

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered March 18, 2021

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

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

Dear Administrator:

On March 11, 2021, the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Dovers 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



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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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,

Davente Stapeon

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

DEPART	MENT OF HEALTH	I AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		C	MB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	Сом	E SURVEY
		245511	B. WING	<u>،</u>			C 21/2021
NAME OF F	ROVIDER OR SUPPLIER	1	1	;	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CENTRA	CARE HEALTH - MOI	NTICELLO			1013 HART BOULEVARD MONTICELLO, MN 55362		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	rs	F	000)		
	was completed at y Department of Hea was not in complian	21/21, an abbreviated survey our facility by the Minnesota Ith to determine if your facility nce with requirements of 42 part B, and Requirements for acilities.					
	The following comp SUBSTANTIATED	laint was found to be with a deficiency:					
	H5511059C MN00 at F689	068755 with a deficiency cited					
	SUBSTANTIATED	laints were found to be with no deficiencies cited due nted by the facility prior to					
	H5511049C MN000 H5511055C MN000 H5511047C MN000 H5511053C MN000 H5511052C MN000 H5511052C MN000	064849 054963 064364 056726					
	The following comp	laints were found to be ED:					
	H5511060C MN000 H5511051C MN000 H5511048C MN000 H5511054C MN000 H5511057C MN000 H5511058C MN000 H5511058C MN000	052372 045066 068886 068430 068726					
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electron	ically 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.

PRINTED: 02/23/2021

	T OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II T	IPLE CONSTRUCTION	DMB NO.	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				IPLETED
						С
		245511	B. WING			21/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
CENTRA	CARE HEALTH - MO	NTICELLO		1013 HART BOULEVARD MONTICELLO, MN 55362		
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F 000	Continued From pa	ige 1	F 00	00		
	The facility's plan o as your allegation o Department's acce enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will				
	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with azards/Supervision/Devices 1)(2)	F 68	39		3/5/21
	supervision and as accidents.	resident receives adequate sistance devices to prevent NT is not met as evidenced				
	Based on interview facility failed to ens planned interventio immediately after a recurrent falls and/ (R5) reviewed for fa	v and document review, the ure assessed and care ns were implemented fall in order to minimize or injury for 1 of 3 residents alls.		It is the policy of the facility that b previous evaluations and current staff will identify interventions rela the resident's specific risks and c try to prevent the residents from f and to try to minimize complicatio falling.	data, the ted to auses to alling	
	12/14/20, identified	nimum Data Set (MDS), dated R5 had intact cognition and lities. Further, the MDS		Resident R5 Post Fall Follow Up Assessments were completed at of the falls on 1/1/21 and 1/5/21. Resident R5 care plan was review		

Facility ID: 00717

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		AND HUMAN SERVICES					APPROVE 0938-039
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			K3) DATE COMF	SURVEY PLETED
		245511	B. WING			01/2) 1/2021
	PROVIDER OR SUPPLIER	240011			TREET ADDRESS, CITY, STATE, ZIP CODE	01/2	1/2021
	CARE HEALTH - MO	NTICELLO		10	13 HART BOULEVARD IONTICELLO, MN 55362		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 689	Continued From pa	ige 2	F 6	89			
	indicated R5 had be occupational therap assist of two staff fe experienced occas incontinence. The I COVID-19, weakne (disorder of the innevertigo (sensation of R5's Baseline Care a section labeled "F potential for falls ar impaired mobility, u required assist with a diagnosis of COV disease to right ear (abnormal blood cla feet. The fall sectio revised on 12/14/20 hearing loss, and h goal was identified interventions were as requested; stand encourage to use if medication reviews therapy referrals as	een working with physical and by, required extensive physical or transfers and toileting, and ional periods of bladder MDS identified diagnosis of ess, Meniere's disease er ear causing dizziness), and of feeling off balance). Plan, dated 12/8/20, identified Falls" that identified R5 had a nd significant injury related to insteadiness, use of meds, activities of daily living (ADL), /ID, weakness, Meniere's r, hypertension, thrombophilia otting), and unsteadiness on 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 t; monthly pharmacy s; lab work as indicated; a indicated; reposition per ileting per elimination plan of		09	 updated 1/6/21. Updates included states assist resident with toileting before arrafter meals, midday, at bedtime and second night shift rounds. Resident I call light was changed to a larger pad sensitive type, call light. Resident R5 re-enrolled into therapy services. Res R5 had not experienced additional fait thereafter. Facility Fall Prevention Policy, Readmission Checklist and Fall Checkwere reviewed. Facility Readmission Checklist has been updated to include risk assessment to be completed on the one of readmission. Fall checklist has been updated to include risk assessment to hospital for evaluation. Post fall, residents will have a Post Fall Follow Up Assessment completed, to include Residents who are transported hospital post fall. Staff will identify potential root cause of fall and care p and implement additional relevant fall interventions as applicable to try to 	nd R5 d, 5 was sident Ills cklist day as of event call o call o co co co co co co co co co co co co c	
	R5 had admitted to	V2, dated 12/9/20, identified the facility on 12/8/20, and			minimize serious consequences of fa All readmissions, including post	-	
	admission. R5 was oriented with no me used her call light of had no sensory def	fall in the month prior to recorded to be alert and emory loss issues noted and consistently to ask for help. R5 ficits identified and no			hospitalization after a fall, will have a Risk Assessment and Admission Assessment Part One completed on one of return. (The Admission Assessment Part One includes	day	
	with position chang	n change in blood pressure e) present; however, R5 was ence dizziness during the			assessment/screening of the followin areas: orientation, vitals, neurological respiratory, cardiac, genitourinary, sle	l,	

