Electronically delivered
February 12, 2021

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

RE: CCN: 245511
Cycle Start Date: January 21, 2021

Dear Administrator:

On January 21, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 21, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by July 21, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245511	A. BUILDING _____ B. WING _____	C 01/21/2021

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

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F 000	INITIAL COMMENTS From 1/13/21 to 1/21/21, an abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED with a deficiency: H5511059C MN00068755 with a deficiency cited at F689 The following complaints were found to be SUBSTANTIATED with no deficiencies cited due to actions implemented by the facility prior to survey. H5511049C MN00068465 H5511055C MN00064849 H5511047C MN00054963 H5511053C MN00064364 H5511052C MN00056726 H5511050C MN00048920 The following complaints were found to be UNSUBSTANTIATED: H5511060C MN00068428 H5511051C MN00052372 H5511048C MN00045066 H5511054C MN00068886 H5511057C MN00068430 H5511058C MN00068726 H5511056C MN00065940	F 000		

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

Electronically Signed | 02/22/2021

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

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F 000	Continued From page 1 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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure assessed and care planned interventions were implemented immediately after a fall in order to minimize recurrent falls and/or injury for 1 of 3 residents (R5) reviewed for falls. Findings include: R5's admission Minimum Data Set (MDS), dated 12/14/20, identified R5 had intact cognition and communication abilities. Further, the MDS	F 689	It is the policy of the facility that based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the residents from falling and to try to minimize complications from falling. Resident R5 Post Fall Follow Up Assessments were completed at the time of the falls on 1/1/21 and 1/5/21. Resident R5 care plan was reviewed and	3/5/21

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F 689	Continued From page 2 indicated R5 had been working with physical and occupational therapy, required extensive physical assist of two staff for transfers and toileting, and experienced occasional periods of bladder incontinence. The MDS identified diagnosis of COVID-19, weakness, Meniere's disease (disorder of the inner ear causing dizziness), and vertigo (sensation of feeling off balance). R5's Baseline Care Plan, dated 12/8/20, identified a section labeled "Falls" that identified R5 had a potential for falls and significant injury related to impaired mobility, unsteadiness, use of meds, required assist with activities of daily living (ADL), a diagnosis of COVID, weakness, Meniere's disease to right ear, hypertension, thrombophilia (abnormal blood clotting), and unsteadiness on feet. The fall section was identified to have been revised on 12/14/20 to include minimally impaired hearing loss, and history of falling. R5's initial fall goal was identified as "[R5] will not fall." Initial fall interventions were identified to include eye exams as requested; standard call light within reach and encourage to use it; monthly pharmacy medication reviews; lab work as indicated; therapy referrals as indicated; reposition per tissue tolerance; toileting per elimination plan of care. R5's Fall Risk Eval V2, dated 12/9/20, identified R5 had admitted to the facility on 12/8/20, and had experienced a fall in the month prior to admission. R5 was recorded to be alert and oriented with no memory loss issues noted and used her call light consistently to ask for help. R5 had no sensory deficits identified and no orthostasis (sudden change in blood pressure with position change) present; however, R5 was identified to experience dizziness during the	F 689	updated 1/6/21. Updates included staff to assist resident with toileting before and after meals, midday, at bedtime and second night shift rounds. Resident R5 call light was changed to a larger pad, sensitive type, call light. Resident R5 was re-enrolled into therapy services. Resident R5 had not experienced additional falls thereafter. Facility Fall Prevention Policy, Readmission Checklist and Fall Checklist were reviewed. Facility Readmission Checklist has been updated to include fall risk assessment to be completed on day one of readmission. Fall checklist has been updated to include completion of post fall follow up assessment in the event the resident is sent to hospital for evaluation. Post fall, residents will have a Post Fall Follow Up Assessment completed, to include Residents who are transported to hospital post fall. Staff will identify potential root cause of fall and care plan and implement additional relevant fall interventions as applicable to try to minimize serious consequences of falling. All readmissions, including post hospitalization after a fall, will have a Fall Risk Assessment and Admission Assessment Part One completed on day one of return. (The Admission Assessment Part One includes assessment/screening of the following areas: orientation, vitals, neurological, respiratory, cardiac, genitourinary, sleep	

