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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 3VWI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00091

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245232**
2.STATE VENDOR OR MEDICAID NO.
(L2) **535845101**

3. NAME AND ADDRESS OF FACILITY
(L3) **CUYUNA REGIONAL MEDICAL CENTER**
(L4) **320 EAST MAIN STREET**
(L5) **CROSBY, MN** (L6) **56441**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **08/01/2016**

6. DATE OF SURVEY **01/23/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
03/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **113** (L18)
13.Total Certified Beds **113** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	113			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 01/24/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/30/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1980
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/23/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245232 January 24, 2018

Ms. Nancy Stratman, Administrator
Cuyuna Regional Medical Center
320 East Main Street
Crosby, MN 56441

Dear Ms. Stratman:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 8, 2018 the above facility is recommended for:

113 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 113 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 24, 2018

Ms. Nancy Stratman, Administrator
Cuyuna Regional Medical Center
320 East Main Street
Crosby, MN 56441

RE: Project Number S5232025

Dear Ms. Stratman:

On December 13, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 1, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 23, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 12, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 1, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 8, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 1, 2017, effective January 8, 2018 and therefore remedies outlined in our letter to you dated December 13, 2017, will not be imposed.

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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

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(L4) **320 EAST MAIN STREET**
(L5) **CROSBY, MN** (L6) **56441**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **08/01/2016**

6. DATE OF SURVEY **12/01/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
03/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **113** (L18)
13.Total Certified Beds **113** (L17)

10.THE FACILITY IS CERTIFIED AS:
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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	113			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Vienna Andresen, HFE - NE II 12/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/23/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

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3. Both of the Above :

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02/01/1980
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23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 13, 2017

Ms. Nancy Stratman, Administrator
Cuyuna Regional Medical Center
320 East Main Street
Crosby, MN 56441

RE: Project Number S5232025

Dear Ms. Stratman:

On December 1, 2017, a standard 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 10, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 10, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 March 1, 2018 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 1, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. BUILDING _____ B. WING _____	12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUYUNA REGIONAL MEDICAL CENTER	320 EAST MAIN STREET CROSBY, MN 56441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted November 28 through December 1, 2017 by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other	F 561		1/8/18

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

Electronically Signed | 12/20/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. BUILDING _____ B. WING _____	12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUYUNA REGIONAL MEDICAL CENTER	320 EAST MAIN STREET CROSBY, MN 56441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 1 applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the residents choice for bathing preferences had been provided for 1 of 1 resident (R43) who indicated bathing frequency had not been provided as promised, three times a week. Findings include: R43 was admitted to the facility with diagnoses that included, but were not limited to: low back pain with radiculopathy, major depressive disorder, anxiety disorder, dysphagia (difficulty swallowing). Review of R43's Minimum Data Set (MDS) dated 10/16/17, indicated R43 had no cognitive impairment, was unable to ambulate, was independent with bed mobility and transfers, was unable to ambulate, and required physical assistance with bathing.	F 561	CRMC strives to promotes the rights of each resident to exercise his or her autonomy, regarding what each resident considers to be important facets of his or her life. R43 will be offered bath three times per week, per schedule. NAR flowsheet for R43 was updated on 11/30/17, for NAR to indicate whether R43 accepts or refuses bathing, so bathing frequency can be monitored. Treatment administration record for R43 was updated 12/18/17, for nurse to check with NAR whether R43 received bath per schedule, and to document reason in R43's clinical record, if bathing schedule was not followed. R43's care plan was reviewed and revised on 12/15/2017 to reflect bathing preference and history of refusal of care,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. BUILDING _____ B. WING _____	12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUYUNA REGIONAL MEDICAL CENTER	320 EAST MAIN STREET CROSBY, MN 56441

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F 561	Continued From page 2 R43 was interviewed on 11/28/17, at 11:42 a.m. and stated she was upset because at the last care conference in October 2017, R43 had requested to have a bath or shower three times a week and was promised to get a bath every Monday, Wednesday, and Friday, however R43 had continued to be offered a bath only one time a week. Review of R43's documentation Nursing Care Conference Review dated 10/26/17, revealed a care conference was held, however, there was no indication a discussion regarding bathing preferences had occurred. Review of R43's care plan revised 11/21/17, revealed the following related to bathing: Monday evening-tub bath. Wednesday morning- shower. Friday morning-shower. Review of R43's progress notes from 10/16/17-12/1/17, revealed R43 received a bath on 10/23/17, 11/6/17, 11/15/17, and 11/29/17 (every 10-14 days). A progress note dated 11/20/17, at 8:46 p.m. indicated the following: "Resident refused to take a shower this shift because she feels sick... She has requested to get have a shower Wednesday morning and I educated her that I cant promise she will get it but I can pass it on. She is upset because she stated she was suppose to be getting three showers a week and she barley gets one." Progress notes the week of 11/27-12/3/17, revealed R43 had been offered a bath or shower on Monday 11/27/17, and Wednesday 11/29/17. R43 was interviewed again on 11/29/17, at 5:04 p.m. and stated she was thankful she had been	F 561	including bathing. Social Services will meet with interviewable residents, to ensure preferences for bathing have been addressed and honored. Documentation of bathing preferences and bathing schedules will be updated to reflect individual resident preferences, as necessary. Preference for bathing for all residents will be reviewed with resident and/or resident representative, upon admission, quarterly and upon request. Preferences will be documented and bathing schedules added/updated as needed. Policy for Self Determination and Participation was developed and approved by the interdisciplinary team on December 15, 2017. Care Center staff will be trained on new policy for Resident Choice and providing resident focused care on Dec 28th, 2017 at team meeting. Audits will be conducted by RN or designee 3x per week x 4 weeks or until compliance is achieved, to ensure resident's preferences for bathing are honored. Results of audits will be reported to the QA committee for review and further recommendations.	

