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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7PTX

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)

6. DATE OF SURVEY **02/01/2016** (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 **117** (L18)
13.Total Certified Beds **117** (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
	117			
(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 03/03/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 03/03/2016 (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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/01/2016
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245232

March 3, 2016

Ms. Nancy Stratman, Administrator
Cuyuna Regional Medical Center
320 East Main Street
Crosby, Minnesota 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 26, 2016 the above facility is certified for:

117 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 117 skilled nursing facility bed.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 24, 2016

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

RE: Project Number S5232023

Dear Ms. Stratman:

On January 4, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 17, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On February 1, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 10, 2016, 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 17, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 26, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 17, 2015, effective January 26, 2016 and therefore remedies outlined in our letter to you dated January 4, 2016, 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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245232 Y1	A. Building B. Wing Y2	2/1/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0279	Correction	ID Prefix F0282	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	01/26/2016	LSC	01/26/2016	LSC	01/26/2016
ID Prefix F0312	Correction	ID Prefix F0314	Correction	ID Prefix F0315	Correction
Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(d)	Completed
LSC	01/26/2016	LSC	01/26/2016	LSC	01/26/2016
ID Prefix F0322	Correction	ID Prefix F0332	Correction	ID Prefix F0369	Correction
Reg. # 483.25(g)(2)	Completed	Reg. # 483.25(m)(1)	Completed	Reg. # 483.35(g)	Completed
LSC	01/26/2016	LSC	01/26/2016	LSC	01/26/2016
ID Prefix F0431	Correction	ID Prefix F0441	Correction	ID Prefix F0465	Correction
Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed	Reg. # 483.70(h)	Completed
LSC	01/26/2016	LSC	01/26/2016	LSC	01/26/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	LB/mm	02/24/2016	28035	02/01/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/17/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245232 Y1	A. Building 01 - NURSING HOME B. Wing Y2	2/10/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0017	01/26/2016	LSC K0029	01/26/2016	LSC K0056	01/26/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0076	01/26/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	TL/mm	02/24/2016	27200	02/10/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/17/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7PTX

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: **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)

6. DATE OF SURVEY **12/17/2015** (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 **117** (L18)
13.Total Certified Beds **117** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___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
	117			
(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 :
Theresa Gullingsrud, HFE NE II 01/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/01/2016 (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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/01/2016
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

Electronically delivered
January 4, 2016

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

RE: Project Number S5232023, H5232022

Dear Ms. Stratman:

On December 17, 2015, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the December 17, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5232022 that was found to be unsubstantiated.

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

<u>Informal Dispute Resolution</u> - 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
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 26, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a 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:

- 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 17, 2016 (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 17, 2016 (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 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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 _____	12/17/2015

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 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. Investigation of complaint H5232022 was also completed. The complaint was not substantiated.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide grooming and / or dressing assistance related to the removal of facial hair or the provision of clean arm protectors in order to maintain dignity for 2 of 5 residents (R38, R51) who were observed with long facial hair or soiled arm protectors and required assistance with grooming/dressing needs.	F 241	F 241 - Dignity and Respect of Individuality CRMC's policy is to respect each resident's privacy and dignity; and to assist, as needed, to maintain and improve self-esteem and worth. The facility policy for privacy and dignity has been reviewed by the interdisciplinary team.	1/26/16

