

Protecting, Maintaining and Improving the Health of All Minnesotans

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: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm">https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</a>

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: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 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

Downes Stapson

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

PRINTED: 02/23/2021 FORM APPROVED OMB NO. 0938-0391

F 000 INITIAL COMMENTS  From 1/13/21 to 1/21/21, an abbreviated survey was completed at your facility by the Minnesotal 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 H5511049C MN00068484 H5511047C MN0006493 H5511052C MN00064364 H5511052C MN0006493 The following complaints were found to be UNSUBSTANTIATED:  H5511060C MN00068428 H5511051C MN00068428 H5511051C MN00068428 H5511048C MN00068428 H5511048C MN00068430 H5511058C MN00068430 H5511058C MN00068766 H5511058C MN0006876 H5511058C MN0006876 H5511058C MN0006876 H5511058C MN0006876		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION		E SURVEY PLETED
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PRÉFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  FOOD  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 no 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  H5511053C MN00068469  The following complaints were found to be SUBSTANTIATED with no deficiencies cited due to actions implemented by the facility prior to survey.  H5511059C MN00068469  H5511059C MN00068469  The following complaints were found to be UNSUBSTANTIATED:  H5511060C MN00068428  H5511050C MN00068428  H5511060C MN00068428  H5511060C MN00068428  H5511056C MN0006876			NTICELLO		10	13 HART BOULEVARD	1 011	- 17202 T
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 H5511059C MN00064849 H5511059C MN00064849 H5511059C MN00064864 H5511059C MN00064864 H5511059C MN00068726 H5511050C MN00068428 H5511061C MN00068428 H5511061C MN00068428 H5511061C MN00068428 H5511051C MN00068428	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
H5511058C MN00068726 H5511056C MN00065940	F 000	From 1/13/21 to 1/was completed at y Department of Hea was not in complian CFR Part 483, Sub Long Term Care Father following compsuBSTANTIATED H5511059C MN00 at F689  The following compsuBSTANTIATED to actions impleme survey.  H5511049C MN00 H5511055C MN00 H5511053C MN00 H551	/21/21, an abbreviated survey your facility by the Minnesota alth to determine if your facility nee with requirements of 42 part B, and Requirements for acilities.  Dlaint was found to be with a deficiency:  0068755 with a deficiency cited blaints were found to be with no deficiencies cited due nted by the facility prior to  068465 064849 054963 064364 056726 048920 blaints were found to be ED:  068428 052372 045066 068886	F	000	DEFICIENCY)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		H5511058C MN00 H5511056C MN00	068726 065940	NATURE.		TITLE		(X6) DATE