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F 561	Continued From page 3	F 561		

provided a bath on Wednesday which was the first time since she had been promised a bath three times a week.

Review of R43's physician orders revealed on 11/30/17, a verbal order was recorded for the following: Bath three times a week Monday, Wednesday, and Friday.

Nursing assistant (NA)-H was interviewed on 11/30/17, at 9:13 a.m. and stated R43 had requested to have a bath or shower three times a week on or around the week of 11/7/17, and the bath schedule had been changed at that time. NA-H stated she was not aware if R43 had been offered a bath three times a week since the schedule had been changed because the facility didn't document each time a resident had a bath.

The RN Manager who attended R43's care conference was not available for interview during the survey due to being on a personal leave. RN Manager (RN)-A who was currently coordinating R43's care was interviewed on 12/1/17, at 9:22 a.m. confirmed R43 was a reliable reporter, R43's last care conference occurred on 10/26/17, and there was no documented evidence that R43 had been offered a bath three times a week since the care conference on 10/26/17.

Review of the facility policy Person Centered Care Planning dated 6/23/04, and revised 11/21/17, revealed the following purpose: To ensure each resident is the locus of control, with the facility staff supporting the resident in making their own choices and having control over their daily lives.

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F 583	Continued From page 4	F 583		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 583	CRMC's policy is to promote care for all	1/8/18

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F 583	Continued From page 5 review, the facility failed to ensure residents' right to personal privacy for 2 of 2 residents (R51, R40) who voiced concern regarding staff not knocking on room door and/or knocking and not waiting for a response prior to entering their room. Findings include: R51's significant change Minimum Data Set (MDS) dated 10/23/17, indicated R51 was cognitively intact and required extensive assistance of one staff member for most activities of daily living. On 11/28/17, at 2:41 p.m. R51 stated there was one staff member who consistently entered his room without knocking. During this conversation, nursing assistant (NA)-E knocked softly on the door as she entered the room. NA-E did not wait for a response prior to entering the room. After NA-E exited the room, R51 identified NA-E as the staff member who entered his room without knocking and indicated he did not like it when she did so. R40's quarterly MDS dated 10/16/17, indicated R40 was cognitively intact and required extensive assistance of one staff member for most activities of daily living. On 11/29/17, at 3:20 p.m. during the resident group interview, residents were asked about their rights in the facility and if their right to privacy was respected. R40 replied staff might knock on his room door but indicated they walked right in and didn't wait for a response. R40 indicated he did not like it when staff just walked into his room.	F 583	residents in an approach that makes certain that each resident's privacy and dignity is protected and valued by staff. R51 was discharged from the facility on 12/6/17. R 40's care plan was reviewed and revised on 12/15/17 to reflect preferences for personal privacy. Policy for Privacy and Dignity was reviewed and revised on 12/15/17 by the Interdisciplinary team. Revisions include staff to knock on door, and seek consent before entering the resident's room. Care Center staff will review education on updated Privacy and Dignity Policy at the team meeting on Dec 28th, 2017 with importance on knocking and seeking consent, before entering a resident's room. Social worker will meet with R40 weekly x 4 weeks to ensure R40's privacy is being protected and valued. Random audits will be conducted daily x 2 weeks by RN or designee, to ensure resident privacy is protected and valued as evidenced by staff knocking on doors and seeking consent, prior to entering. After 2 weeks, if compliance is achieved, audits will be changed to twice per week x 2 weeks, then, weekly until reviewed by QA Committee for further recommendations.	

