's representative/family was notified. Review of facility report number 353911 to the SA dated 9/25/23, indicated R1 reported she coughed on her tea and NA indicated the tea appeared to not be thickened. Further, facility report lacked evidence R1's representative/family was notified. R1's medical record lacked evidence R1's representative/family was notified. Review of R1's record lacked evidence R1's physician was notified of potential of aspiration after the two incidents occurred on 9/3/23 and 9/25/23.	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00313	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & TH	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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
21830	Continued From page 6 On 10/4/23 at 10:56 a.m. licensed practical nurse (LPN)-A indicated nursing staff were expected to notify the resident's representative/family/guardian right away if there was a possibility of aspiration following the incident. On 10/4/23 at 12:13 p.m., registered nurse (RN)-B indicated nursing staff were expected to notify resident's representative or emergency contact right away following an incident. On 10/4/23 at 5:12 p.m., RN-C confirmed R1's representative was not notified following the incidents that occurred on 9/3/23 or 9/25/23. On 10/5/23 at 8:48 a.m., director of nursing (DON) stated when an incident occurs or a vulnerable adult report had been submitted nursing staff have a thorough checklist to complete, and on the checklist, it directs staff to resident representative, but DON stated she would revise the checklist to include family and/or guardian to make it clearer for staff. R2's quarterly MDS dated 8/21/23, indicated R2 had diagnoses which included intellectual disabilities, dysphasia, and moderately impaired cognition. Further, R2's MDS identified R2 was independent with eating after setting up. R2's Physician Order Report, revealed R2's diet order dated 6/20/23 was moderately thick liquids. R2's progress note dated 9/25/23, revealed R2 notified the nurse that evening shift gave him regular liquids and that he understood they were not thick liquids but drank it anyway. However, R2's record lacked evidence R2's physician was notified.	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00313	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & TH	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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
21830	Continued From page 7 On 10/4/23 at 10:56 a.m. licensed practical nurse (LPN)-A indicated nursing staff were expected to notify the resident's physician right away if there was a possibility of aspiration following the incident. On 10/4/23 at 12:13 p.m., registered nurse (RN)-B indicated nursing staff were expected to notify the resident's physician right away following an incident. On 10/4/23 at 5:12 p.m., RN-C confirmed R1's physician was not notified following the incidents that occurred on 8/26/23, 9/3/23, or 9/25/23. RN-C also confirmed R2's physician was not notified following the incident that was identified on 9/25/23. Further, RN-C indicated nursing staff were expected to complete a physician communication form as soon as they were able to ensure the physician was aware of the incident and if there were any potential for an adverse outcome to the resident. On 10/5/23 at 8:48 a.m., director of nursing (DON) stated when an incident occurs or a vulnerable adult report had been submitted nursing staff have a thorough checklist to complete, and on the checklist, it directs staff to notify physician however it states notify if there is an injury. DON indicated staff are expected to notify physician whether there was an injury or no injury, and the checklist would be updated to be clearer for staff. AND R4's admission MDS dated 9/17/23, indicated R4 had diagnoses of atrial fibrillation, hypertension,	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00313	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & TH	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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
21830	Continued From page 8 wound infection and had moderately impaired cognition. R4 required extensive staff assistance with activities of daily living (ADLs) such as bed mobility, transfers, dressing and toileting. R4's medication administration record (MAR) dated 10/4/23, revealed R4 had orders for Losartan 25 mg once a day for essential hypertension start date of 9/22/23, Toprol X: extended release 100 mg twice a day for essential hypertension start date of 9/11/23, and Torsemide 10 mg once a day for essential hypertension start date of 9/12/23. Further review of R4's MAR revealed Losartan was not administered on 9/23/23, 9/24/23, 9/25/23, 10/1/23, 10/2/23, or 10/3/23 "due to condition" or low blood pressure (BP); Toprol was not administered 9/23/23, 9/24/23 AM or PM, 9/25/23, 10/1/23 AM or PM, 10/2/23, and 10/3/23 "due to condition" or low BP; and Torsemide was not administered on 9/23/23, 9/24/23, 10/1/23, 10/2/23, or 10/3/23 "due to condition" and low BP. R4's physician orders lacked perimeters for BPs and when to notify the physician and/or not administer blood pressure medications. Review of R4's BP record revealed R4 was noted to have low BP on 9/23/23, 9/24/23, 9/25/23, 9/26/23, 9/28/23, 10/1/23, and 10/2/23. R4's record lacked evidence R4 physician was notified of R4's continued low BP's or staff not administering blood pressure medications as ordered due to R4's low BP and condition from 9/22/23 until 10/2/23. Review of facility document titled Physician Communication dated 10/2/23, indicated R4 slipped down from the EZ stand while transferring from bed to bathroom. R4 became dizzy and was	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00313	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & TH	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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
21830	Continued From page 9 unable to hold on to EZ stand. R4 had been noted to not be feeling well, complaints of dizziness with standing, nausea, dry heaves and has frequent loose stools. However, document did not address R4's low BPs. On 10/5/23 at 9:42 a.m., registered nurse (RN)-D indicated since R4 admitted to the facility she continued to have hypotensive episodes. RN-D indicated since 9/13/23, R4 was noted to have low blood pressures and since have stayed low. RN-D confirmed there had been no further communication with R4's physician between 9/22/23 through 10/3/23, when R4 was discharged to the hospital. RN-D stated staff would be expected to notify and communicate with the resident's physician regarding changes with resident's condition. On 10/5/23 at 11:37 a.m. attempt to contact and interview medical doctor (MD)-A but unsuccessful. On 10/5/23 at 12:09 p.m., director of nursing (DON) nursing staff was expected to update the physician if they are holding any medications and reasoning as well as asking the physician for perimeters on blood pressure medications. Review of facility policy titled Incident Reports dated 10/23, defines incident as any adverse occurrence or allegation of an occurrence regardless of the presence of adverse outcomes. Occurrence may include by was not limited to choking episode, elopement, fall, abrasion, skin tear, bruise, burn, allegation of abuse of neglect. Further, policy revealed the resident's provider and/or their designee would be notified of incidents which have occurred as well as resident's representative was also to be notified.	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00313	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE WILLMAR CARE CENTER & TH	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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
21830	Continued From page 10 Review of facility policy titled Vital Signs dated 3/23, directs staff if vital signs are abnormal based on resident baseline, update provider as necessary. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement measure to ensure timely notification to the physician and resident representative. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. The facility should perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		