Electronically Signed

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

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 DEFICIENCII AND PLAN OF CORRECTION	ES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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as your alleg Department' enrolled in e at the bottom form. Your e be used as vulpon receip on-site revision validate that regulations by your verifica. F 689 Free of Acci CFR(s): 483 Pree of Acci CFR(s): 483 Pree of accidents. This REQUI by: Based on infacility failed planned inte immediately recurrent fall (R5) reviews Findings inc.	s plan of gation of gation of gation of spaces. POC, yet of the electron verification of the spaces	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required of first page of the CMS-2567 ic submission of the POC will tion of compliance.  Cacceptable electronic POC, an our facility may be conducted to intial compliance with the en attained in accordance with eazards/Supervision/Devices 1)(2)  Ints.  Issure that -  resident environment remains hazards as is possible; and  The resident receives adequate estance devices to prevent of and document review, the correct was essessed and care on serve implemented fall in order to minimize our injury for 1 of 3 residents	F 0		It is the policy of the facility that bas previous evaluations and current da staff will identify interventions related the resident's specific risks and cautry to prevent the residents from falling and to try to minimize complications falling.  Resident R5 Post Fall Follow Up Assessments were completed at the of the falls on 1/1/21 and 1/5/21. Resident R5 care plan was reviewed.	ta, the d to ses to ing from	3/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION ING	· ,	E SURVEY PLETED
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occupational therassist of two staff experienced occarincontinence. The COVID-19, weaking (disorder of the invertigo (sensation R5's Baseline Carasection labeled potential for falls impaired mobility, required assist with a diagnosis of Cordisease to right eredised on 12/14/hearing loss, and goal was identified interventions were as requested; state encourage to use medication review therapy referrals at tissue tolerance; for care.  R5's Fall Risk Even R5 had admitted had experienced admission. R5 was oriented with no roused her call light had no sensory dorthostasis (suddiscording control of two stars is to start the same courage to use medication review therapy referrals at the same courage to use medication review therapy referrals at the same courage to use medication review therapy referrals at the same courage to use medication review therapy referrals at the same courage to use medication review therapy referrals at the same courage to use medication review therapy referrals at the same courage to use medication review therapy referrals at the same courage to use medication review therapy referrals at the same courage to use medication review therapy referrals at the same courage to use medication review therapy referrals at the same courage to use medication review therapy referrals at the same courage to use medication review therapy referrals at the same courage to use medication review therapy referrals at the same courage to use medication review therapy referrals at the same courage to use medication review the same courage to use medication review the same course of th	been working with physical and apy, required extensive physical for transfers and toileting, and asional periods of bladder MDS identified diagnosis of ness, Meniere's disease mer ear causing dizziness), and of feeling off balance).  The Plan, dated 12/8/20, identified "Falls" that identified R5 had a and significant injury related to unsteadiness, use of meds, th activities of daily living (ADL), DVID, weakness, Meniere's ar, hypertension, thrombophilia clotting), and unsteadiness on ion was identified to have been 20 to include minimally impaired history of falling. R5's initial fall de identified to include eye exams indard call light within reach and it; monthly pharmacy ws; lab work as indicated; as indicated; reposition per toileting per elimination plan of all V2, dated 12/9/20, identified to the facility on 12/8/20, and a fall in the month prior to as recorded to be alert and memory loss issues noted and a consistently to ask for help. R5 eficits identified and no en change in blood pressure age) present; however, R5 was	F 6	updated 1/6/21. Updates inclusive assist resident with toileting be after meals, midday, at bedtin second night shift rounds. Recall light was changed to a lar sensitive type, call light. Resire-enrolled into therapy service R5 had not experienced addit thereafter.  Facility Fall Prevention Policy, Readmission Checklist and Face were reviewed. Facility Read Checklist has been updated to risk assessment to be completed one of readmission. Fall checkles and the resident is sent to hospital evaluation.  Post fall, residents will have a Follow Up Assessment complinctude Residents who are trathospital post fall. Staff will idepotential root cause of fall and and implement additional releinterventions as applicable to minimize serious consequence.  All readmissions, including pothospitalization after a fall, will Risk Assessment and Admiss Assessment Part One completone of return. (The Admission Assessment Part One include assessment/screening of the areas: orientation, vitals, neur	efore and ne and esident R5 ger pad, dent R5 was es. Resident ional falls all Checklist mission o include fall eted on day cklist has oletion of t in the event I for a Post Fall leted, to insported to entify d care plan evant fall try to ees of falling. The est on day in es following	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY IPLETED
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				1013 HART BOULEVARD		
CENTRA	CARE HEALTH - MO	NTICELLO		MONTICELLO, MN 55362		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
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F 689	Continued From pa	age 3	F 68	89		