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F 583	Continued From page 6 On 12/01/17, at 8:46 a.m. NA-F stated R51 preferred his door closed in order to keep the heat in and noise out and he also R51 liked his privacy. On 12/01/17, at 10:59 a.m. the director of nursing (DON) stated she would expect staff to respect resident privacy and to wait for a response prior to entering resident rooms after knocking. The Privacy and Dignity policy dated 4/7/2003, indicated staff would respect resident's private space and property by knocking on doors before entering room and not moving or inspecting resident's personal property without asking permission.	F 583	Results of audits will be reported to the QA committee for review and further recommendations.	
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement individual exercise programs as directed by the care plan for 2 of 3 residents (R21, R72) residents reviewed for range of motion services. Findings include: R72's care plan dated 11/14/17, indicated activities of daily living (ADL)/mobility impairment	F 659	CRMC□s policy is ensure each resident receives services and care to maintain or improve his or her highest level of range of motion and mobility, within the activity restraints/constraints of their individual health status. The policy for Nursing Service Rehabilitation Services was reviewed and revised on 12/15/17 by the	1/8/18

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F 659	Continued From page 7 due to weakness, diabetes, and refusal of cares. The plan indicated R72 was to perform the HEP twice per (bid) day as outlined under "Rehab and Therapy tab." The care plan referred the reader to R72's "closet care plan." R72's nursing assistant documentation form for November 2017, located in the Lakeview NAR charting book revealed a daily directive to provide personal exercise program two times a day per exercise program instructions located in R72's closet. R72's HEP program was initialed by staff indicating the program had been provided/implemented. R72's Individual Resident Care Plan, posted in his closet, read "Rehab: HEP exercised bid with cares. See sheet." R72's HEP directions posted in his closet directed the following: -The Personal Exercise Program sheet dated 6/28/16, indicated R72 was to perform eight separate lower extremity exercises 10 to 20 repetitions each exercise three times per day. -The Hip Abduction and Adduction Caregiver PROM [passive range of motion] sheet dated 12/22/16, directed the staff to provide hip abduction and adduction exercises 10 repetitions each five times a week and the Hip and Knee Extension and Flexion Caregiver PROM section directed the staff to provide hip/knee extension/flexion exercises 10 repetitions each, five times a week. -The Foot Dorsiflexion PROM Caregiver sheet directed staff to perform foot exercises 10 repetitions each foot, five times a week. The Foot Inversion and Eversion PROM Caregiver section	F 659	interdisciplinary team. Revisions include: NAR to report to nurse when exercise program is no longer appropriate. If resident is unable or unwilling to participate in exercise program per care plan, RN will send screen request to therapy, so program may be reviewed and adapted to meet the individual needs and preferences of the resident. All resident exercise plans will be reviewed for continued appropriateness by RN. Screen requests will be sent to therapy for review of programs that are no longer appropriate or attainable. The physician will be consulted to discontinue programs no longer appropriate. New exercise program will be developed using person centered approach, which includes preferences of the residents. Resident exercise programs will be reviewed quarterly and as needed by the RN, to ensure goals for the program are being attained. If goals are not being attained, RN will send screen to Therapy to reassess the exercise program. R72 was screened by PT on 12/14/17 for exercise program. Care plan was reviewed and revised on 12/14/17 to reflect new changes to exercise program. R21 was screened by PT on 12/5/17 for lower extremity exercise program. OT screening completed 12/19/17 for review of upper extremity exercise program. OT indicated R21 had intact upper extremity range of motion and did not require	

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F 659	Continued From page 8 directed staff to provide inversion and eversion exercises each foot, 110 repetitions each, five times a week. On 11/29/17, form 3:10 p.m. until 6:26 p.m. R72 was observed in his room, seated in a recliner with legs elevated, soundly sleeping. R72 had slept through the supper meal. At 7:15 p.m. R72 remained in his room seated upright in his recliner. R72 was served his supper meal. -From 7:15 p.m. until 7:32 p.m. R72 was observed to eat his meal without difficulty. -At 8:07 p.m. R72 remained seated upright in the recliner as nursing assistant (NA)-I and NA-A entered his room. Both NAs were observed to transfer R72 into bed via a standing lift and provide evening. Following completion of the cares, staff exited the room. No exercises were provided. On 11/29/17, at 4:43 p.m. NA-A confirmed R72 was to perform his HEP twice a day with cares. On 11/30/17, at 2:03 p.m. R72's HEP was reviewed with NA-B and NA-C and both stated other than stretching out or lifting up R72's arms/legs to thread clothing when dressing or providing cares, they had not provided any additional exercises nor repetitive movements as directed by the HEP. Both also stated the only time available to perform exercises with the residents' was during cares and confirmed R72's HEP had not been provided as directed. On 11/30/17, at 3:47 p.m. NA-A stated staff tried to help R72 stretch out his arms/legs when doing cares or transferring, however, do not provide any type of formal exercise program.	F 659	continued upper extremity exercises. R21□s care plan was reviewed and revised on 12/19/17. Staff meeting was held on 12/15/17 to discuss and solicit suggestions and concerns from team members on resident exercise programs. Mandatory staff meeting is scheduled for Dec 28, 2017 and will include review of revised Nursing Service Rehabilitation Services policy and need for staff to report when exercise programs are no longer appropriate. CRMC Therapy Department will provided range of motion and exercise program refresher at the team meeting on 12/28/7 for nursing staff. Random audits will be conducted by RN or designee daily x 2 weeks, to ensure exercise programs are being followed and are attainable by resident, per care plan. If compliance is met, audits will be changed to twice per week x 2 weeks, then weekly, until reviewed by QA Committee for further recommendations. Results of audits will be reported to the QA committee for review and further recommendations.	