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CENTER	KS FOR MEDICARE	& MEDICAID SERVICES	1		OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245511	B. WING _		C 01/21/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
				1013 HART BOULEVARD	
CENTRA	CARE HEALTH - MO	NTICELLO		MONTICELLO, MN 55362	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLÉTIC
F 689	Continued From pa	ao 3	ГСО	0	
1 009	• · · · · · · · · · · · · · · · · · · ·	-	F 68		antion)
		essure checks with an Iment that R5 has a diagnosis		and behavioral/additional inform	
		dication use was reviewed		Both, Fall Risk Assessment and Admission Assessment Part Or	
		histamine and cardiovascular		reviewed by staff to identify pote	
		with indications R5 had three		causes or risk factors associate	
		ed] health conditions and/or		potential of, or history of, falls a	
	risk factors present. R5 was identified to be			in determining potential change	
		continent" in which she had		and care plan updates.	
		with device with assist of one			
		evaluation, R5 had been		All resident's care plans will be	
		for falls. The assessment		ensure all care plans include ap	opropriate
		nal section for any new		fall interventions.	
		ns/approaches; however, this			
	section was left bla			Licensed Nursing staff will be re regarding the Facility Fall Preve	
		dical record (EMR) had been		Policy.	
	free of any subsequ	uent Fall Risk Eval V2s.		Licensed Nursing staff will be e	
	A			regarding the Fall Checklist and	
		erapy treatment note, dated		Facility Readmission Checklist,	
		m., reported R5 had leaned t and placed her head in her		the updates and additions made	
		g not felt well. R5 had stated		DON or designee will complete	audits on
	she felt like she mig			all Resident falls that occur with	
		.		The audit will include reviewing	- , -
	R5's record lacked	evidence the incident noted at		completion of the Facility Fall Č	hecklist,
	9:34 am was report	ted to nursing staff for follow		which includes the Post Fall Fo	llow Up
	up.			Assessment, identification of th	
				cause and implementation of ca	are plan
		Up V2, dated 12/23/20,		interventions.	
		fall on 12/23/20, at 2:30 p.m.		Audits will be completed weekly	
		(NA) had responded to R5's light and found R5 on the BR		monthly X 3 and as determined thereafter.	by QA
	()	The NA had reported she had			
		2:20 p.m. at which time R5 had		DON or designee will complete	audits on
		ired to remain on the toilet to		all readmissions to facility.	
		ement (BM). After the fall, R5		The audit will include reviewing	
		herself to the floor after she		completion of the Facility Read	mission
		veaty and knew she was going		Checklist, which includes the Fa	
		ted she had been constipated.		Assessment and Admission As	