	orthostatic blood praccompanying comof vertigo. R5's med which included antimedications, along or more [unidentifierisk factors present "independent and osteady ambulation staff. Based on the identified as at risk identified an addition nursing intervention section was left black to a section was left black. R5's electronic med free of any subsequence of any subsequence of any subsequence of the toile hands due to having she felt like she might R5's record lacked 9:34 am was report up.  A Post Fall Follow identified R5 had a	ressure checks with an ament that R5 has a diagnosis dication use was reviewed histamine and cardiovascular with indications R5 had three ed] health conditions and/or at R5 was identified to be continent" in which she had with device with assist of one evaluation, R5 had been for falls. The assessment onal section for any new as/approaches; however, this nk.  dical record (EMR) had been uent Fall Risk Eval V2s.  erapy treatment note, dated m., reported R5 had leaned at and placed her head in her g not felt well. R5 had stated		and behavioral/additional inform Both, Fall Risk Assessment and Admission Assessment Part Or reviewed by staff to identify pote causes or risk factors associate potential of, or history of, falls a in determining potential change and care plan updates.  All resident's care plans will be ensure all care plans include a fall interventions.  Licensed Nursing staff will be regarding the Facility Fall Prevencies.  Licensed Nursing staff will be eregarding the Fall Checklist and Facility Readmission Checklist, the updates and additions made.  DON or designee will complete all Resident falls that occur with The audit will include reviewing completion of the Facility Fall Checklist, which includes the Post Fall Form Assessment, identification of the cause and implementation of contents will be completed weekly monthly X 3 and as determined.	dee, will be ential root d with and will aide of status audited to propriate e-educated attempts and the to include e. audits on in facility. The cklist, low Up er root are plan	
	bathroom (BR) call floor near the toilet, checked on R5 at 2 verbalized she desi have a bowel move stated she lowered had felt cold and sw	light and found R5 on the BR. The NA had reported she had 2:20 p.m. at which time R5 had ired to remain on the toilet to ement (BM). After the fall, R5 herself to the floor after she weaty and knew she was going ted she had been constipated.		thereafter.  DON or designee will complete all readmissions to facility. The audit will include reviewing completion of the Facility Read Checklist, which includes the Facility Resessment and Admission As	audits on nission all Risk	
ORM CMS-25	667(02-99) Previous Versions	·	I	Facility ID: 00717 If con	inuation shee	t Page 4 of 13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		` ´COM	E SURVEY PLETED
		245511	B. WING			C <b>21/2021</b>
	PROVIDER OR SUPPLIER	NTICELLO		STREET ADDRESS, CITY, STATE, ZIP C 1013 HART BOULEVARD MONTICELLO, MN 55362		
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F 689	R5's rectum had be with fecal matter at assessment. A roof intervention had be determined R5 had medical provider has scheduled laxative labeled conclusion.  On 12/23/20, a revito stay with R5 whill safety.  A subsequent occurnote, dated 12/24/2 on a SLUMs (Saint Examination) cognicognitive impairme stated she felt she.  A Post Fall Follow I a.m. indicated R5 h bed when staff enterfree of incontinence follow up indicated night that she had home; however, what 2:15 a.m. R5 had identified factors of indicated this had be R5 had not been at labeled New Intervesent to the emerge following vitals and Post Fall Follow Up information related	the time of the post fall to cause analysis and en completed which constipation which led to the aving been updated for a medication. The section was left blank on the form.  sed fall care plan directed staff e she was on the toilet for pational therapy treatment to, identified R5 scored 19/30 Louis University Mental Status tive screen which indicated int. The note reported R5 had had trouble with her memory.  Up V2, dated 1/1/21, at 3:00 had been found lying near her ered the room. R5 had been eat the time of the fall. The R5 had told NA earlier in the needed to get ready to return her staff checked on R5 after dibeen asleep. A section that in the served at the time of the fall been unable to determine as one to communicate. A section that in the needed to get ready to return the staff checked on R5 after dibeen asleep. A section that in the needed to get ready to return the staff checked on R5 after dibeen asleep. A section that in the needed to get ready to return the needed	F 689	Part One. Audits will be completed were monthly X 3 and as determine thereafter.  Date this will be corrected: N	ned by QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL <sup>*</sup> A. BUILDI	TIPLE CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED	
		245511	B. WING			C / <b>21/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1013 HART BOULEVARD MONTICELLO, MN 55362		
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F 689	Continued From pa		F 6	89		
	at 8:30 a.m. indicat (IDT) had met on 1 and determined R5 and that R5 had be hospital to be evalu	press note, entered on 1/4/21, ted the interdisciplinary team /4/21 to review R5's 1/1/21 fall b's care plan had been followed een sent and admitted to the justed.  agency (SA) submitted				
	investigation, dated completed investig 1/1/21, at 2:50 a.m fall and placed her had been found lyin	d 1/8/21, identified the facility's ation into the 1/1/21 fall. On . R5's roommate had heard R5 call light on to alert staff. R5 ng prone next to her bed with de and had been unable to				
	verbalize details of had indicated staff 1:35 a.m. to assist had been awake a	the incident. A call light report entered the room earlier at the roommate. At that time, R5 nd conversed with staff about				
	her belongings. Th time and offered to declined the BR as	n home and the need to pack e NA had reminded her of the cassist R5 to the BR. R5 sist and had replied she would				
	a.m. staff had visua bed. During the fall with garbled speed	The report indicated at 2:15 alized R5 to be asleep in her I assessment, R5 presented h, altered mental status, and sea. R5 had an elevated blood				
	pressure of 168/95 had also started to temple. Staff conta	, along with a pulse of 121. R5 develop a bruise to her right cted the on-call physician and				
	emergency room for report identified R5	ed to send R5 to the or further evaluation. The had returned to the facility on a course of antibiotic				
	treatment for a UT to her prior baselin with COVID-19 on	I and that R5 had not returned e after having been diagnosed 12/5/20 and had continued to				
		D-19 signs and symptoms, ed progression with ADLs and				