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F 659	Continued From page 9 On 12/1/17, at 8:20 a.m. RN-A confirmed R72's HEP directives and stated it was her expectation for staff to implement the care plan as written. On 12/1/17, at 9:37 a.m. the director of nursing (DON) confirmed the care plans should have been implemented as written. R21's Care Plan dated as last reviewed 10/5/17, indicated R21 had an alteration in mobility secondary to needing assistance with transfers and mobility. The care plan indicated R21 had a history of poor vision, arthritis, cognitive impairment and a left hip fracture with left hip hemiarthroplasty (replacement of one half of the hip joint). The care plan directed staff to assist R21 with ambulation twice daily with cares and staff assist of 1 and front wheeled walker. The care plan also directed staff R21 was to complete a home exercise program (HEP) as described in rehab and therapy tab with staff assist twice daily with cares. On 11/29/17, at 1:22 p.m. R21 was observed in her wheelchair propelling herself with her feet down the hallway toward her room. --at 1:23 p.m. R21 was observed standing by her recliner in her room with a shopping bag. R21 took several steps independently in her room. A unidentified staff member walked by the room and entered to assist R21 to sit in her recliner. --at 6:00 p.m. R21 was again observed to propel herself in her wheelchair independently through the dining room and down the hall toward her room. On 11/30/17, at 11:00 a.m. NA-G stated mobility interventions for R21 included ambulation to the bathroom with staff and to offer ambulation in the	F 659		

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hallway. NA-G stated R21's HEP involved the motions required to assist with dressing herself such as placing her arms out in front and raising them above her head to put on a shirt. NA-G indicated she had not assisted R21 with repetitions of these movements and had not assisted with anything additional for R21's lower extremities, just walking.

On 11/30/17, at 3:08 p.m. physical therapist (PT) indicated HEP stood for the resident home exercise program which was an individualized program based on resident needs. PT stated they typically wrote a HEP to be done during cares with staff and could include upper and lower extremity exercises. PT confirmed the actions involved in putting on a shirt or getting dressed would not constitute an exercise program.

On 11/30/17, at 3:38 PM the Parkview NA charting book was reviewed and included HEP two times a day for exercise. Complete home exercise program with staff assist twice daily with cares. The charting book also contained the following exercise sheets for R21:
--Sheet 1 contained 4 lower extremity exercises with illustrations. 1 set, 20 reps lower extremity daily was handwritten on the page.
--Sheet 2 contained instructions for resistive band exercises. 1 set 10 reps, work up to 2 sets of 15 reps with yellow and red T-bands 3 times per week was handwritten on the page.
--Sheet 3 contained three illustrations with instructions for upward pull, downward pull and upward diagonal resistive band upper extremity exercises.
--Sheet 4 contained three illustrations with instructions for outward pull, outward rotation and

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overhead pulldown resistive band upper extremity exercises.
--Sheet 5 contained three illustrations with instructions for forward punch, elbow bends and elbow extension resistive band upper extremity exercises.

On 12/01/17, at 7:50 a.m. R21 was observed seated in a wheelchair in her room, combing her hair. R21 stated staff had not assisted her with exercises that morning or the previous evening. R21 stated she sometimes did exercises in the activity room but had not done them in her room lately.

On 12/01/17, at 9:04 a.m. RN-A stated the Individual Resident Care Plan directed R21 required a HEP and referred to a posted sheet. RN-A stated this care plan should be posted in R21's closet. RN-A also indicated the NAs documented completion of the exercises in their charting book which also had copies of required exercises. RN-A obtained the Parkview NA charting book and verified R21's HEP should be completed twice daily as directed by the care plan. RN-A also verified copies of the required exercises were posted in the book and confirmed putting on clothing was not the prescribed program.

On 12/01/17, at 11:10 a.m. the DON confirmed R21 should have received restorative services as outlined on the HEP and directed by the care plan.

The Daily Resident Cares policy and procedure dated 10/92, directed the staff to consult the closet care plan for specific needs of each resident.

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F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the home exercise programs were implemented as directed for 2 of 2 residents (R72, R21) reviewed for nursing rehabilitation. Findings include: R72's quarterly Minimum Data Set (MDS) dated 11/14/17, indicated R72 had moderate cognitive impairment, required extensive assist of two staff for bed mobility, transfers and toileting, and one staff assist for locomotion in the wheelchair. R72 does not ambulate, has poor balance and bilateral limited functional range of motion of the lower extremities.	F 688	CRMC□s policy is ensure each resident receives services and care to maintain or improve his or her highest level of range of motion and mobility, within the activity restraints/constraints of their individual health status. The policy for Nursing Service Rehabilitation Services was reviewed and revised on 12/15/17 by the interdisciplinary team. Revisions include: NAR to report to nurse when exercise program is no longer appropriate. If resident is unable or unwilling to participate in exercise program per care plan, RN will send screen request to therapy, so program may be reviewed and	1/8/18