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DAT	E SURVEY PLETED
					C
	245511	B. WING		•	21/2021
PROVIDER OR SUPPLIER					
CARE HEALTH - MO	NTICELLO		MONTICELLO, MN 55362		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETIO DATE
R5's rectum had be with fecal matter at assessment. A roo intervention had be determined R5 had medical provider ha scheduled laxative labeled conclusion On 12/23/20, a rev to stay with R5 whi safety. A subsequent occu note, dated 12/24/2 on a SLUMs (Saint Examination) cogn cognitive impairme stated she felt she A Post Fall Follow a.m. indicated R5 h bed when staff enter free of incontinence follow up indicated night that she had h home; however, wh at 2:15 a.m. R5 had identified factors of	een assessed to be obstructed the time of the post fall t cause analysis and een completed which I constipation which led to the aving been updated for a medication. The section was left blank on the form. ised fall care plan directed staff le she was on the toilet for upational therapy treatment 20, identified R5 scored 19/30 Louis University Mental Status itive screen which indicated nt. 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 e at the time of the fall. The R5 had told NA earlier in the needed to get ready to return hen staff checked on R5 after d been asleep. A section that pserved at the time of the fall	F 68	Part One. Audits will be completed weekly monthly X 3 and as determined thereafter.	by QA	
	PROVIDER OR SUPPLIER CARE HEALTH - MO SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa R5's rectum had be with fecal matter at assessment. A roo intervention had be determined R5 had medical provider ha scheduled laxative labeled conclusion On 12/23/20, a rev to stay with R5 whi safety. A subsequent occu note, dated 12/24/2 on a SLUMs (Saint Examination) cogn cognitive impairme stated she felt she A Post Fall Follow a.m. indicated R5 h bed when staff ento free of incontinenco follow up indicated night that she had n home; however, wh at 2:15 a.m. R5 had indicated this had to R5 had not been al	DF CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 245511 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	COP DEFICIENCIES PF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDIN 245511 B. WING	DF DEFICIENCIES (X1) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 245511 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1031 HART BOULEVARD MONTICELLO, MN 55362 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFINING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION NUMBER: (EACH CORRECTIVE ACTION STATE, ZIP CODE intervention 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. F 689 On 12/23/20, a revised fall care plan directed staff to stay with R5 while she was on the toilet for safety. Date this will be corrected: Man Date this will be corrected: Man 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 Jing 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 been asleep. A section that identified factors observed at the time of the fall. The follow up indicated R5 had been asleep. A section that identified factors observed at the time of the fall. The officiated R5 had been asleep. A section that identified factors observed at the time of the fall. The observed is had been asleep. A section that identified factors observed at the time of the fall indicated this had been asleep. A section that identified factors observed at th	CFOF DEFICIENCIES (X1) PROVIDERSUPPLIER/CLAINING A BUILDING (X2) MULTIPLE CONSTRUCTION (X3) DATA PF CORRECTION 245511 B. WING (X3) MULTIPLE CONSTRUCTION (X3) DATA PROVIDER OR SUPPLIER 245511 STREET ADDRESS, CITY, STATE, ZIP CODE (11) CARE HEALTH - MONTCELLO STREET ADDRESS, CITY, STATE, ZIP CODE 1013 HART BOULEFVARD MONTCELLO, MN 55362 (20) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (20) (20) REGULATORY OR LSC DENTIFYING INFORMATION) PREX PREVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL PREVIDERS PLAN OF CORRECTION PREVIDERS PLAN OF CORRECTION DEFICIENCY Continued From page 4 RS's recturn had been assessed to be obstructed PREVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL RS's recturn had been completed which Hereafter. Deficiency Must BE PRECEDED BY FULL Continued From page 4 RS's recturn had been completed for a scheduled laxative medication. The section labeled conclusion was left blank on the form. F 689 On 12/23/20, a revised fall care plan directed staff to stay with SS while she was on the toilet for safety. Date this will be c

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U LITIE		& MEDICAID SERVICES	1			0.0938-039		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED		
		245511	B. WING _		01	C / 21/2021		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•			
CENTRA	CARE HEALTH - MO	NTICELLO		1013 HART BOULEVARD MONTICELLO, MN 55362				
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 689	A subsequent prog at 8:30 a.m. indicat (IDT) had met on 1 and determined R5 and that R5 had be hospital to be evalue A completed State investigation, dated completed investig 1/1/21, at 2:50 a.m fall and placed her had been found lyin her hands at her sin verbalize details of had indicated staff 1:35 a.m. to assist had been awake an her desire to return her belongings. The time and offered to declined the BR as go back to sleep. T a.m. staff had visual bed. During the fall with garbled speec complained of naus pressure of 168/95 had also started to temple. Staff conta orders were obtain emergency room for report identified R5 1/5/21 to complete treatment for a UTI to her prior baseling	ress note, entered on 1/4/21, eed the interdisciplinary team /4/21 to review R5's 1/1/21 fall is care plan had been followed een sent and admitted to the	F 68	39				

Facility ID: 00717

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		HAND HUMAN SERVICES				FORM	02/23/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245511	B. WING				C 21/2021
NAME OF I	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CENTRA	ACARE HEALTH - MOI	NTICELLO			013 HART BOULEVARD		
				M	IONTICELLO, MN 55362		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	status decline. R5 h asking staff for assi physical limitations; at baseline with tran pursuits as noted pu- investigation had co- no deviation from R abuse or neglect ha addition, the investi to prevent R5 from continue physical at with an adjustment The 1/8/21 facility in assessment and int following R5's 1/1/2 identified in the 1/8/ as a result of a fall of Based on record re- documentation to su- intentionally implem of future falls for R5 A Discharge Summ indicated R5 admitt and discharged on diagnosis of subdur encephalopathy, fal- pulmonary embolus (UTI) with continueor return to the long te chronic pain, and re Further, the report i physical condition a address R5's cogni	had been inconsistent with istance and did not realize her ; however, she had remained nsfer status and leisurely rior to the fall. The oncluded 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.	F 6	689			