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F 689	status decline. R5 asking staff for ass physical limitations at baseline with tra pursuits as noted pinvestigation had on deviation from Fabuse or neglect haddition, the invest to prevent R5 from continue physical awith an adjustment.  The 1/8/21 facility is assessment and in following R5's 1/1/2 identified in the 1/8 as a result of a fall.  Based on record redocumentation to sintentionally implementation ally implementation for the future falls for R5.  A Discharge Summindicated R5 admit and discharged on diagnosis of subduencephalopathy, fapulmonary embolus (UTI) with continue return to the long to chronic pain, and refurther, the report physical condition and address R5's cognitions.	had been inconsistent with istance and did not realize her; however, she had remained nsfer status and leisurely prior to the fall. The concluded that there had been R5's care plan and that no ad been suspected. In igation indicated actions taken recurring falls had been to and occupational therapy along to her toileting plan.  Investigation failed to identify tervention implemented 21 fall. The interventions /21 report were implemented on 1/5/21.  Eview, the facility lacked support interventions were mented to reduce the likelihood 5.  Inary Note Report, dated 1/5/21, ted to the hospital on 1/1/21 1/5/21 with discharge ral hematoma with acute so (clot), urinary tract infection and antibiotic therapy upon term care facility, hypertension, ecent COVID-19 infection. Identified R5 had a "fair" at discharge. The report did not itive status upon discharge.	F 68			
	On 1/5/21, at 6:00	p.m. a progress note identified				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245511	B. WING		01	C / <b>21/2021</b>	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP 1013 HART BOULEVARD MONTICELLO, MN 55362		,21,2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	R5 had a fall at 5 had denied the new had delivered her seated in bed and front of her. After time, the NA had witnessed her on with her head factowards the bed. "Interventions/car been found to be bowel and bladded been assisted bat lift, and R5 had dat that time. The pof additional infor a root cause analyse."	page 7 200 p.m. while in her room. R5 2 eed for anything when the NA 2 supper tray. R5 had been 3 the NA had placed the tray in an undocumented amount of walked by R5's room and the floor lying on her right side ed toward the door and her feet A progress note section labeled the provided" identified R5 had free of injuries and continent of the during an assessment, had the into bed with a mechanical eclined the need to use the toilet progress note lacked evidence mation related to the fall such as the provided of a future	F6	589			
	10:58 p.m. identifing wheelchair from the been alert to self had still been in the not remembered had required assist ADLs and she had progress note did planned intervent readmission and status or dischargereference the fall.  On 1/5/21, at 11:1 identified R5 had which her sentence confused and her sentence in the sentence of the se	progress] Note, dated 1/5/21, at ied R5 had readmitted via a he hospital in which she had and time; however, thought she he St. Cloud Hospital and had why she was at the facility. R5 st of one staff with transfers and d denied pain or headache. The not indicate any new care ions put in place due to status review, a change in ged diagnosis, and did not at 5:00 p.m. earlier that day.  19 p.m. a progress note very confused conversation in ces had been "sometimes or memory recall had been at the day had been at the sometimes are memory recall had been at the sometimes are the sometimes are memory recall had been at the sometimes are memory recall had been at the sometimes are the sometimes are memory recall had been at the sometimes are the sometimes are the sometimes are memory recall had been at the sometimes are the sometimes a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245511	B. WING				C / <b>21/2021</b>
	PROVIDER OR SUPPLIER			1013	ET ADDRESS, CITY, STATE, ZIP CODE HART BOULEVARD TICELLO, MN 55362		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	grandchildren had surprised when re she had not appear conversation.  A subsequent production of the p	r and had further thought her lived there. R5 had appeared minded they did not; however, ared upset about her confused gress note, dated 1/6/21, at ed the IDT had reviewed R5's nich it had been determined R5 uries related to the fall and that plan had been updated. R5's had also been replaced with a nt pad for easier use. The cated R5's care plan had been all was a result of R5 having taff were to continue to monitor e lacked evidence assessment is related to falls considered on R5 had been experiencing.	F6	89			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	COM	E SURVEY PLETED
		245511	B. WING				C <b>21/2021</b>
	PROVIDER OR SUPPLIER	NTICELLO		101	REET ADDRESS, CITY, STATE, ZIP CODE 3 HART BOULEVARD NTICELLO, MN 55362	1 0111	172021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	explained R5 had r COVID", had vertig transfer despite R5 one staff, and had light at times. RN-AR5 to be a fall risk. days and bad days to remain in bed. R returned from the returned from the returned from the returned from their staff not been sure if a returned or however, she state real change in their staff not been sure if a returned from their staff not been sure if a returned real changes based the hospital "so concare she had prior."  When interviewed MDS Coordinator/r fall risk assessment be completed by no every quarter [three needed. RN-B deni process for the Fal returned from the return	y intact; however, she not "bounced back from o with nausea, would self 's need for physical assist of not consistently used her call a voiced she had considered RN-A stated R5 had "good" in which she often preferred N-A confirmed R5 had rospital on 1/5/21 at 2:30 p.m. bes not complete a Fall Risk ts when they return from the re were to be a significant us. RN-A explained she had fall Risk Eval V2 should have a R5 upon her return on 1/5/21; d she had not felt R5 had any d on the report received from a nitinued with the same plan of to going to the hospital."  Ton 1/14/21, at 12:11 p.m. the registered nurse (RN)-B stated tts [Fall Risk Eval V2] were to ursing staff upon admission, a months] thereafter, and as red knowledge about the likisk Eval V2 when a resident	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245511	B. WING		01	C / <b>21/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1013 HART BOULEVARD MONTICELLO, MN 55362		·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 689	assessment [Fall Fall Fall Fall Fall Fall Fall Fal	ny R5 had not had a fall risk Risk Eval V2] completed upon cility. The DON stated she assessment [Fall Risk Eval ed on a resident is there were	F 68			
	would be put into p	ation and assessment more place as needed. Further, the e would expect staff to review				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245511	B. WING		01	C / <b>21/2021</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1013 HART BOULEVARD MONTICELLO, MN 55362		72172021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 689	Continued From page 11 the care plan and make any adjustments based		F 68	9			
	on the review. The immediate action f been to send her to evaluated; however placement upon he place so that staff faster.	DON confirmed their or R5 after her 1/1/21 fall had the emergency room to be r, she stated R5's room er return had been put into could attend to R5's needs					
	on the day of readi any changes" and assessments and	mission Checklist directed staff mit to "Update Care Plan with to complete multiple evaluations; however, the rect staff to complete a Fall readmission.					
	Strategies form dir identified steps to I fall. The check list complete Risk Marintervention "MUS" indicated a Post Facompleted and "MI Additionally, a sect progress note in Post Facompletes and "MI Additionally, a sect progress note in Post Facompletes and "MI Additionally, a section of the progress note in Post Facompletes and "MI Additionally, a section of the progress note in Post Facompletes and "MI Additionally, a section of the progress note in Post Facompletes and "MI Additionally, a section of the progress note in Post Facompletes and "MI Additionally, a section of the progress and the progress note in Post Facompletes and "MI Additionally, a section of the progress note in Post Facompletes and "MI Additionally, a section of the progress note in Post Facompletes and "MI Additionally, a section of the progress note in Post Facompletes and "MI Additionally, a section of the progress note in Post Facompletes and "MI Additionally, a section of the progress note in Post Facompletes and "MI Additionally, a section of the progress note in Post Facompletes and "MI Additionally, a section of the progress note in Post Facompletes and "MI Additionally, a section of the progress note in Post Facompletes and "MI Additionally, a section of the progress note in Post Facompletes and "MI Additionally and "MI Additionally a section of the progress note in Post Facompletes and "MI Additional of the progress note in Post Facompletes and "MI Additional of the progress note in Post Facompletes note and "MI Additional of the progress note in Post Facompletes note and "MI Additional of the progress note in Post Facompletes note and "MI Additional of the progress note in Post Facompletes note and "MI Additional of the progress note in Post Facompletes note and "MI Additional of the progress note in Post Facompletes note and "MI Additional of the progress note in Post Facompletes note and "MI Additional of the progress note in Post Facompletes note and "MI Additional of the progress note and "MI Additional of the progress note	Check List and Prevention ected staff to complete be addressed after a resident indicated staff were to hagement in which an I' be included. Another section all Assessment was also to be JST" include an intervention. ion labeled, "Complete a FALL CC [electronic health record]" IST include your intervention."					
	Monticello, dated 9 identify intervention evaluations and curresident's specific prevent the resident complications from indicated if a residential interventions additional or differential interventions additional or differential interventions.	ntion Policy - Care Center 0/2019, indicated staff were to as based on previous arrent data, along with the risks and causes, to try and at from falling and to minimize a falling. Further, the policy ent continued to fall despite, staff were to implement ent interventions or indicate proach remained relevant					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
	245511	B. WING		l l	C / <b>21/2021</b>		
ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE  1013 HART BOULEVARD  MONTICELLO, MN 55362				
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI) TAG	( (EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE		
	ROVIDER OR SUPPLIER CARE HEALTH - MOI SUMMARY STA (EACH DEFICIENCY	F CORRECTION IDENTIFICATION NUMBER:	TORRECTION IDENTIFICATION NUMBER:  A. BUILDI  245511  B. WING  ROVIDER OR SUPPLIER  CARE HEALTH - MONTICELLO  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX	A. BUILDING  245511  B. WING  ROVIDER OR SUPPLIER  CARE HEALTH - MONTICELLO  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  1013 HART BOULEVARD  MONTICELLO, MN 55362  ID PROVIDER'S PLAN OF CORRECT  PREFIX (EACH CORRECTIVE ACTION SHOWN STATEMENT OF CORRECT OF THE APPLICATION SHOWN STATEMENT OF THE APPLICATION STATE	A. BUILDING  A. BUILDING  A. BUILDING  A. BUILDING  A. BUILDING  A. BUILDING  B. WING  CARE HEALTH - MONTICELLO  STREET ADDRESS, CITY, STATE, ZIP CODE  1013 HART BOULEVARD  MONTICELLO, MN 55362  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  B. WING  DIVERTIFY TO THE STREET ADDRESS, CITY, STATE, ZIP CODE  1013 HART BOULEVARD  MONTICELLO, MN 55362  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		