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

Electronically Signed | 01/14/2016

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 _____	12/17/2015

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F 241	Continued From page 1 Findings include: R38 was observed with long facial hair and the staff failed to assist with grooming needs. R38's Diagnosis Report dated 12/17/15, indicated R38's diagnoses included depression, anxiety and malaise. R38's quarterly Minimum Data Set dated 11/13/15, indicated R38 had moderately impaired cognition, did not have any behaviors or rejection of cares, had moderately impaired vision and required extensive staff assistance for personal hygiene. R38's activities of daily living (ADL) care plan revised on 8/5/15, indicated R38 required assistance with maintaining personal appearance and directed staff to alternate rest periods when performing grooming activity. Discuss with R38 portions of the task she would be willing to attempt and praise R38 for completed steps in personal hygiene for her appearance. The care plan further indicated R38 had the inability to focus on objects, discriminate color and adjust to changes in light and dark related to impaired vision due to macular degeneration. R38's Individual Care Plan dated 11/5/15, directed staff to set up R38 to wash her hands and face. The care plan lacked direction for the removal of facial hair.	F 241	Resident R38's care plan has been reviewed and revised to include her choice for facial hair removal, via tweezer removal. The TAR for R38 has been updated to include weekly checks for need for plucking of facial hair by licensed staff. Resident R51's care plan has been reviewed with no revisions needed. R51's TAR has been updated to include am and pm checks by licensed staff, to ensure Dermasavers are clean. All residents wearing Dermasavers have had their TAR updated for checks twice daily to ensure Dermasavers are neat and clean. Practice and adherence to the correction will be monitored by weekly review of TAR, to see that documentation has been completed for one month. If found to be in compliance with plan of correction, audits will be done monthly for 3 months and quarterly thereafter for up to one year. All reviews and audits will be brought to the monthly QA meeting. On 1/22/16, the Regional Ombudsman Maisie Blaine will provide education on dignity and resident rights at all staff meeting. Also, the facility policy on privacy and dignity will be reviewed with staff during all staff meetings on 1/22/16. Corrective action will be complete by 1/26/16.	

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F 241	Continued From page 2	F 241		

Throughout the survey on 12/14/15 11:30 a.m. until 8:00 p.m.; 12/15/15, from 8:00 a.m. until 4:30 p.m.; 12/16/15, from 7:00 a.m. until 3:30 p.m.; 12/17/15, from 8:00 a.m. until 11:30 a.m. R38 was observed to have several long hairs on her chin approximately three quarters of an inch long and several on her upper lip, at the corners of her mouth approximately a half an inch long and a few longer ones approximately an inch long on the right side under her jaw. Each day R38 was observed to have her hair done and was nicely dressed in a blouse, slacks and shoes.

On 12/16/15, at 7:35 a.m. R38 stated she did not like the long facial hair. R38 stated she tried to get the staff to pluck them. R38 stated the staff had shaved and cut her facial hair with a scissors once but she did not like that and would not let them do that again. R38 stated she only wanted the facial hair plucked because "that's the only thing that works." R38 stated she had visited the beauty shop in which sometimes the hairs were plucked if they had time but "they don't like to do that." R38 stated she had poor vision and could not see them to do it herself.

On 12/17/15, at 9:35 a.m. nursing assistant (NA)-E stated if he saw a female resident with facial hair he would trim it up. However, NA-E was responsible for R38's cares and had not offered to trim R38's facial hair.

On 12/17/15, at 10:30 a.m. registered nurse (RN)-C stated although R38's care plan lacked

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F 241	Continued From page 3 direction for the removal of facial hair, the facical hair should have been removed and if a resident would not allow facial hair to be shaved then it should be trimmed. RN-C confirmed staff could pluck facial hair if the resident's family allowed it. RN-C did not know if the beauty shop provided the plucking or waxing of facial hair. R51 required the use of bilateral arm protectors and staff failed to remove and replace when soiled. R51's Diagnosis Report dated 12/17/15, indicated R51's diagnoses included Parkinson's disease, dementia, osteoarthritis, chronic pain, anxiety and stroke. R51's quarterly MDS dated 9/16/15, indicated R51 had moderately impaired cognition, had no behaviors or rejection of cares and required extensive assistance of one staff with dressing and personal hygiene. R51's alteration in skin integrity care plan dated 1/3/14, indicated R51 was at risk for skin impairment and required assistance with ADLs. The care plan also indicated R51 had decreased mobility and a history of skin tears due to fragile skin with risk for recurrence due to uncontrolled Parkinson's movements. The care plan directed staff to encourage R51 to wear Dermasavers (arm protectors) to arms and legs for protection, as R51 would allow.	F 241		