Facility ID: 00717

If continuation sheet Page 7 of 13

		AND HUMAN SERVICES				FORM	02/23/2021 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245511	B. WING	i			C 21/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	ACARE HEALTH - MOI	NTICELLO			013 HART BOULEVARD		
				N	MONTICELLO, MN 55362		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	R5 had a fall at 5:00 had denied the nee had delivered her s seated in bed and t front of her. After at time, the NA had w witnessed her on th with her head faced towards the bed. A "Interventions/care been found to be fro bowel and bladder been assisted back lift, and R5 had ded at that time. The pro of additional inform a root cause analys	0 p.m. while in her room. R5 d for anything when the NA supper tray. R5 had been the NA had placed the tray in n undocumented amount of alked by R5's room and he floor lying on her right side d toward the door and her feet progress note section labeled provided" identified R5 had ee of injuries and continent of during an assessment, had a into bed with a mechanical clined the need to use the toilet ogress note lacked evidence ation related to the fall such as	F	689			
	R5's Admission [pro 10:58 p.m. identifie wheelchair from the been alert to self ar had still been in the not remembered with had required assist ADLs and she had progress note did n planned intervention readmission and st status or discharge reference the fall at On 1/5/21, at 11:19 identified R5 had very which her sentence confused" and her the	ogress] Note, dated 1/5/21, at d R5 had readmitted via a e hospital in which she had nd time; however, thought she e St. Cloud Hospital and had hy she was at the facility. R5 of one staff with transfers and denied pain or headache. The not indicate any new care ns put in place due to atus review, a change in d diagnosis, and did not t 5:00 p.m. earlier that day. p.m. a progress note ery confused conversation in es had been "sometimes memory recall had been thought she had been at					

If continuation sheet Page 8 of 13

		HAND HUMAN SERVICES				FORM	02/23/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245511	B. WING	i			C 21/2021
NAME OF F	PROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	CARE HEALTH - MOI	NTICELLO			1013 HART BOULEVARD MONTICELLO, MN 55362		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	grandchildren had I surprised when rem she had not appear conversation. A subsequent progr 11:22 a.m. indicated fall on 1/6/21 in whi had no current injur R5's toileting care p standard call light h larger grey call light progress note indication followed and the fall self transferred. Sta for any injuries. Review of IDT note of care plan needs increased confusion On 1/6/21, R5's elin adjustment that direct toilet pre/post meal along with second r	and had further thought her lived there. R5 had appeared ninded they did not; however, red upset about her confused ress note, dated 1/6/21, at d the IDT had reviewed R5's ich it had been determined R5 ries related to the fall and that blan had been updated. R5's had also been replaced with a t pad for easier use. The sated R5's care plan had been II was a result of R5 having aff were to continue to monitor e lacked evidence assessment related to falls considered n R5 had been experiencing. mination care plan indicated an ected staff to assist R5 to the ls, midday and prior to bed, night rounds.	F	689			
	adjustment that dire pad call light within her bedroom and e care plan did not id 12/23/20, 1/1/21, or impairments, or R5	R5's reach while she was in R5's reach while she was in encourage her to utilize it. The entify R5 had a fall on r 1/5/21, R5's cognitive 's self transferring habits.					
	nursing supervisor/	registered nurse (RN)-A fall on 1/1/21 R5 had been					

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1		OMB NC	0938-039	
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED	
		245511	B. WING _		01	C / 21/2021	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	•		
CENTRA	CARE HEALTH - MO	NTICELLO		1013 HART BOULEVARD MONTICELLO, MN 55362			
(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 SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 689	alert and cognitivel explained R5 had r COVID", had vertig transfer despite R5 one staff, and had light at times. RN-A R5 to be a fall risk. days and bad days to remain in bed. R returned from the h RN-A stated she do Eval V2 on residen hospital unless the change in their stat not been sure if a F been completed on however, she state real changes based the hospital "so cor care she had prior" When interviewed of MDS Coordinator/r fall risk assessmen be completed by n every quarter [three needed. RN-B deni process for the Fal returned from the h During interview of director of nursing had been that nurs risk assessment [F annually, with any f status, and if during portion of the IDT r	y intact; however, she not "bounced back from to with nausea, would self d'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 the confirmed R5 had hospital 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 trus. RN-A explained she had Fall Risk Eval V2 should have to R5 upon her return on 1/5/21; d she had not felt R5 had any d on the report received from ntinued with the same plan of to going to the hospital." on 1/14/21, at 12:11 p.m. the egistered nurse (RN)-B stated tts [Fall Risk Eval V2] were to ursing staff upon admission, e months] thereafter, and as ied knowledge about the I Risk Eval V2 when a resident nospital. n 1/14/21, at 12:40 p.m. the (DON) stated her assumption ing staff would complete a fall all Risk Eval V2] on admission, MDS significant changes in g the resident readmission neeting that the IDT e would be required. The DON	F 68	39			