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F 689	Continued From page 3 orthostatic blood pressure checks with an accompanying comment that R5 has a diagnosis of vertigo. R5's medication use was reviewed which included antihistamine and cardiovascular medications, along with indications R5 had three or more [unidentified] health conditions and/or risk factors present. R5 was identified to be "independent and continent" in which she had steady ambulation with device with assist of one staff. Based on the evaluation, R5 had been identified as at risk for falls. The assessment identified an additional section for any new nursing interventions/approaches; however, this section was left blank. R5's electronic medical record (EMR) had been free of any subsequent Fall Risk Eval V2s. An occupational therapy treatment note, dated 12/22/20 at 9:34 a.m., reported R5 had leaned forward on the toilet and placed her head in her hands due to having not felt well. R5 had stated she felt like she might pass out. R5's record lacked evidence the incident noted at 9:34 am was reported to nursing staff for follow up. A Post Fall Follow Up V2, dated 12/23/20, identified R5 had a fall on 12/23/20, at 2:30 p.m. A nursing assistant (NA) had responded to R5's bathroom (BR) call light and found R5 on the BR floor near the toilet. The NA had reported she had checked on R5 at 2:20 p.m. at which time R5 had verbalized she desired to remain on the toilet to have a bowel movement (BM). After the fall, R5 stated she lowered herself to the floor after she had felt cold and sweaty and knew she was going to pass out. R5 stated she had been constipated.	F 689	and behavioral/additional information). Both, Fall Risk Assessment and Admission Assessment Part One, will be reviewed by staff to identify potential root causes or risk factors associated with potential of, or history of, falls and will aide in determining potential change of status and care plan updates. All resident's care plans will be audited to ensure all care plans include appropriate fall interventions. Licensed Nursing staff will be re-educated regarding the Facility Fall Prevention Policy. Licensed Nursing staff will be educated regarding the Fall Checklist and the Facility Readmission Checklist, to include the updates and additions made. DON or designee will complete audits on all Resident falls that occur within facility. The audit will include reviewing completion of the Facility Fall Checklist, which includes the Post Fall Follow Up Assessment, identification of the root cause and implementation of care plan interventions. Audits will be completed weekly X 4, monthly X 3 and as determined by QA thereafter. DON or designee will complete audits on all readmissions to facility. The audit will include reviewing completion of the Facility Readmission Checklist, which includes the Fall Risk Assessment and Admission Assessment	

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F 689	Continued From page 4 R5's rectum had been assessed to be obstructed with fecal matter at the time of the post fall assessment. A root cause analysis and intervention had been completed which determined R5 had constipation which led to the medical provider having been updated for a scheduled laxative medication. The section labeled conclusion was left blank on the form. On 12/23/20, a revised fall care plan directed staff to stay with R5 while she was on the toilet for safety. A subsequent occupational therapy treatment note, dated 12/24/20, identified R5 scored 19/30 on a SLUMs (Saint Louis University Mental Status Examination) cognitive screen which indicated cognitive impairment. The note reported R5 had stated she felt she had trouble with her memory. A Post Fall Follow Up V2, dated 1/1/21, at 3:00 a.m. indicated R5 had been found lying near her bed when staff entered the room. R5 had been free of incontinence at the time of the fall. The follow up indicated R5 had told NA earlier in the night that she had needed to get ready to return home; however, when staff checked on R5 after at 2:15 a.m. R5 had been asleep. A section that identified factors observed at the time of the fall indicated this had been unable to determine as R5 had not been able to communicate. A section labeled New Interventions indicated R5 had been sent to the emergency room for evaluations following vitals and neurological assessment. The Post Fall Follow UP lacked evidence of additional information related to the fall such as a root cause analysis or interventions implemented to reduce the likelihood of a future fall.	F 689	Part One. Audits will be completed weekly X 4, monthly X 3 and as determined by QA thereafter. Date this will be corrected: March 5, 2021.	

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F 689	Continued From page 5	F 689		

A subsequent progress note, entered on 1/4/21, at 8:30 a.m. indicated the interdisciplinary team (IDT) had met on 1/4/21 to review R5's 1/1/21 fall and determined R5's care plan had been followed and that R5 had been sent and admitted to the hospital to be evaluated.