Protecting, Maintaining and Improving the Health of All Minnesotans

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 <u>only a suggestion</u> 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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. 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,

Jovens Stapson

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

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00717	B. WING		01/2	2 1/2021
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE	<u> </u>	
		1013 HAI	RT BOULEVA	,		
CENTRA	CARE HEALTH - MOI	MONTICE	ELLO, MN 55	5362		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag ale number indicated below. It is several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item aring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	conducted to detern Licensure. Your fact compliance with the indicate in your elect	, an abbreviated survey was mine compliance with State cility was found to be NOT in MN State Licensure. Please ctronic plan of correction that these orders, and identify the				

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

**Electronically Signed** 02/22/21

TITLE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		E SURVEY PLETED
		00717	B. WING			C <b>21/2021</b>
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CENTRA	ACARE HEALTH - MOI	NTICELLO	RT BOULEVA			
		MONTIC	ELLO, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
		laint was found to be with an order issued.				
	H5511059C MN00	068755				
	The following complaints were found to be SUBSTANTIATED with no orders issued due to actions implemented by the facility prior to survey.					
	H5511049C MN000 H5511055C MN000 H5511047C MN000 H5511053C MN000 H5511052C MN000 H5511050C MN000	064849 054963 064364 056726				
	The following comp	olaints were found to be ED:				
	H5511060C MN000 H5511051C MN000 H5511048C MN000 H5511054C MN000 H5511057C MN000 H5511058C MN000 H5511056C MN000	052372 045066 068886 068430 068726				
	the State Licensing federal software. To assigned to Minnes Nursing Homes. The appears in the far let Tag." The state state listed in the "Summ column and replace the correction order the findings which as	nent of Health is documenting Correction Orders using ag numbers have been tota state statutes/rules for the assigned tag number teft column entitled "ID Prefix attute/rule out of compliance is tary Statement of Deficiencies tes the "To Comply" portion of the To Comply includes the in violation of the state tement, "This Rule is not met	"			

Minnesota Department of Health

STATE FORM 6899 IFLS11 If continuation sheet 2 of 14

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.	<del></del>		,
		00717	B. WING		01/2	1/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CENTRA	CARE HEALTH - MOI	NTICELLO	T BOULEVA			
	OLIMAN DV. OTA		LLO, MN 55		ON.	(1.5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From page 2		2 000			
	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/inf obul.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					
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE NUMBER WHICH STATES, IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			3/5/21
	receive nursing car custodial care, and individual needs an the comprehensive	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and				

Minnesota Department of Health

STATE FORM 6899 IFLS11 If continuation sheet 3 of 14

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00717		B. WING			C <b>21/2021</b>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	·	
CENTRA	CARE HEALTH - MOI	NTICELLO		T BOULEVA			
(VA) ID	CHMMADV CTA	TEMENT OF DEFICIENCIE		LLO, MN 5		CORRECTION	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	30 Continued From page 3		2 830				
	of bed as much as written order from t	ing home resident m possible unless thei he attending physicia in in bed or the resion bed.	e is a an that the				
	by: Based on interview facility failed to ens planned interventio immediately after a	ent is not met as evinand document revieure assessed and cans were implemente fall in order to mining injury for 1 of 3 resalls.	w, the are d nize		Corrected		
	Findings include:						
	12/14/20, identified communication abilindicated R5 had be occupational therapassist of two staff for experienced occasi incontinence. The NCOVID-19, weakned (disorder of the inner the communication)	nimum Data Set (MD R5 had intact cognit lities. Further, the MI een working with phy by, required extensive or transfers and toile conal periods of blade MDS identified diagness, Meniere's disease er ear causing dizzin of feeling off balance	ion and DS vsical and e physical ting, and der osis of se ess), and				
	a section labeled "F potential for falls ar impaired mobility, u required assist with a diagnosis of COV disease to right ear	Plan, dated 12/8/20 Falls" that identified Falls significant injury reinsteadiness, use of activities of daily livi (ID, weakness, Menio, hypertension, thronotting), and unsteading	R5 had a elated to meds, ng (ADL), ere's nbophilia				