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F 241	Continued From page 4 Throughout the survey on 12/14/15 11:30 a.m. until 8:00 p.m.; 12/15/15, from 8:00 a.m. until 4:30 p.m.; 12/16/15, from 7:00 a.m. until 3:30 p.m.; 12/17/15, from 8:00 a.m. until 9:40 a.m. R51 was observed to be wearing the same soiled, bilateral arm protectors. The right arm protector had a brown stain near the wrist which extended all the way around the wrist area and up the forearm approximately six inches. There was also a small red area near the elbow. The left arm protector was stained around the wrist area. On 12/17/15, at 9:40 a.m. NA-E verified the arm protectors were soiled. NA-E stated he believed R51 had another pair but thought they were in the laundry. -At 9:50 a.m. NA-E was observed exiting R51's room with a clear plastic bag containing the soiled arm protectors. NA-E stated he had changed R51's arm protectors. On 12/17/15, at 10:00 a.m. R51 stated he wore the arm protectors to protect his skin especially the right elbow he leaned on. R51 stated he liked to be clean and did not like it when the arm protectors were dirty and did not know he could get a clean pair. On 12/17/15, at 10:30 a.m. RN-C stated she would expect staff to change R51's arm protectors when soiled. RN-C further stated clean arm protectors were kept in a supply room on the unit and if there were none available staff were to let health unit coordinator know so they could get more.	F 241		

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F 241	Continued From page 5 The facility's Privacy and Dignity policy dated 4/7/03, indicated the purpose of the policy was to promote care for all residents that makes certain each resident's privacy and dignity was respected. Staff should assist each resident to maintain and improve his or her self esteem and self worth. The policy directed staff to groom residents as they wish to be groomed. Shaving or trimming beard growth for men and facial hair for women.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279		1/26/16

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F 279	Continued From page 6 Based on observation, interview and document review the facility failed to develop a comprehensive care plan related to the removal of facial hair for 1 of 5 residents (R38) who were reviewed for activities of daily living (ADL). The facility also failed to develop a comprehensive care plan for the use of Coumadin (anticoagulant) and insulin glargine (used to treat diabetes) for 1 of 5 residents (R106) who were reviewed for unnecessary medications. Findings include: R38 required assistance with removal of facial hair and the facility failed to develop a comprehensive care plan. R38's Diagnosis Report dated 12/17/15, indicated R38's diagnoses included macular degeneration, anxiety and malaise. R38's quarterly Minimum Data Set dated 11/13/15, indicated R38 had moderately impaired cognition, did not have any behaviors or rejection of cares, had moderately impaired vision and required extensive assistance of one staff with dressing and personal hygiene. R38's activities of daily living (ADL) care plan revised on 8/5/15, indicated R38 required assistance with ADLs, and maintaining of appearance. Interventions directed staff to alternate rest periods during grooming activity, discuss with R38 portions of the task she would	F 279	F279 - Develop Comprehensive Care Plans CRMC's policy for care planning is for each resident to have an individualized interdisciplinary plan of care, which emphasizes the care and development of the whole person, including strengths, needs and problems. The policy for care planning and conferences has been reviewed by the interdisciplinary team. Resident R38's care plan has been reviewed and revised to include her choice for facial hair removal via tweezer removal. The TAR for R38 has been updated to include weekly checks for need for plucking of facial hair by licensed staff. R106's care plan was reviewed and revised to reflect use of high risk medications. Revised care plan includes interventions for monitoring side effects of Coumadin and Insulin. Care plans have been reviewed and revised for all residents receiving high risk medications. Education was provided to MDS nurses on 1/6/15 regarding need to include high risk medications on resident care plans. Education will be provided on 1/22/15 with all nursing staff, regarding the need for care planning high risk medications. Practice and adherence to correction will be monitored with random weekly audits of resident care plans for one month. If found to be in compliance with plan for correction, audits will be done monthly for	