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F 688	Continued From page 13 R72's Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 8/29/17, indicated R72's diagnoses include dementia with paranoia, impulsivity, diabetes, hepatic encephalopathy, neuropathy, and anxiety. The CAA also indicated R72 had impaired bilateral range of motion (ROM) to lower extremities, and required one to two staff assistance for ADLs and transferred with a mechanical standing lift. A home exercise program (HEP) exercises twice a day which R72 occasionally refused but staff continued to offer and encouraged R72 to participate as he was willing. The CAA referred the reader to "see care plan." R72's current December 2017, physician orders revealed an order for personal exercise program twice per day. R72's care plan dated 11/14/17, indicated ADL/mobility impairment due to weakness, diabetes, and refusal of cares. The plan indicated R72 was to perform the HEP twice per (bid) day as outlined under the "Rehab and Therapy tab" and directed staff to refer to R72's closet care plan. R72 had a history of resistiveness to treatment/care related to cognitive impairment and directed staff to allow for flexibility in ADL routine and to discuses implications of not complying with his therapeutic regime. R72's nursing assistant documentation form for November 2017, located in the Lakeview NAR charting book revealed a daily directive to provide a personal exercise program two times a day per exercise program instructions located in R72's closet. Review of R72's September and October 2017, also revealed a daily directive to provide a	F 688	adapted to meet the individual needs and preferences of the resident. All resident exercise plans will be reviewed for continued appropriateness by RN. Screen requests will be sent to therapy for review of programs that are no longer appropriate or attainable. The physician will be consulted to discontinue programs no longer appropriate. New exercise program will be developed using person centered approach, which includes preferences of the residents. Resident exercise programs will be reviewed quarterly and as needed by the RN, to ensure goals for the program are being attained. If goals are not being attained, RN will send screen to Therapy to reassess the exercise program. R72 was screened by PT on 12/14/17 for exercise program. Care plan was reviewed and revised on 12/14/17 to reflect new changes to exercise program. R21 was screened by PT on 12/5/17 for lower extremity exercise program. OT screening completed 12/19/17 for review of upper extremity exercise program. OT indicated R21 had intact upper extremity range of motion and did not require continued upper extremity exercises. R21□s care plan was reviewed and revised on 12/19/17. Staff meeting was held on 12/15/17 to discuss and solicit suggestions and concerns from team members on resident	

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	245232	A. BUILDING _____ B. WING _____	12/01/2017

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F 688	Continued From page 14 personal exercise program twice per day. All three forms were initialed by staff on a daily basis indicating the program was provided twice per day. R72's Individual Resident Care Plan, posted in his closet, read "Rehab: HEP exercised bid with cares. See sheet." R72's HEP sheets posted in his closet directed the following: -The Personal Exercise Program sheet dated 6/28/16, indicated R72 was to perform eight separate lower extremity exercises 10 to 20 repetitions each exercise three times per day. -The Hip Abduction and Adduction Caregiver PROM [passive range of motion] sheet dated 12/22/16, directed the staff to provide hip abduction and adduction exercises 10 repetitions each five times a week and the Hip and Knee Extension and Flexion Caregiver PROM section directed the staff to provide hip/knee extension/flexion exercises 10 repetitions each, five times a week. -The Foot Dorsiflexion PROM Caregiver sheet directed staff to perform foot exercises 10 repetitions each foot, five times a week. The Foot Inversion and Eversion PROM Caregiver section directed staff to provide inversion and eversion exercises each foot, 110 repetitions each, five times a week. On 11/29/17, from 3:10 p.m. until 6:26 p.m. R72 was observed in his room, seated in a recliner with legs elevated, soundly sleeping. -At 7:15 p.m. R72 remained in his room, seated in his recliner and was served his supper meal. -At 8:07 p.m. R72 remained seated in the recliner	F 688	exercise programs. Mandatory staff meeting is scheduled for Dec 28, 2017 and will include review of revised Nursing Service Rehabilitation Services policy and need for staff to report when exercise programs are no longer appropriate. CRMC Therapy Department will provided range of motion and exercise program refresher at the team meeting on 12/28/7 for nursing staff. Random audits will be conducted by RN or designee daily x 2 weeks, to ensure exercise programs are being followed and are attainable by resident, per care plan. If compliance is met, audits will be changed to twice per week x 2 weeks, then weekly, until reviewed by QA Committee for further recommendations. Results of audits will be reported to the QA committee for review and further recommendations. Date of correction Jan 8, 2018	

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F 688	Continued From page 15	F 688		

as nursing assistant (NA)-I and NA-A entered his room. Both NAs were observed to transfer R72 into bed via a standing lift and provide evening cares. Following completion of the cares, staff exited the room. No exercises were provided or offered.

On 11/29/17, at 4:43 p.m. registered nurse (RN)-C confirmed R72 was to perform the HEP twice per day with cares. When asked about staff documentation related to the provision of the HEP program, RN-C stated the Lakeview NAR charting book was the only place the NAs were required to document in.