Minnesota Department of Health

STATE FORM 6899 IFLS11 If continuation sheet 4 of 14

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00717	B. WING		01/2	; 1/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CENTRA	CARE HEALTH - MO	NIICELLO	T BOULEVA LLO, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	feet. The fall section revised on 12/14/20 hearing loss, and high goal was identified interventions were as requested; standencourage to use it medication reviews therapy referrals as tissue tolerance; to care.  R5's Fall Risk Eval R5 had admitted to had experienced a admission. R5 was oriented with no me used her call light of had no sensory deforthostasis (sudder with position changidentified to experie orthostatic blood praccompanying comof vertigo. R5's med which included antimedications, along or more [unidentifier risk factors present "independent and steady ambulation staff. Based on the identified as at risk identified as at risk identified an addition ursing interventior section was left blars."	n was identified to have been 0 to include minimally impaired istory of falling. R5's initial fall as "[R5] will not fall." Initial fall identified to include eye exams dard call light within reach and it; monthly pharmacy; lab work as indicated; indicated; reposition per illeting per elimination plan of v2, dated 12/9/20, identified the facility on 12/8/20, and fall in the month prior to recorded to be alert and emory loss issues noted and consistently to ask for help. R5 icits identified and no in change in blood pressure e) present; however, R5 was ence dizziness during the ressure checks with an ament that R5 has a diagnosis dication use was reviewed histamine and cardiovascular with indications R5 had three end] health conditions and/or in R5 was identified to be continent" in which she had with device with assist of one evaluation, R5 had been for falls. The assessment and section for any new ins/approaches; however, this	2 830			

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00717		B. WING			C <b>21/2021</b>
	PROVIDER OR SUPPLIER	NTICELLO	1013 HAF	DRESS, CITY, S RT BOULEVA ELLO, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCY MUST BE PRECEDED E SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	An occupational the 12/22/20 at 9:34 a. forward on the toile hands due to havin she felt like she mig R5's record lacked 9:34 am was report up.  A Post Fall Follow lidentified R5 had a A nursing assistant bathroom (BR) call floor near the toilet checked on R5 at 2 verbalized she desi have a bowel move stated she lowered had felt cold and sw to pass out. R5 star R5's rectum had be with fecal matter at assessment. A roof intervention had be determined R5 had medical provider has cheduled laxative labeled conclusion  On 12/23/20, a revito stay with R5 whil safety.  A subsequent occurnote, dated 12/24/2 on a SLUMs (Saint Examination) cognicognitive impairme stated she felt she	erapy treatment not m., reported R5 hat and placed her he g not felt well. R5 hat tand placed her he ght pass out.  evidence the incide ted to nursing staff  Up V2, dated 12/23 fall on 12/23/20, at (NA) had respondight and found R5. The NA had report 2:20 p.m. at which the time to remain on the ment (BM). After the herself to the floor weaty and knew she ted she had been deen assessed to be the time of the post cause analysis an en completed which aving been updated medication. The sewas left blank on the sed fall care plan of the she was on the test pational therapy treational therapy treationa	d leaned ead in her had stated ent noted at for follow ed to R5's on the BR ted she had ime R5 had he toilet to he fall, R5 after she e was going constipated. To obstructed et fall de he had ection he form. Eatment ored 19/30 ental Status ndicated ted R5 had ead status ndicated ted R5 had	2 830			

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Minnesc	<u>ota Department of He</u>	ealth				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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		00717	B. WING			
		00717			01/2	1/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1013 HAF	RT BOULEVA	ARD		
CENTRA	CARE HEALTH - MO	NTICELLO	LLO, MN 55			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
		,	.,.0	DEFICIENCY)		
2 830	Continued From pa	ige 6	2 830			
	Δ Post Fall Follow I	Up V2, dated 1/1/21, at 3:00				
		nad been found lying near her				
		ered the room. R5 had been				
		e at the time of the fall. The				
		R5 had told NA earlier in the				
		needed to get ready to return				
		nen staff checked on R5 after				
		d been asleep. A section that				
		served at the time of the fall				
		een unable to determine as				
		ole to communicate. A section				
		entions indicated R5 had been				
		ncy room for evaluations				
	following vitals and	neurological assessment. The				
	Post Fall Follow UF	Placked evidence of additional				
	information related	to the fall such as a root				
	cause analysis or ir	nterventions implemented to				
	reduce the likelihoo					
	A subsequent prog	ress note, entered on 1/4/21,				
		ed the interdisciplinary team				
		/4/21 to review R5's 1/1/21 fall				
		's care plan had been followed				
		en sent and admitted to the				
	hospital to be evalu					
	nospital to be evalu	atou.				
	A completed State	agency (SA) submitted				
		I 1/8/21, identified the facility's				
		ation into the 1/1/21 fall. On				
		. R5's roommate had heard R5				
		call light on to alert staff. R5				
		ng prone next to her bed with				
		de and had been unable to				
		the incident. A call light report				
		entered the room earlier at				
		the roommate. At that time, R5				
		nd conversed with staff about				
	her desire to return	home and the need to pack				
	her belongings. The	e NA had reminded her of the				