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F 279	Continued From page 7 be willing to attempt and praise R38 for completed steps in personal hygiene for her appearance. R38's Individual Care Plan dated 11/5/15, directed staff to set up R38 to wash her hands and face and staff was to assist for peri care. The care plan lacked direction for the removal of facial hair. Throughout the survey on 12/14/15 11:30 a.m. until 8:00 p.m.; 12/15/15, from 8:00 a.m. until 4:30 p.m.; 12/16/15, from 7:00 a.m. until 3:30 p.m.; 12/17/15, from 8:00 a.m. until 11:30 a.m. R38 was observed to have several long hairs on her chin approximately three quarters of an inch long and several on her upper lip, at the corners of her mouth approximately a half an inch long and a few longer ones approximately an inch long on the right side under her jaw. Each day R38 was observed to have her hair done and was nicely dressed in a blouse, slacks and shoes. On 12/16/15, at 7:35 a.m. R38 stated she did not like the long facial hair. R38 stated she tried to get the staff to pluck them. R38 stated the staff had shaved and cut her facial hair with a scissors once but she did not like that and would not let them do that again. R38 stated she only wanted the facial hair plucked because "that's the only thing that works." R38 stated she had visited the beauty shop in which sometimes the hairs were plucked if they had time but "they don't like to do that." R38 stated she had poor vision and could not see them to do it herself.	F 279	3 months, then quarterly thereafter for up to one year. Results of audits will be brought to the monthly QA meeting. Corrective action will be complete by 1/26/16.	

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F 279	Continued From page 8 On 12/17/15, at 10:30 a.m. registered nurse (RN)-C verified R38's care plan lacked direction for the removal of facial hair. RN-C stated if a resident would not allow facial hair to be shaved then it should be trimmed and the care plan should indicate such. R106's care plan did not address the use of Coumadin or insulin glargine R106's current physician orders dated 12/17/15, directed Coumadin 3 milligrams (mg) by mouth every Sunday, Tuesday, Wednesday, Thursday and Saturday and 4 mg by mouth every Monday and Friday for history of deep vein thrombosis. The orders also directed insulin glargine inject 20 units subcutaneously at bedtime for diabetes. R106's care plan dated 11/11/15, failed to identify the use of Coumadin and insulin glargine and interventions for the monitoring of side effects. On 12/17/2015, at 11:08 a.m. the director of nursing (DON) confirmed the care plan did not address the use of Coumadin or insulin glargine and should have. The Care Planning and Conferences policy dated 6/23/04, indicated the comprehensive care plan served as an interdisciplinary planning document which identified individual problems, needs and strengths, established measurable time goals and listed appropriate approaches to achieve stated	F 279		

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F 279	Continued From page 9 goals.	F 279		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must 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 ensure the care plan was followed for 1 of 1 resident (R58) who required adaptive eating equipment, for 1 of 1 resident (R106) who required assistance with oral cares and for 2 of 2 residents (R113, R70) who required assistance with toileting and repositioning. Findings include: R58's meal was not served on an inner lipped plate as directed by the care plan. R58's care plan dated 9/11/15, indicated a potential for altered nutritional status and directed staff to serve R58's meals on an inner lipped plate. On 12/14/15, at 5:20 p.m. R58 was observed seated in a wheelchair at a dining room table. R58's place setting included two handled cups	F 282	F282 - Services by Qualified Persons/Per Care Plan CRMC's policy is to ensure that each resident receives the care and services most appropriate to meet his/her needs. R58 care plan for adaptive lip plate at meals has been reviewed by interdisciplinary team and reviewed with staff. R106 care plan for oral care has been reviewed by the interdisciplinary team and reviewed with staff. R113 care plan for toileting and repositioning has been reviewed by the interdisciplinary team and reviewed with staff. R70 care plan for toileting and repositioning has been reviewed by the interdisciplinary team and reviewed with staff. Staff education will be provided in daily team huddles from 1/8-1/15/16, on importance of following the resident's care plan. Education will also be provided at the all staff meeting on 1/22/16 and will include the importance of providing	1/26/16