A completed State agency (SA) submitted investigation, dated 1/8/21, identified the facility's completed investigation into the 1/1/21 fall. On 1/1/21, at 2:50 a.m. R5's roommate had heard R5 fall and placed her call light on to alert staff. R5 had been found lying prone next to her bed with her hands at her side and had been unable to verbalize details of the incident. A call light report had indicated staff entered the room earlier at 1:35 a.m. to assist the roommate. At that time, R5 had been awake and conversed with staff about her desire to return home and the need to pack her belongings. The NA had reminded her of the time and offered to assist R5 to the BR. R5 declined the BR assist and had replied she would go back to sleep. The report indicated at 2:15 a.m. staff had visualized R5 to be asleep in her bed. During the fall assessment, R5 presented with garbled speech, altered mental status, and complained of nausea. R5 had an elevated blood pressure of 168/95, along with a pulse of 121. R5 had also started to develop a bruise to her right temple. Staff contacted the on-call physician and orders were obtained to send R5 to the emergency room for further evaluation. The report identified R5 had returned to the facility on 1/5/21 to complete a course of antibiotic treatment for a UTI and that R5 had not returned to her prior baseline after having been diagnosed with COVID-19 on 12/5/20 and had continued to indicate post COVID-19 signs and symptoms, along with continued progression with ADLs and

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F 689	Continued From page 6	F 689		

status decline. R5 had been inconsistent with asking staff for assistance and did not realize her physical limitations; however, she had remained at baseline with transfer status and leisurely pursuits as noted prior to the fall. The investigation had concluded that there had been no deviation from R5's care plan and that no abuse or neglect had been suspected. In addition, the investigation indicated actions taken to prevent R5 from recurring falls had been to continue physical and occupational therapy along with an adjustment to her toileting plan.

The 1/8/21 facility investigation failed to identify assessment and intervention implemented following R5's 1/1/21 fall. The interventions identified in the 1/8/21 report were implemented as a result of a fall on 1/5/21.

Based on record review, the facility lacked documentation to support interventions were intentionally implemented to reduce the likelihood of future falls for R5.

A Discharge Summary Note Report, dated 1/5/21, indicated R5 admitted to the hospital on 1/1/21 and discharged on 1/5/21 with discharge diagnosis of subdural hematoma with acute encephalopathy, fall, right upper lobe acute pulmonary embolus (clot), urinary tract infection (UTI) with continued antibiotic therapy upon return to the long term care facility, hypertension, chronic pain, and recent COVID-19 infection. Further, the report identified R5 had a "fair" physical condition at discharge. The report did not address R5's cognitive status upon discharge.

On 1/5/21, at 6:00 p.m. a progress note identified

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F 689	Continued From page 7	F 689		

R5 had a fall at 5:00 p.m. while in her room. R5 had denied the need for anything when the NA had delivered her supper tray. R5 had been seated in bed and the NA had placed the tray in front of her. After an undocumented amount of time, the NA had walked by R5's room and witnessed her on the floor lying on her right side with her head faced toward the door and her feet towards the bed. A progress note section labeled "Interventions/care provided" identified R5 had been found to be free of injuries and continent of bowel and bladder during an assessment, had been assisted back into bed with a mechanical lift, and R5 had declined the need to use the toilet at that time. The progress note lacked evidence of additional information related to the fall such as a root cause analysis or interventions implemented to reduce the likelihood of a future fall.

R5's Admission [progress] Note, dated 1/5/21, at 10:58 p.m. identified R5 had readmitted via a wheelchair from the hospital in which she had been alert to self and time; however, thought she had still been in the St. Cloud Hospital and had not remembered why she was at the facility. R5 had required assist of one staff with transfers and ADLs and she had denied pain or headache. The progress note did not indicate any new care planned interventions put in place due to readmission and status review, a change in status or discharged diagnosis, and did not reference the fall at 5:00 p.m. earlier that day.

On 1/5/21, at 11:19 p.m. a progress note identified R5 had very confused conversation in which her sentences had been "sometimes confused" and her memory recall had been inaccurate. R5 had thought she had been at

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F 689	Continued From page 8	F 689		

home the day prior and had further thought her grandchildren had lived there. R5 had appeared surprised when reminded they did not; however, she had not appeared upset about her confused conversation.