Facility ID: 00717

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		I AND HUMAN SERVICES				FORM	: 02/23/2021 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245511	B. WING	i			C 21/2021
NAME OF	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	CARE HEALTH - MO	NTICELLO			013 HART BOULEVARD IONTICELLO, MN 55362		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	possible reason wh assessment [Fall R her return to the face expected a fall risk V2] to be completed changes in the resid During a subsequee 1/20/21, at 1:32 p.m had not been updat intervention/s after 1/5/21 when R5 had however, she explai updated on 1/6/21 th were directed to ap in relation to R5's 1 interventions should after a fall and verb after the 1/1/21 fall emergency room. A RN-A confirmed the R5's care plan with decrease R5's fall r 1/5/21: however, RI reviewed R5's return made a decision to to the COVID-19 qu for as long as R5 return interventions would situation;" however expected the "floor intervention in place would then be revier based on collaborar would be put into place	y R5 had not had a fall risk isk Eval V2] completed upon cility. The DON stated she assessment [Fall Risk Eval d on a resident is there were	F	689			

Facility ID: 00717

If continuation sheet Page 11 of 13

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE C	CONSTRUCTION	· · ·	TE SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			MPLETED	
		245511	B. WING				C / 21/2021	
NAME OF F	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
CENTRA	CARE HEALTH - MO	NTICELLO			3 HART BOULEVARD NTICELLO, MN 55362			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 689	Continued From pa the care plan and r	age 11 make any adjustments based	F6	89				
	on the review. The immediate action f been to send her to evaluated; howeve placement upon he	DON confirmed their or R5 after her 1/1/21 fall had o the emergency room to be er, she stated R5's room er return had been put into could attend to R5's needs						
	on the day of read 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 Mar intervention "MUS" indicated a Post Fa completed and "MI Additionally, a sect progress note in P	Check List and Prevention rected staff to complete be addressed after a resident indicated staff were to magement in which an T" be included. Another section all Assessment was also to be UST" include an intervention. tion labeled, "Complete a FALL CC [electronic health record]" JST include your intervention."						
	Monticello, dated 9 identify intervention evaluations and cur resident's specific prevent the residen complications from indicated if a reside initial interventions additional or different	ntion Policy - Care Center 0/2019, indicated staff were to ns based on previous irrent data, along with the risks and causes, to try and nt from falling and to minimize n falling. Further, the policy ent continued to fall despite , staff were to implement ent interventions or indicate proach remained relevant.						

If continuation sheet Page 12 of 13

		AND HUMAN SERVICES				FORM	02/23/2021 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245511	B. WING	€			C 21/2021	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CENTRA	CARE HEALTH - MO	NTICELLO		1013 HART BOULEVARD MONTICELLO, MN 55362				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
			1					

Facility ID: 00717



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 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,

Dovertes Stapson

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

Centracare Health - Monticello February 12, 2021 Page 3 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

Minnesc	ota Department of He	alth				
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00717	B. WING		01/2	C 1/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CENTRA	CARE HEALTH - MOI	NTICELLO	RT BOULEVA			
(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
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh 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				
	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 fac compliance with the indicate in your elec you have reviewed date when they will	, an abbreviated survey was nine compliance with State ility was found to be NOT in MN State Licensure. Please ctronic plan of correction that these orders, and identify the				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	SNATURE	TITLE		(X6) DATE 02/22/21

Electronically Signed

6899

STATEMEN	ta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED C
		00717	B. WING			21/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CENTRA	CARE HEALTH - MOI	NTICELLO	RT BOULEVA			
(X4) ID	SUMMARY STA	SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
		The following complaint was found to be SUBSTANTIATED 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.		<i>.</i>			
	H5511049C MN000 H5511055C MN000 H5511047C MN000 H5511053C MN000 H5511052C MN000 H5511052C MN000)64849)54963)64364)56726				
	The following comp	laints were found to be ED:				
	H5511060C MN000 H5511051C MN000 H5511048C MN000 H5511054C MN000 H5511057C MN000 H5511058C MN000 H5511058C MN000	052372 045066 068886 068430 068726				
	the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state sta	nent of Health is documenting Correction Orders using ag numbers have been tota state statutes/rules for ne assigned tag number eft column entitled "ID Prefix atute/rule out of compliance is ary Statement of Deficiencies"	п			
	column and replace the correction order the findings which a	es the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION		
		00717	B. WING			
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
CENTRA	CARE HEALTH - MO	NTICELLO	RT BOULEVAF ELLO, MN 553			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000			
		llowing the surveyors findings Method of Correction and rection.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si obul.htm. The State delineated on the a Department of Hea you electronically. is necessary for State enter the word "CO available for text. Y electronic State lice heading completion be corrected prior to the Minnesota Depa is enrolled in ePOC	in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf clicensing orders are				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and e; 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