On 11/30/17, at 2:03 p.m. R72's HEP was reviewed with NA-B and NA-C in which both stated other than stretching out or lifting up arms/legs to thread clothing when dressing or providing cares, they had not provided any additional exercises nor repetitive joint movements as directed by the HEP and felt there was "no way" R72 could perform the repetitious exercises as directed. NA-B and NA-c stated stated the only time available for staff to perform any type of exercises with the residents' was during cares and confirmed R72's HEP had not been provided as directed.

On 11/30/17, at 3:47 p.m. NA-A stated staff had tried to help R72 stretch out his arms/legs when doing cares or transferring, however, had not provided any type of formal exercise program nor any type of repetitious movement. NA-A stated R72 has had no change in his range of motion ability.

11/30/17, at 4:05 p.m. RN-B stated the physical therapist had developed R72's HEP program

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F 688	Continued From page 16	F 688		

based on his evaluation of R72's needs and it was her expectation of staff to implement the HEP program as directed.

On 12/1/17, at 8:20 a.m. RN-A confirmed R72's HEP program and stated the facility did not have a restorative aide to provide the exercises programs therefore, it was the expectation that the NAs implemented the programs, as directed. RN-A stated if the program was no longer appropriate for R72, she would have him reevaluated by the physical therapist, if R72 accepted.

On 12/1/17, at 9:37 a.m. the director of nursing (DON) confirmed R72's care plan directive should have been implemented, as written.

R21's significant change MDS dated 9/18/17, indicated R21 had moderate cognitive impairment and diagnoses which included vascular dementia without behavioral disturbance and arthritis. The MDS indicated R21 required extensive assist of two staff for bed mobility, transfer, walk in room and toilet use and required extensive assist of one staff for locomotion, dressing, eating, and personal hygiene. The MDS also indicated R21 had functional limitation in range of motion of lower extremities with impairment on one side.

R21's Diagnosis Report dated 12/1/17, indicated R21 had diagnoses which included a fracture of part of neck of left femur and encounter for orthopedic aftercare.

R21's ADL Functional/Rehabilitation Potential CAA dated 9/18/17, indicated R21 had required more support with eating skills, personal hygiene,

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F 688	Continued From page 17	F 688		

increased urinary incontinence and had not ambulated in the hallway. R21 had a hospital stay in June for a left hip fracture. The CAA further indicated R21 had a physical therapy screening on 9/19/17, and was approved for the use of the Nustep (a recumbent cross trainer). Staff were to encourage R21 to participate in ADL/mobility and exercise program.

R21's Order Summary Report dated 12/1/17, indicated post-surgical hip precautions had been posted outside R21's closet. The report also indicated rehab services were discontinued due to plateau in progress and ordered ambulation twice daily with cares and staff assist of 1 with front wheeled walker (FWW). The Report also included an order to complete HEP [home exercise program] as described in "rehab and therapy" tab with staff assist twice daily with cares.

R21's Care Plan dated as last reviewed 10/5/17, indicated R21 had an alteration in mobility secondary to needing assistance with transfers and mobility. The care plan indicated R21 had a history of poor vision, arthritis, cognitive impairment and a left hip fracture with left hip hemiarthroplasty (replacement of one half of the hip joint). The care plan directed staff to assist R21 with ambulation twice daily with cares and staff assist of 1 and front wheeled walker. The care plan also directed staff R21 was to complete a HEP as described in rehab and therapy tab with staff assist twice daily with cares.

On 11/29/17, at 1:22 p.m. R21 was observed in her wheelchair propelling herself with her feet down the hallway toward her room.
--at 1:23 p.m. R21 was observed standing by her

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F 688	Continued From page 18	F 688		

recliner in her room with a shopping bag. R21 took several steps independently in her room. A unidentified staff member walked by the room and entered to assist R21 to sit in her recliner. --at 6:00 p.m. R21 was again observed to propel herself in her wheelchair independently through the dining room and down the hall toward her room.

On 11/30/17, at 11:00 a.m. NA-G stated mobility interventions for R21 included ambulation to the bathroom with staff and to offer ambulation in the hallway. NA-G stated R21's HEP involved the motions required to assist with dressing herself such as placing her arms out in front and raising them above her head to put on a shirt. NA-G indicated she had not assisted R21 with repetitions of these movements and had not assisted with anything additional for R21's lower extremities, just walking.

On 11/30/17, at 3:08 p.m. physical therapist (PT) indicated HEP stood for the resident home exercise program. PT stated it was an individualized program based on resident needs. PT stated they typically wrote a HEP to be done during cares with staff and could include upper and lower extremity exercises. PT confirmed the actions involved in putting on a shirt or getting dressed would not constitute an exercise program.