A subsequent progress note, dated 1/6/21, at 11:22 a.m. indicated the IDT had reviewed R5's fall on 1/6/21 in which it had been determined R5 had no current injuries related to the fall and that R5's toileting care plan had been updated. R5's standard call light had also been replaced with a larger grey call light pad for easier use. The progress note indicated R5's care plan had been followed and the fall was a result of R5 having self transferred. Staff were to continue to monitor for any injuries.

Review of IDT note lacked evidence assessment of care plan needs related to falls considered increased confusion R5 had been experiencing.

On 1/6/21, R5's elimination care plan indicated an adjustment that directed staff to assist R5 to the toilet pre/post meals, midday and prior to bed, along with second night rounds.

On 1/14/21, R5's fall care plan indicated an adjustment that directed staff to keep a grey soft pad call light within R5's reach while she was in her bedroom and encourage her to utilize it. The care plan did not identify R5 had a fall on 12/23/20, 1/1/21, or 1/5/21, R5's cognitive impairments, or R5's self transferring habits.

During interview on 1/14/21, at 11:40 a.m. nursing supervisor/registered nurse (RN)-A stated before R5's fall on 1/1/21 R5 had been

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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 689	Continued From page 9	F 689		

alert and cognitively intact; however, she explained R5 had not "bounced back from COVID", had vertigo with nausea, would self transfer despite R5's need for physical assist of one staff, and had not consistently used her call light at times. RN-A voiced she had considered R5 to be a fall risk. RN-A stated R5 had "good days and bad days" in which she often preferred to remain in bed. RN-A confirmed R5 had returned from the hospital on 1/5/21 at 2:30 p.m. RN-A stated she does not complete a Fall Risk Eval V2 on residents when they return from the hospital unless there were to be a significant change in their status. RN-A explained she had not been sure if a Fall Risk Eval V2 should have been completed on R5 upon her return on 1/5/21; however, she stated she had not felt R5 had any real changes based on the report received from the hospital "so continued with the same plan of care she had prior to going to the hospital."

When interviewed on 1/14/21, at 12:11 p.m. the MDS Coordinator/registered nurse (RN)-B stated fall risk assessments [Fall Risk Eval V2] were to be completed by nursing staff upon admission, every quarter [three months] thereafter, and as needed. RN-B denied knowledge about the process for the Fall Risk Eval V2 when a resident returned from the hospital.

During interview on 1/14/21, at 12:40 p.m. the director of nursing (DON) stated her assumption had been that nursing staff would complete a fall risk assessment [Fall Risk Eval V2] on admission, annually, with any MDS significant changes in status, and if during the resident readmission portion of the IDT meeting that the IDT determined that one would be required. The DON explained she had been uncertain as to a

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F 689	Continued From page 10	F 689		

possible reason why R5 had not had a fall risk assessment [Fall Risk Eval V2] completed upon her return to the facility. The DON stated she expected a fall risk assessment [Fall Risk Eval V2] to be completed on a resident is there were changes in the resident's status.

During a subsequent follow up interview on 1/20/21, at 1:32 p.m. RN-A stated R5's care plan had not been updated with fall prevention intervention/s after the fall on 1/1/21 and before 1/5/21 when R5 had returned to the facility; however, she explained R5's care plan had been updated on 1/6/21 to reflect a change when staff were directed to approach R5 for toileting assist in relation to R5's 1/5/21 fall. RN-A stated interventions should be an immediate response after a fall and verbalized R5's immediate action after the 1/1/21 fall had been to send her to the emergency room. After further conversation, RN-A confirmed the facility should have adjusted R5's care plan with an intervention to help decrease R5's fall risk prior to her return on 1/5/21: however, RN-A stated facility staff had reviewed R5's return room placement and they made a decision to place her as close as possible to the COVID-19 quarantine unit's nurses station for as long as R5 required placement on that unit.

During a subsequent follow up interview on 1/20/21, at 3:25 p.m. the DON stated fall interventions would be put into place "pending the situation;" however, the DON explained she expected the "floor staff" would put an immediate intervention in place after a fall. This intervention would then be reviewed by the IDT and then based on collaboration and assessment more would be put into place as needed. Further, the DON explained she would expect staff to review

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F 689	Continued From page 11	F 689		

the care plan and make any adjustments based on the review. The DON confirmed their immediate action for R5 after her 1/1/21 fall had been to send her to the emergency room to be evaluated; however, she stated R5's room placement upon her return had been put into place so that staff could attend to R5's needs faster.