IFLS11

If continuation sheet 3 of 14

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURV COMPLETE	
	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	:		D
		00717	B. WING		C 01/21/20)21
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
CENTRA	CARE HEALTH - MO	NTICELLO	RT BOULEV ELLO, MN 5			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE
2 830	Continued From pa	age 3	2 830			
	of bed as much as written order from t	ing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed.				
	by: Based on interview facility failed to ens planned interventio immediately after a	ent is not met as evidenced and document review, the sure assessed and care ons were implemented a fall in order to minimize for injury for 1 of 3 residents alls.		Corrected		
	Findings include:					
	12/14/20, identified communication abi indicated R5 had b occupational therap assist of two staff f experienced occas incontinence. The I COVID-19, weakne (disorder of the inn	himum Data Set (MDS), dated I R5 had intact cognition and ilities. Further, the MDS een working with physical and py, required extensive physical or transfers and toileting, and ional periods of bladder MDS identified diagnosis of ess, Meniere's disease er ear causing dizziness), and of feeling off balance).				
	a section labeled "If potential for falls ar impaired mobility, u required assist with a diagnosis of COV disease to right ear	Plan, dated 12/8/20, identified Falls" that identified R5 had a nd significant injury related to unsteadiness, use of meds, n activities of daily living (ADL), /ID, weakness, Meniere's r, hypertension, thrombophilia otting), and unsteadiness on				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
		00717				01/21/2021
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
ENTRA	CARE HEALTH - MO	NTICELLO	RT BOULEVAI ELLO, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	revised on 12/14/20 hearing loss, and h goal was identified interventions were if as requested; stand encourage 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 def	n was identified to have been 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 ; monthly pharmacy ; lab work as indicated; indicated; reposition per ileting 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 onsistently to ask for help. R5 icits identified and no in change in blood pressure				
	identified to experie orthostatic blood pr accompanying com of vertigo. R5's med which included antii medications, along or more [unidentifie risk factors present "independent and c steady ambulation staff. Based on the identified as at risk identified as at risk identified an additio nursing interventior section was left bla R5's electronic med	e) present; however, R5 was ence dizziness during the essure checks with an iment that R5 has a diagnosis dication use was reviewed histamine and cardiovascular with indications R5 had three d] health conditions and/or . R5 was identified to be continent" in which she had with device with assist of one evaluation, R5 had been for falls. The assessment nal section for any new ns/approaches; however, this nk. dical record (EMR) had been uent Fall Risk Eval V2s.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00717				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
					01/	21/2021
	PROVIDER OR SUPPLIER	1013 HA	DDRESS, CITY, S RT BOULEVA I			
CENTRA	CARE HEALTH - MO	NTICELLO	ELLO, MN 55			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					
2 830	Continued From pa	ige 5	2 830			
	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.					
	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.					
	to stay with R5 whil safety. A subsequent occu note, dated 12/24/2 on a SLUMs (Saint Examination) cogni cognitive impairment	sed fall care plan directed staf e she was on the toilet for pational therapy treatment 20, identified R5 scored 19/30 Louis University Mental Status tive screen which indicated nt. The note reported R5 had had trouble with her memory.				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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iame of F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
ENTRA	CARE HEALTH - MO		T BOULEVA			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLE DATE
2 830	Continued From pa	age 6	2 830			
	a.m. indicated R5 H bed when staff enter free of incontinence follow up indicated night that she had home; however, wh at 2:15 a.m. R5 had identified factors of indicated this had h R5 had not been al labeled New Intervy sent to the emerge following vitals and Post Fall Follow UF information related cause analysis or in reduce the likelihood A subsequent prog at 8:30 a.m. indicated (IDT) had met on 1 and determined R5	press note, entered on 1/4/21, ted the interdisciplinary team /4/21 to review R5's 1/1/21 fall 5's care plan had been followed een sent and admitted to the				
	investigation, dated completed investig 1/1/21, at 2:50 a.m fall and placed her had been found lyin her hands at her si verbalize details of had indicated staff 1:35 a.m. to assist had been awake an	agency (SA) submitted 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 the incident. A call light report entered the room earlier at the roommate. At that time, R5 nd conversed with staff about				
nnesota D	her desire to return	home and the need to pack e NA had reminded her of the				