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STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00717	B. WING		01/2	) 1/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CENTRA	CARE HEALTH MOI	1013 HAR	T BOULEVA	ARD .		
CENTRA	CARE HEALTH - MOI	MONTICE	LLO, MN 55	362		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 7	2 830			
	time and offered to declined the BR ass go back to sleep. T a.m. staff had visual bed. During the fall with garbled speech complained of naus pressure of 168/95, had also started to temple. Staff contact orders were obtained emergency room for report identified R5 1/5/21 to complete treatment for a UTI to her prior baselined with COVID-19 on indicate post COVII along with continued status decline. R5 hasking staff for assiphysical limitations; at baseline with transpursuits as noted prinvestigation had continue of the investigation of the investigation of the investity of the investigation of the investigation that continue physical a with an adjustment. The 1/8/21 facility in assessment and intended in the 1/8/ as a result of a fall of the investigation	assist R5 to the BR. R5 sist and had replied she would he report indicated at 2:15 dized R5 to be asleep in her assessment, R5 presented in, altered mental status, and sea. R5 had an elevated blood along with a pulse of 121. R5 develop a bruise to her right country and the control of the properties				

STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
			D WING			
		00717	B. WING		01/2	1/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CENTRA	CARE HEALTH - MOI	NTICELLO	T BOULEVA LLO, MN 55			
(VA) ID	STIMMADV STA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 8	2 830			
	intentionally implemented to reduce the likelihood of future falls for R5.					
	indicated R5 admitt and discharged on diagnosis of subdur encephalopathy, fal pulmonary embolus (UTI) with continued return to the long techronic pain, and refurther, the report in physical condition and address R5's cognion on 1/5/21, at 6:00 proposed R5 had a fall at 5:00 had denied the neem had delivered her seated in bed and the front of her. After an time, the NA had we witnessed her on the with her head faced towards the bed. A "Interventions/care been found to be from the been assisted back lift, and R5 had decapt at that time. The proof additional information of cause analysis."	lary Note Report, dated 1/5/21, ed to the hospital on 1/1/21 1/5/21 with discharge ral hematoma with acute II, right upper lobe acute (clot), urinary tract infection d antibiotic therapy upon erm care facility, hypertension, ecent COVID-19 infection. dentified R5 had a "fair" at discharge. The report did not tive status upon discharge.  b.m. a progress note identified D p.m. while in her room. R5 d for anything when the NA upper tray. R5 had been he NA had placed the tray in a undocumented amount of alked by R5's room and the floor lying on her right side I toward the door and her feet progress note section labeled provided" identified R5 had see of injuries and continent of during an assessment, had into bed with a mechanical lined the need to use the toilet ogress note lacked evidence ation related to the fall such as its or interventions uce the likelihood of a future				
		ogress] Note, dated 1/5/21, at d R5 had readmitted via a				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
			A. BUILDING:	<del></del>		_
		00717	B. WING		l l	C <b>21/2021</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
CENTRA	ACARE HEALTH - MO	NTICELLO	RT BOULEVA ELLO, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	wheelchair from the been alert to self at had still been in the not remembered whad required assist ADLs and she had progress note did replanned intervention readmission and st status or discharge reference the fall at On 1/5/21, at 11:19 identified R5 had which her sentence confused" and her inaccurate. R5 had home the day prior grandchildren had surprised when remake had not appear conversation.  A subsequent prog 11:22 a.m. indicate fall on 1/6/21 in which had no current injurence R5's toileting care patential standard call light had represent the fall self transferred. Standard call call sign progress note indicate followed and the fall self transferred. Standard can injuries.  Review of IDT note of care plan needs increased confusion.	e hospital in which she had and time; however, thought she e St. Cloud Hospital and had thy she was at the facility. R5 to one staff with transfers and denied pain or headache. The not indicate any new care on put in place due to satus review, a change in ed diagnosis, and did not to 5:00 p.m. earlier that day.  Dep.m. a progress note ery confused conversation in the shad been "sometimes memory recall had been at and had further thought her lived there. R5 had appeared ninded they did not; however, and upset about her confused the IDT had reviewed R5's ich it had been determined R5 ries related to the fall and that plan had been updated. R5's had also been replaced with a to pad for easier use. The stated R5's care plan had been all was a result of R5 having aff were to continue to monitor.  De lacked evidence assessment related to falls considered in R5 had been experiencing.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/	SUPPLIER/CLIA TION NUMBER:	1 ' '	E CONSTRUCTION		SURVEY PLETED
ANDFLAN	OF CONNECTION	IDENTIFICA	TION NOWIBER.	A. BUILDING:	<del></del>	COM	LLILD
		00717		B. WING		l l	C <b>21/2021</b>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CENTRA	CARE HEALTH - MO	NTICELLO	1013 HAR	T BOULEVA	ARD		
OLIVINA	IOARE HEAETH - MO	ITTIOLLEO	MONTICE	LLO, MN 55	3362		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 10		2 830			
	adjustment that direction properties and the second of the	ected staff to a s, midday and					
	On 1/14/21, R5's fa adjustment that dire pad call light within her bedroom and e care plan did not id 12/23/20, 1/1/21, of impairments, or R5	ected staff to k R5's reach wh ncourage her entify R5 had a r 1/5/21, R5's o 's self transfer	teep a grey soft nile she was in to utilize it. The a fall on cognitive ring habits.				
	During interview on nursing supervisor/ stated before R5's alert and cognitively explained R5 had ricovID", had vertig transfer despite R5 one staff, and had light at times. RN-AR5 to be a fall risk. days and bad days to remain in bed. Rreturned from the hRN-A stated she do Eval V2 on residen hospital unless their change in their state not been sure if a Fibeen completed on however, she state real changes based the hospital "so cor care she had prior"	registered nur fall on 1/1/21 F y intact; however to be on with nausea the registered for physical consistent of the registered for the reportation on the reportation of the registered for the registered	se (RN)-A R5 had been ver, she vack from , would self ysical assist of y used her call ad considered R5 had "good often preferred d R5 had '21 at 2:30 p.m. ete a Fall Risk eturn from the a significant ained she had /2 should have return on 1/5/21; felt R5 had any received from e same plan of hospital."				
	When interviewed of MDS Coordinator/refall risk assessmen	egistered nurs	e (RN)-B stated				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION						COM		
		00747		B. WING			C	
00717				b. WINO		01/	21/2021	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CENTRA	CARE HEALTH - MO	NTICELLO		T BOULEVA LLO, MN 55				
(X4) ID	SUMMARY STA	TEMENT OF DEF	FICIENCIES	ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)	
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)			
2 830	Continued From pa	ıge 11		2 830				
	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 director of nursing had been that nurs risk assessment [F annually, with any I status, and if during portion of the IDT ridetermined that on explained she had possible reason whassessment [Fall Righer return to the face expected a fall risk V2] to be complete changes in the resi	(DON) stated ing staff would all Risk Eval MDS significated the resident neeting that the would be resident and R5 had not lisk Eval V2] collity. The DO assessment don a resider	her assumption d complete a fall V2] on admission, nt changes in readmission he IDT equired. The DON in as to a had a fall risk completed upon N stated she [Fall Risk Eval nt is there were					
	During a subseque 1/20/21, at 1:32 p.r had not been updar intervention/s after 1/5/21 when R5 ha however, she explaupdated on 1/6/21 were directed to ap in relation to R5's 1 interventions shoul after a fall and verbafter the 1/1/21 fall emergency room. ARN-A confirmed the R5's care plan with decrease R5's fall 1/5/21: however, R reviewed R5's retuing at 1:32 p.r.	n. RN-A state ted with fall pathe fall on 1/1 defended R5's can to reflect a chaproach R5 fo /5/21 fall. RN defended R5's in had been to state facility shou an interventionsk prior to he N-A stated fall the facility shou facility shou an interventionsk prior to he N-A stated facility fall pathe facility shou facility should faci	ed R5's care plan orevention 1/21 and before the facility; re plan had been lange when staff or toileting assist 1-A stated ediate response mediate action send her to the conversation, ald have adjusted on to help er return on cility staff had					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00717	B. WING			C <b>21/2021</b>
NAME OF PROVIDER OR SUPPLIER  CENTRACARE HEALTH - MONTICELLO  MONTICELLO, MN 55362						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	made a decision to to the COVID-19 quering a subseque 1/20/21, at 3:25 p.m. interventions would situation;" however expected the "floor intervention in place would then be reviet based on collaborar would be put into place would be put into place and mon the review. The immediate action for been to send her to evaluated; however placement upon her place so that staff of faster.  An undated Re-Adron the day of reading any changes" and the assessments and expected the checklist did not directly assessments and expected the checklist did not directly assessments and expected the checklist did not directly assessments and expected the check list in complete Risk Manintervention "MUST indicated a Post Facompleted and "MUST indicated and "MUS	place her as close as possible parantine unit's nurses station equired placement on that unit.  Int follow up interview on the DON stated fall be put into place "pending the the thick that the thick that the DON explained she staff" would put an immediate expect a fall. This intervention where the thick that the thick t	2 830			