An undated Re-Admission Checklist directed staff on the day of readmit to "Update Care Plan with any changes" and to complete multiple assessments and evaluations; however, the checklist did not direct staff to complete a Fall Risk Eval V2 after readmission.

An undated Falls Check List and Prevention Strategies form directed staff to complete identified steps to be addressed after a resident fall. The check list indicated staff were to complete Risk Management in which an intervention "MUST" be included. Another section indicated a Post Fall Assessment was also to be completed and "MUST" include an intervention. Additionally, a section labeled, "Complete a FALL progress note in PCC [electronic health record]" identified staff "MUST include your intervention."

A policy Fall Prevention Policy - Care Center Monticello, dated 9/2019, indicated staff were to identify interventions based on previous evaluations and current data, along with the resident's specific risks and causes, to try and prevent the resident from falling and to minimize complications from falling. Further, the policy indicated if a resident continued to fall despite initial interventions, staff were to implement additional or different interventions or indicate why the current approach remained relevant.

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Electronically delivered
February 12, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: IFLS11

Dear Administrator:

The above facility was surveyed on January 13, 2021 through January 21, 2021 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, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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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: On 1/13/21-1/21/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED with an order issued. H5511059C MN00068755 The following complaints were found to be SUBSTANTIATED with no orders issued due to actions implemented by the facility prior to survey. H5511049C MN00068465 H5511055C MN00064849 H5511047C MN00054963 H5511053C MN00064364 H5511052C MN00056726 H5511050C MN00048920 The following complaints were found to be UNSUBSTANTIATED: H5511060C MN00068428 H5511051C MN00052372 H5511048C MN00045066 H5511054C MN00068886 H5511057C MN00068430 H5511058C MN00068726 H5511056C MN00065940 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	2 000		

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2 000	Continued From page 2 as evidence by." Following the surveyors 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 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. 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and	2 830		3/5/21

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2 830	Continued From page 3 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure assessed and care planned interventions were implemented immediately after a fall in order to minimize recurrent falls and/or injury for 1 of 3 residents (R5) reviewed for falls. Findings include: R5's admission Minimum Data Set (MDS), dated 12/14/20, identified R5 had intact cognition and communication abilities. Further, the MDS indicated R5 had been working with physical and occupational therapy, required extensive physical assist of two staff for transfers and toileting, and experienced occasional periods of bladder incontinence. The MDS identified diagnosis of COVID-19, weakness, Meniere's disease (disorder of the inner ear causing dizziness), and vertigo (sensation of feeling off balance). R5's Baseline Care Plan, dated 12/8/20, identified a section labeled "Falls" that identified R5 had a potential for falls and significant injury related to impaired mobility, unsteadiness, use of meds, required assist with activities of daily living (ADL), a diagnosis of COVID, weakness, Meniere's disease to right ear, hypertension, thrombophilia (abnormal blood clotting), and unsteadiness on	2 830	Corrected	

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2 830	Continued From page 4 feet. The fall section was identified to have been revised on 12/14/20 to include minimally impaired hearing loss, and history of falling. R5's initial fall goal was identified as "[R5] will not fall." Initial fall interventions were identified to include eye exams as requested; standard call light within reach and encourage to use it; monthly pharmacy medication reviews; lab work as indicated; therapy referrals as indicated; reposition per tissue tolerance; toileting per elimination plan of care. R5's Fall Risk Eval V2, dated 12/9/20, identified R5 had admitted to the facility on 12/8/20, and had experienced a fall in the month prior to admission. R5 was recorded to be alert and oriented with no memory loss issues noted and used her call light consistently to ask for help. R5 had no sensory deficits identified and no orthostasis (sudden change in blood pressure with position change) present; however, R5 was identified to experience dizziness during the orthostatic blood pressure checks with an accompanying comment that R5 has a diagnosis of vertigo. R5's medication use was reviewed which included antihistamine and cardiovascular medications, along with indications R5 had three or more [unidentified] health conditions and/or risk factors present. R5 was identified to be "independent and continent" in which she had steady ambulation with device with assist of one staff. Based on the evaluation, R5 had been identified as at risk for falls. The assessment identified an additional section for any new nursing interventions/approaches; however, this section was left blank. R5's electronic medical record (EMR) had been free of any subsequent Fall Risk Eval V2s.	2 830		