Innesota Department of Herat TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		E SURVEY PLETED	
	IDENTIFICATION NOMBER.	A. BUILDING:				
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ENTRACARE HEALTH - MO						
		ELLO, MN 55				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830 Continued From pa	age 7	2 830				
declined the BR as go back to sleep. T a.m. staff had visus bed. During the fall with garbled speed complained of nau pressure of 168/95 had also started to temple. Staff conta orders were obtain emergency room fa report identified R5 1/5/21 to complete treatment for a UT to her prior baselin with COVID-19 on indicate post COVI along with continue status decline. R5 asking staff for ass physical limitations at baseline with tra pursuits as noted p investigation had c no deviation from F abuse or neglect h addition, the invest to prevent R5 from continue physical a with an adjustment The 1/8/21 facility i assessment and in following R5's 1/1/2	assist R5 to the BR. R5 sist and had replied she would The report indicated at 2:15 alized R5 to be asleep in her l assessment, R5 presented th, altered mental status, and sea. R5 had an elevated blood 5, along with a pulse of 121. R5 develop a bruise to her right acted the on-call physician and ed to send R5 to the or further evaluation. The 5 had returned to the facility on a course of antibiotic I and that R5 had not returned e after having been diagnosed 12/5/20 and had continued to ID-19 signs and symptoms, ed progression with ADLs and had been inconsistent with sistance and did not realize her is; however, she had remained unsfer status and leisurely prior to the fall. The concluded that there had been R5's care plan and that no ad been suspected. In tigation indicated actions taken recurring falls had been to and occupational therapy along to her toileting plan.					

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ENTRA	CARE HEALTH - MO	NTICELLO	RT BOULEVAI ELLO, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED T		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 8	2 830			
	intentionally implen of future falls for R	nented to reduce the likelihood 5.				
	indicated R5 admitt and discharged on diagnosis of subdu encephalopathy, fa pulmonary embolus (UTI) with continue return to the long te chronic pain, and re Further, the report physical condition a address R5's cogni On 1/5/21, at 6:00 µ R5 had a fall at 5:0 had denied the nee had delivered her s seated in bed and t front of her. After a time, the NA had w witnessed her on th with her head faced towards the bed. A "Interventions/care been found to be fr bowel and bladder been assisted back lift, and R5 had ded at that time. The pr of additional inform a root cause analys	hary Note Report, dated 1/5/21 ted to the hospital on 1/1/21 1/5/21 with discharge ral hematoma with acute II, right upper lobe acute is (clot), urinary tract infection d antibiotic therapy upon erm care facility, hypertension, ecent COVID-19 infection. identified R5 had a "fair" at discharge. The report did no itive status upon discharge. p.m. a progress note identified 0 p.m. while in her room. R5 ed for anything when the NA supper tray. R5 had been the NA had placed the tray in n undocumented amount of alked by R5's room and he floor lying on her right side d toward the door and her feet progress note section labeled provided" identified R5 had ee of injuries and continent of during an assessment, had a into bed with a mechanical clined the need to use the toilef ogress note lacked evidence ation related to the fall such as sis or interventions fluce the likelihood of a future	t			
	R5's Admission [pr 10:58 p.m. identifie	ogress] Note, dated 1/5/21, at				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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(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 ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From no	200	2 830	DEFICIENC	Y)		
2 630	been alert to self and had still been in the not remembered with ADLs and she had progress note did right planned intervention readmission and st status or discharge reference the fall and On 1/5/21, at 11:19 identified R5 had with which her sentence confused" and her inaccurate. R5 had home the day prior grandchildren had surprised when rem	age 9 e hospital in which she had nd time; however, thought she e St. Cloud Hospital and had hy she was at the facility. R5 t of one staff with transfers and denied pain or headache. The not indicate any new care ons put in place due to tatus review, a change in ed diagnosis, and did not t 5:00 p.m. earlier that day. P p.m. a progress note ery confused conversation in es had been "sometimes memory recall had been thought she had been at and had further thought her lived there. R5 had appeared ninded they did not; however, red upset about her confused					
	11:22 a.m. indicate fall on 1/6/21 in whi had no current injur R5's toileting care p standard call light h larger grey call ligh progress note indic followed and the fa self transferred. Sta for any injuries. Review of IDT note of care plan needs	ress note, dated 1/6/21, at ad 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 t pad for easier use. The cated R5's care plan had been II was a result of R5 having aff were to continue to monitor e lacked evidence assessment related to falls considered n R5 had been experiencing.					
		mination care plan indicated ar					