On 11/30/17, at 3:38 PM the Parkview NA charting book was reviewed and included Home Exercise Program HEP two times a day for exercise. Complete home exercise program with staff assist twice daily with cares. The charting book also contained the following exercise sheets for R21:

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F 688	Continued From page 19 --Sheet 1 contained 4 lower extremity exercises with illustrations. 1 set, 20 reps lower extremity daily was handwritten on the page. --Sheet 2 contained instructions for resistive band exercises. 1 set 10 reps, work up to 2 sets of 15 reps with yellow and red T-bands 3 times per week was handwritten on the page. --Sheet 3 contained three illustrations with instructions for upward pull, downward pull and upward diagonal resistive band upper extremity exercises. --Sheet 4 contained three illustrations with instructions for outward pull, outward rotation and overhead pulldown resistive band upper extremity exercises. --Sheet 5 contained three illustrations with instructions for forward punch, elbow bends and elbow extension resistive band upper extremity exercises. On 12/01/17, at 7:50 a.m. R21 was observed seated in a wheelchair in her room, combing her hair. R21 stated staff had not assisted her with exercises that morning or the previous evening. R21 stated she sometimes did exercises in the activity room but had not done them in her room lately. On 12/01/17, at 9:04 a.m. RN-A stated the Individual Resident Care Plan directed R21 required a HEP and referred to a posted sheet. RN-A stated this care plan should be posted in R21's closet. RN-A also indicated the NAs documented completion of the exercises in their charting book which also had copies of required exercises. RN-A obtained the Parkview NA charting book and verified R21's HEP should be completed twice daily as directed by the care plan. RN-A also verified copies of the required	F 688		

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F 688	Continued From page 20 exercises were posted in the book and confirmed putting on clothing was not the prescribed program. On 12/01/17, at 11:10 a.m. the DON confirmed R21 should have received restorative services as outlined on the HEP and directed by the care plan. The Nursing Service Rehabilitation Services policy dated 1/27/98, indicated nursing would provide maintenance or restorative services to residents as directed by the MD, Physical Therapy and/or Occupational Therapy. The policy indicated services which may be offered included active range of motion, passive range of motion, ambulation, and strengthening exercise program. The policy further indicated nursing assistants would assist resident with their exercise treatment play, report to charge nurse or unit coordinator any changes noted in the functional capabilities of the resident and participate in training updates to maintain/develop rehabilitation expertise.	F 688		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		1/8/18

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F 755	Continued From page 21 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a mouth rinse was provided after the administration of a steroid medication (Pulmicort) via nebulizer as directed by the medication's manufacturer recommendations for 1 of 2 residents (R10) who was observed during administration of medications via nebulizer. Findings include: R10's Order Summary Report dated 12/1/17, included an order for Pulmicort Suspension 0.5 milligrams (mg)/2 milliliters (ml) (budesonide) 0.5 mg inhale orally two times a day for chronic obstructive pulmonary disease. The order start date was 11/28/17.	F 755	CRMC strives to ensure best practice and clinical standards of care are maintained when administering medications via nebulizer to residents in our care. The consultant pharmacist was consulted regarding best practice for administration of inhaled corticosteroid medications. New policy for Inhaled Medication Administration was implemented on 12/15/17. All residents receiving inhaled corticosteroid medications will be offered mouth rinse/swab, depending on individual's ability/NPO status, following medication administration.	

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F 755	Continued From page 22 On 12/01/17, at 9:50 a.m. registered nurse (RN)-D was observed to enter R10's room, wash her hands and place R10's tube feeding on hold. RN-D placed albuterol suspension (a drug to relax the airway muscles) into the reservoir of a nebulizer (device used to administer medication in the form of a mist inhaled into the lungs) mask, connected the mask to oxygen tubing, turned it on and placed the mask on R10. During the albuterol nebulizer treatment, RN-D checked placement of R10's PEG [percutaneous endoscopic gastrostomy]-tube (a tube placed through the abdominal wall and into the stomach), flushed the tube with water, administered R10's Prevacid medication dissolved in water, and again flushed the PEG-tube with water. At this time, the nebulizer treatment was complete. RN-D removed the reservoir from the nebulizer mask and squeezed a unit dose of budesonide medication into the reservoir. She reattached the reservoir to the mask to begin the treatment. RN-D administered R10's remaining medications via PEG-tube, instilled eye drops into each of R10's eyes and restarted R10's tube feeding. At this time the second nebulizer treatment was completed and RN-D turned off the oxygen, removed the nebulizer mask from R10, rinsed and dried the nebulizer mask and reservoir and exited the room without providing oral care for R10. --At 10:13 RN-D indicated she was not aware of the recommendation for a mouth rinse after the administration of budesonide. She retrieved the package insert from the medication cart and verified the manufacturer's recommendations included a mouth rinse after inhalation of the medication to reduce the risk of thrush (a fungal	F 755	R10's orders were reviewed and revised on 12/5/17 to reflect need to provide oral care with swab following completion of corticosteroid nebulizer. All residents receiving inhaled corticosteroid medications orders were reviewed and revised to reflect need to assist with oral rinse or swab following administration of medication. Education on policy for Inhaled Medication Administration, which includes assisting residents with oral rinse & spit with water (or swab for NPO residents) was provided to staff during team meeting on Dec 15th, 2017 and will be reviewed on Dec 28th, 2017 at mandatory staff meeting. MAR's for corticosteroid nebulizers will be updated to include instruction for rinse/swab following administration. Random audits will be conducted daily x 2 weeks by RN of designee, to ensure care plan for oral rinse or swab is offered to resident's following administration of Corticosteroid nebulizers. If compliance is achieved, audits will be conducted twice weekly for 2 weeks, then weekly until reviewed by QA Committee for further. Results of audits will be reported to the QA committee for review and further recommendations.	