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2 830	Continued From page 5 An occupational therapy treatment note, dated 12/22/20 at 9:34 a.m., reported R5 had leaned forward on the toilet and placed her head in her hands due to having not felt well. R5 had stated she felt like she might pass out. R5's record lacked evidence the incident noted at 9:34 am was reported to nursing staff for follow up. A Post Fall Follow Up V2, dated 12/23/20, identified R5 had a fall on 12/23/20, at 2:30 p.m. A nursing assistant (NA) had responded to R5's bathroom (BR) call light and found R5 on the BR floor near the toilet. The NA had reported she had checked on R5 at 2:20 p.m. at which time R5 had verbalized she desired to remain on the toilet to have a bowel movement (BM). After the fall, R5 stated she lowered herself to the floor after she had felt cold and sweaty and knew she was going to pass out. R5 stated she had been constipated. R5's rectum had been assessed to be obstructed with fecal matter at the time of the post fall assessment. A root cause analysis and intervention had been completed which determined R5 had constipation which led to the medical provider having been updated for a scheduled laxative medication. The section labeled conclusion was left blank on the form. On 12/23/20, a revised fall care plan directed staff to stay with R5 while she was on the toilet for safety. A subsequent occupational therapy treatment note, dated 12/24/20, identified R5 scored 19/30 on a SLUMs (Saint Louis University Mental Status Examination) cognitive screen which indicated cognitive impairment. The note reported R5 had stated she felt she had trouble with her memory.	2 830		

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2 830	Continued From page 6 A Post Fall Follow Up V2, dated 1/1/21, at 3:00 a.m. indicated R5 had been found lying near her bed when staff entered the room. R5 had been free of incontinence at the time of the fall. The follow up indicated R5 had told NA earlier in the night that she had needed to get ready to return home; however, when staff checked on R5 after at 2:15 a.m. R5 had been asleep. A section that identified factors observed at the time of the fall indicated this had been unable to determine as R5 had not been able to communicate. A section labeled New Interventions indicated R5 had been sent to the emergency room for evaluations following vitals and neurological assessment. The Post Fall Follow UP lacked evidence of additional information related to the fall such as a root cause analysis or interventions implemented to reduce the likelihood of a future fall. A subsequent progress note, entered on 1/4/21, at 8:30 a.m. indicated the interdisciplinary team (IDT) had met on 1/4/21 to review R5's 1/1/21 fall and determined R5's care plan had been followed and that R5 had been sent and admitted to the hospital to be evaluated. A completed State agency (SA) submitted investigation, dated 1/8/21, identified the facility's completed investigation into the 1/1/21 fall. On 1/1/21, at 2:50 a.m. R5's roommate had heard R5 fall and placed her call light on to alert staff. R5 had been found lying prone next to her bed with her hands at her side and had been unable to verbalize details of the incident. A call light report had indicated staff entered the room earlier at 1:35 a.m. to assist the roommate. At that time, R5 had been awake and conversed with staff about her desire to return home and the need to pack her belongings. The NA had reminded her of the	2 830		

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2 830	Continued From page 7 time and offered to assist R5 to the BR. R5 declined the BR assist and had replied she would go back to sleep. The report indicated at 2:15 a.m. staff had visualized R5 to be asleep in her bed. During the fall assessment, R5 presented with garbled speech, altered mental status, and complained of nausea. R5 had an elevated blood pressure of 168/95, along with a pulse of 121. R5 had also started to develop a bruise to her right temple. Staff contacted the on-call physician and orders were obtained to send R5 to the emergency room for further evaluation. The report identified R5 had returned to the facility on 1/5/21 to complete a course of antibiotic treatment for a UTI and that R5 had not returned to her prior baseline after having been diagnosed with COVID-19 on 12/5/20 and had continued to indicate post COVID-19 signs and symptoms, along with continued progression with ADLs and status decline. R5 had been inconsistent with asking staff for assistance and did not realize her physical limitations; however, she had remained at baseline with transfer status and leisurely pursuits as noted prior to the fall. The investigation had concluded that there had been no deviation from R5's care plan and that no abuse or neglect had been suspected. In addition, the investigation indicated actions taken to prevent R5 from recurring falls had been to continue physical and occupational therapy along with an adjustment to her toileting plan. The 1/8/21 facility investigation failed to identify assessment and intervention implemented following R5's 1/1/21 fall. The interventions identified in the 1/8/21 report were implemented as a result of a fall on 1/5/21. Based on record review, the facility lacked documentation to support interventions were	2 830		