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00717	B. WING		C 01/21/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ENTRA	CARE HEALTH - MO	NTICELLO	RT BOULEVAI ELLO, MN 553			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 10	2 830			
		ected staff to assist R5 to the s, midday and prior to bed, night rounds.				
adjustment pad call ligh her bedroor care plan di 12/23/20, 1/	adjustment that dire pad call light within her bedroom and e care plan did not id 12/23/20, 1/1/21, o	all care plan indicated an ected staff to keep a grey soft R5's reach while she was in ncourage her to utilize it. The entify R5 had a fall on r 1/5/21, R5's cognitive 's self transferring habits.				
	nursing supervisor/ stated before R5's alert and cognitivel explained R5 had r COVID", had vertig transfer despite R5 one staff, and had light at times. RN-A R5 to be a fall risk. days and bad days to remain in bed. R returned from the h RN-A stated she do Eval V2 on residen hospital unless the change in their stat not been sure if a F been completed on however, she state real changes based the hospital "so cor	a 1/14/21, at 11:40 a.m. (registered nurse (RN)-A fall on 1/1/21 R5 had been 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 toospital 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 tus. 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 ntinued with the same plan of				
	care she had prior	to going to the hospital."				

Minnesota Department of He STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 01/21/2021	
		00717				
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CENTRA	CARE HEALTH - MO	NTICELLO	RT BOULEVAI ELLO, MN 553			
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	CTION SHOULD BE COMPLET	
2 830	Continued From page 11		2 830			
	every quarter [three needed. RN-B deni process for the Fall returned from the h During interview on director of nursing had been that nursi risk assessment [F annually, with any N status, and if during portion of the IDT n determined that on	1/14/21, at 12:40 p.m. the (DON) stated her assumption ing staff would complete a fall all Risk Eval V2] on admission MDS significant changes in g the resident readmission neeting that the IDT e would be required. The DON	,			
	possible reason wh assessment [Fall R her return to the fac expected a fall risk	been uncertain as to a by R5 had not had a fall risk tisk Eval V2] completed upon cility. The DON stated she assessment [Fall Risk Eval d on a resident is there were dent's status.				
	1/20/21, at 1:32 p.n had not been updat intervention/s after 1/5/21 when R5 hat however, she expla- updated on 1/6/21 t were directed to ap in relation to R5's 1 interventions should after a fall and verb	nt follow up interview on n. RN-A stated R5's care plan ted with fall prevention the fall on 1/1/21 and before d returned to the facility; ained R5's care plan had been to reflect a change when staff proach R5 for toileting assist /5/21 fall. RN-A stated d be an immediate response palized R5's immediate action				
	after the 1/1/21 fall emergency room. <i>A</i> RN-A confirmed the R5's care plan with decrease R5's fall r 1/5/21: however, R	had been to send her to the After further conversation, e facility should have adjusted an intervention to help risk prior to her return on N-A stated facility staff had rn room placement and they				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00717	B. WING		C 01/21/2021	
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ENTRA	CARE HEALTH - MOI	NTICELLO	RT BOULEVAI ELLO, MN 553			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From page 12		2 830			
	made a decision to place her as close as possible					
		uarantine 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					
	• •	could attend to R5's needs				
	faster.					
	An undated Re-Adr	mission Checklist directed staf	F			
	on the day of readmit to "Update Care Plan with					
		o complete multiple				
		evaluations; however, the				
	checklist did not dir Risk Eval V2 after r	rect staff to complete a Fall readmission.				
	An undated Falls C	heck List and Prevention				
		ected 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					
		" be included. Another section				
		Ill Assessment was also to be				
		JST" include an intervention.				
		on labeled, "Complete a FALL CC [electronic health record]"				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00717		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING			C 01/21/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
ENTRA	CARE HEALTH - MO	NTICELLO	RT BOULEVAR ELLO, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPL THE APPROPRIATE DAT	
2 830	Continued From page 13		2 830			
	identified staff "MUST include your intervention."					
	Monticello, dated 9, identify intervention evaluations and cur resident's specific r prevent the residen complications from indicated if a reside initial interventions, additional or differe why the current app SUGGESTED MET The director of nurs review/revise policie falls, accidents and proper assessment implemented and th of a change in cond staff on the policies for evaluating and r implementation of t developed, with the brought to the facili Committee for review	ntion Policy - Care Center /2019, indicated staff were to is based on previous rrent data, along with the isks and causes, to try and t from falling and to minimize falling. Further, the policy ent continued to fall despite staff were to implement nt interventions or indicate proach remained relevant. THOD OF CORRECTION: sing or designee, could es and procedures related to resident supervision to assure and interventions are being the provider is promptly notified dition. They could re-educate and procedures. A system monitoring consistent hese policies could be results of these audits being ty's Quality Assurance ew. R CORRECTION: Twenty-one				