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F 755	Continued From page 23 infection of the mouth and throat). On 12/1/17, at 10:40 a.m. the director of nursing (DON) indicated R10 was NPO (a medical instruction to withhold oral intake of food and fluids) and would be unable spit after a mouth rinse. DON stated she would defer to the consultant pharmacist if swabbing R10's mouth would be appropriate after the administration of budesonide. On 12/1/17, at 11:40 a.m. the consulting pharmacist (CP) indicated, in general, she would recommend standard mouth care such as swabbing the mouth with a toothette after the administration of budesonide for residents who were not capable to rinse and spit. CP recommended this should have been attempted for R10. The Nebulization Treatments policy dated 6/20/17, indicated the purpose of the policy was to provide guidelines in the following areas: Indications, contraindications, associated hazards, associated complications, equipment needed, steps for performance, and equipment cleaning (as appropriate). The policy did not address provision of a mouth rinse or oral cares after administration of steroid medication.	F 755		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. 01 Main Building A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Cuyuna Regional Medical Center C&NC 01 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/20/2017

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Cuyuna Regional Medical Center C&NC is a 1-story building with a basement. The original building was constructed in 1962, attached to a hospital, separated with a 2-hour fire rated barrier and was determined to be of Type II (000) construction. The major addition was constructed east of the existing building in 1982, was determined to be of Type II (000) construction with additions to the main entrance area (dining room) and south wing (dayroom) in 1996 of Type II (111) construction. In 2007 a 10 feet by 30 feet dayroom addition was constructed to the north west wing, was determined to be Type II (111) construction and separated with a 2-hour fire barrier. The building is divided into 7 smoke compartments by 30 minute and 2- hour fire barriers.	K 000		

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	245232	A. BUILDING **02 - 2007 DAYROOM** B. WING _____	**11/28/2017**

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K 000	Continued From page 2 The entire building is protected with a complete automatic fire sprinkler system and has a fire alarm system with smoke detection throughout the corridor system, in common areas and hazardous areas. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2015 edition. The facility has a capacity of 113 beds and had a census of 82 at the time of the survey. The requirement at 42 CFR, Subpart 485.623 (d) is **NOT MET**.	K 000		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This **REQUIREMENT** is not met as evidenced by: Based on review of reports, records and staff	K 712	Drills for 2018 have been scheduled	12/19/17

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K 712	Continued From page 3 interview, it was determined that the facility failed to conduct several fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 82 of 82 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 11/28/2017, during the review of all available fire drill documentation and interview with the Maintenance Supervisor the following deficient conditions were found 1. The facility did not conduct a fire drill during the afternoon shift in the first quarter and during the overnight shift in the third quarter. 2. The facility did not conduct 2 of 12 monthly tests of the DACT. This deficient condition was verified by a Maintenance Supervisor.	K 712	through our work order system to assure that the requirement of conducting fire drills on all 3 shifts at least quarterly will be conducted. Responsible Person: Dan Hoffard, Director of Facilities	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	K 901		12/28/17

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K 901	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 82 of 82 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 11/28/2017, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility could not provide any risk assessment documenting or proof that the risk assessment had been completed at the time of the inspection. This deficient condition was verified by a Maintenance Supervisor.	K 901	Risk assessments have been started and will be complete on 12/28/2017. They are on file in our work order system. Responsible Person: Dan Hoffard, Director of Facilities	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are	K 914		1/2/18

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K 914	Continued From page 5 tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 82 of 82 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 11/28/2017, during a records review and an interview with the Maintenance Supervisor, the facility could not provide any documentation for the completion of the annual electrical outlet inspection and testing for the electrical outlets located in the patient/resident rooms located throughout the facility. This deficient condition was verified by a Maintenance Supervisor.	K 914	All electrical outlets located in resident rooms will be completely tested by a licensed electrician the week of Dec. 25-29, 2017. A preventive maintenance plan has been entered to assure that this is done annually. Responsible Person: Dan Hoffard, Facilities Director	

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K 920	Continued From page 6	K 920		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview with the staff the facility had multiple deficient conditions affecting the facility's electrical system that were not in accordance with NFPA 70 (11), National Electrical Code. This deficient practice could negatively affect 12 of 82 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 920	All power strips that were daisy-chained have been removed following reorganization of the desk and med cart, additional outlet was installed for the need of power. Responsible Person: Dan Hoffard, Facilities Director	12/19/17

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K 920	Continued From page 7 On facility tour between 10:00 a.m. to 3:00 p.m. on 11/28/2017, observations revealed that there is a refrigerator and a blanket warmer that is plugged into a power strip that has been daisy chained to two other power strips. This deficient condition was located in the memory care unit by the nurses' station. This deficient condition was verified by a Maintenance Supervisor.	K 920		