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2 830	Continued From page 8 intentionally implemented to reduce the likelihood of future falls for R5. A Discharge Summary Note Report, dated 1/5/21, indicated R5 admitted to the hospital on 1/1/21 and discharged on 1/5/21 with discharge diagnosis of subdural hematoma with acute encephalopathy, fall, right upper lobe acute pulmonary embolus (clot), urinary tract infection (UTI) with continued antibiotic therapy upon return to the long term care facility, hypertension, chronic pain, and recent COVID-19 infection. Further, the report identified R5 had a "fair" physical condition at discharge. The report did not address R5's cognitive status upon discharge. On 1/5/21, at 6:00 p.m. a progress note identified R5 had a fall at 5:00 p.m. while in her room. R5 had denied the need for anything when the NA had delivered her supper tray. R5 had been seated in bed and the NA had placed the tray in front of her. After an undocumented amount of time, the NA had walked by R5's room and witnessed her on the floor lying on her right side with her head faced toward the door and her feet towards the bed. A progress note section labeled "Interventions/care provided" identified R5 had been found to be free of injuries and continent of bowel and bladder during an assessment, had been assisted back into bed with a mechanical lift, and R5 had declined the need to use the toilet at that time. The progress note lacked evidence of additional information related to the fall such as a root cause analysis or interventions implemented to reduce the likelihood of a future fall. R5's Admission [progress] Note, dated 1/5/21, at 10:58 p.m. identified R5 had readmitted via a	2 830		

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2 830	Continued From page 9 wheelchair from the hospital in which she had been alert to self and time; however, thought she had still been in the St. Cloud Hospital and had not remembered why she was at the facility. R5 had required assist of one staff with transfers and ADLs and she had denied pain or headache. The progress note did not indicate any new care planned interventions put in place due to readmission and status review, a change in status or discharged diagnosis, and did not reference the fall at 5:00 p.m. earlier that day. On 1/5/21, at 11:19 p.m. a progress note identified R5 had very confused conversation in which her sentences had been "sometimes confused" and her memory recall had been inaccurate. R5 had thought she had been at home the day prior and had further thought her grandchildren had lived there. R5 had appeared surprised when reminded they did not; however, she had not appeared upset about her confused conversation. A subsequent progress note, dated 1/6/21, at 11:22 a.m. indicated the IDT had reviewed R5's fall on 1/6/21 in which it had been determined R5 had no current injuries related to the fall and that R5's toileting care plan had been updated. R5's standard call light had also been replaced with a larger grey call light pad for easier use. The progress note indicated R5's care plan had been followed and the fall was a result of R5 having self transferred. Staff were to continue to monitor for any injuries. Review of IDT note lacked evidence assessment of care plan needs related to falls considered increased confusion R5 had been experiencing. On 1/6/21, R5's elimination care plan indicated an	2 830		