NAME OF PROVIDER OR SUPPLIER  CENTRACARE HEALTH - MONTICELLO  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  STREET ADDRESS, CITY, STATE, ZIP CODE  MONTICELLO, MN 55362  (X5)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NI IMPER:			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1013 HART BOULEVARD  MONTICELLO, MN 55362   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 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	AND PLAN OF CORRECTION		IDENTIFICATION NOMBER.	A. BUILDING:				
CENTRACARE HEALTH - MONTICELLO  1013 HART BOULEVARD MONTICELLO, MN 55362  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 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			00717	B. WING				
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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	identified staff "MU  A policy Fall Prever Monticello, dated 9 identify intervention evaluations and curesident's specific reprevent the resident complications from indicated if a reside initial interventions, additional or differently why the current approper assessment implemented and the facility of a change in constaff on the policies for evaluating and implementation of the developed, with the brought to the facility Committee for review TIME PERIOD FOR	ST include your intervention."  Intion Policy - Care Center I/2019, indicated staff were to the based on previous Intervent data, along with the Insks and causes, to try and Interventions and to minimize Interventions of indicate Interventions or indicate Interventions are leaded to Interventions are being Interventions are being Interventions or indicate Interventions are being Interventions are being Interventions or indicate Interventions are being Interventions are being Interventions or indicate Interventions are being Interventions are being Interventions or indicate Interventions are being Interventions are being Interventions or indicate Interventions are being Interventions are being Interventions or indicate Interventions are being Interventions are being Interventions or indicate Interventions or indicate Interventions Intervention	2 830				

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