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2 830	Continued From page 10 adjustment that directed staff to assist R5 to the toilet pre/post meals, midday and prior to bed, along with second night rounds. On 1/14/21, R5's fall care plan indicated an adjustment that directed staff to keep a grey soft pad call light within R5's reach while she was in her bedroom and encourage her to utilize it. The care plan did not identify R5 had a fall on 12/23/20, 1/1/21, or 1/5/21, R5's cognitive impairments, or R5's self transferring habits. During interview on 1/14/21, at 11:40 a.m. nursing supervisor/registered nurse (RN)-A stated before R5's fall on 1/1/21 R5 had been alert and cognitively intact; however, she explained R5 had not "bounced back from COVID", had vertigo with nausea, would self transfer despite R5's need for physical assist of one staff, and had not consistently used her call light at times. RN-A voiced she had considered R5 to be a fall risk. RN-A stated R5 had "good days and bad days" in which she often preferred to remain in bed. RN-A confirmed R5 had returned from the hospital on 1/5/21 at 2:30 p.m. RN-A stated she does not complete a Fall Risk Eval V2 on residents when they return from the hospital unless there were to be a significant change in their status. RN-A explained she had not been sure if a Fall Risk Eval V2 should have been completed on R5 upon her return on 1/5/21; however, she stated she had not felt R5 had any real changes based on the report received from the hospital "so continued with the same plan of care she had prior to going to the hospital." When interviewed on 1/14/21, at 12:11 p.m. the MDS Coordinator/registered nurse (RN)-B stated fall risk assessments [Fall Risk Eval V2] were to	2 830		

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2 830	Continued From page 11 be completed by nursing staff upon admission, every quarter [three months] thereafter, and as needed. RN-B denied knowledge about the process for the Fall Risk Eval V2 when a resident returned from the hospital. During interview on 1/14/21, at 12:40 p.m. the director of nursing (DON) stated her assumption had been that nursing staff would complete a fall risk assessment [Fall Risk Eval V2] on admission, annually, with any MDS significant changes in status, and if during the resident readmission portion of the IDT meeting that the IDT determined that one would be required. The DON explained she had been uncertain as to a possible reason why R5 had not had a fall risk assessment [Fall Risk Eval V2] completed upon her return to the facility. The DON stated she expected a fall risk assessment [Fall Risk Eval V2] to be completed on a resident is there were changes in the resident's status. During a subsequent follow up interview on 1/20/21, at 1:32 p.m. RN-A stated R5's care plan had not been updated with fall prevention intervention/s after the fall on 1/1/21 and before 1/5/21 when R5 had returned to the facility; however, she explained R5's care plan had been updated on 1/6/21 to reflect a change when staff were directed to approach R5 for toileting assist in relation to R5's 1/5/21 fall. RN-A stated interventions should be an immediate response after a fall and verbalized R5's immediate action after the 1/1/21 fall had been to send her to the emergency room. After further conversation, RN-A confirmed the facility should have adjusted R5's care plan with an intervention to help decrease R5's fall risk prior to her return on 1/5/21: however, RN-A stated facility staff had reviewed R5's return room placement and they	2 830		

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2 830	Continued From page 12 made a decision to place her as close as possible to the COVID-19 quarantine unit's nurses station for as long as R5 required placement on that unit. During a subsequent follow up interview on 1/20/21, at 3:25 p.m. the DON stated fall interventions would be put into place "pending the situation;" however, the DON explained she expected the "floor staff" would put an immediate intervention in place after a fall. This intervention would then be reviewed by the IDT and then based on collaboration and assessment more would be put into place as needed. Further, the DON explained she would expect staff to review the care plan and make any adjustments based on the review. The DON confirmed their immediate action for R5 after her 1/1/21 fall had been to send her to the emergency room to be evaluated; however, she stated R5's room placement upon her return had been put into place so that staff could attend to R5's needs faster. An undated Re-Admission Checklist directed staff on the day of readmit to "Update Care Plan with any changes" and to complete multiple assessments and evaluations; however, the checklist did not direct staff to complete a Fall Risk Eval V2 after readmission. An undated Falls Check List and Prevention Strategies form directed staff to complete identified steps to be addressed after a resident fall. The check list indicated staff were to complete Risk Management in which an intervention "MUST" be included. Another section indicated a Post Fall Assessment was also to be completed and "MUST" include an intervention. Additionally, a section labeled, "Complete a FALL progress note in PCC [electronic health record]"	2 830		

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2 830	Continued From page 13 identified staff "MUST include your intervention." A policy Fall Prevention Policy - Care Center Monticello, dated 9/2019, indicated staff were to identify interventions based on previous evaluations and current data, along with the resident's specific risks and causes, to try and prevent the resident from falling and to minimize complications from falling. Further, the policy indicated if a resident continued to fall despite initial interventions, staff were to implement additional or different interventions or indicate why the current approach remained relevant. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented and the provider is promptly notified of a change in condition. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		