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F 282	Continued From page 10 with lids, a curved fork and spoon with raised handles, a regular plate (a non-inner lipped plate) and dycem (a nonslip mat) attached to the bottom of R58's plate. -At 5:38 p.m. R58 used her fork and pushed the shepards pie across the plate with some of the shepards pie falling off the rim of the plate and onto the table and R58's clothing protector and pants. R58 remained eating this way, spilling food over the plate onto the table and her clothing with some of the food falling around her on the floor. -At 5:45 p.m. R58 used her fingers and scooped up the shepards pie, pushed it across the plate and brought it to her mouth. -At 6:00 p.m. R58 had finished her meal. Clumps of shepards pie and pieces of chocolate bar surrounded R58's plate, down the front of R58's clothing protector, on R58's pants and the floor surrounding her wheelchair. On 12/14/15, at 5:54 p.m. licensed practical nurse (LPN)-D confirmed R58's meal had been served on a regular dinner plate (non-inner lipped). LPN-D stated the inner lipped plates were a bit deeper and had a ledge around the rim of the plate. On 12/14/15, at 6:10 p.m. registered nurse (RN)-C verified R58 had not been served her meal on an inner lipped plate as directed and that R58's meal ticket which would also have this directive was not available. On 12/15/15, at 8:15 a.m. RN-C provided a sample meal ticket for R58. This meal ticket	F 282	adaptive equipment at meals, providing good oral care with am & pm cares and toileting and repositioning residents per individualized care plan. Education will include reapproaching resident if necessary to assure that care plan goals are met. Practice and adherence to correction will be monitored with random weekly audits of resident care for one month. If found to be in compliance with plan of correction, audits will be done monthly for 3 months, then quarterly thereafter for up to 1 year. Results of audits will be brought to the monthly QA meeting. Corrective action will be complete by 1/26/16.	

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F 282	Continued From page 11 directed staff to serve R58's meals on an inner lipped plate. RN-C confirmed R58's evening meal on 12/14/15, had not been served on an inner lipped plate. On 12/16/15, at 1:04 p.m. the director of nursing (DON) stated she expected staff to follow each resident's plan of care as it related to adaptive eating equipment. R106 was not offered assistance with oral care on the morning of 12/16/15, as directed by the care plan. R106's care plan dated 11/11/15, indicated R106 had a lower partial with his own teeth and an upper plate. The care plan directed staff to assist R106 with cleaning and placement of dentures daily and to provide set up and assistance to brush remaining lower teeth. R106's Individual Resident Care Plan dated 12/15/15, indicated R106 had upper dentures and lower partial and directed staff R106 required assist of one staff to clean dentures and set up for brushing of lower teeth. On 12/16/2015, at 8:30 a.m. nursing assistant (NA)-F and NA-G were observed to assist R106 to get up for the day. NA-G assisted R106 to wash and dry face and armpits and assisted R106 to apply deodorant. NA-G then assisted R106 to donne a T-shirt . NA-G provided peri cares for R106 and applied an incontinent brief	F 282		

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F 282	Continued From page 12	F 282		

and pants. NA-F and NA-G placed a sling under R106 and attached the sling to a mechanical lift and lifted him into a wheelchair. NA-G assisted R106 into a sweatshirt. NA-G opened the drawer in R106's dresser to retrieve a hair brush. Toothpaste and a toothbrush were observed in the drawer. NA-G brushed R106's hair, offered him a hat and assisted R106 to put it on. NA-G washed R106's glasses and brought him his upper denture plate and lower partial plate and assisted him to put them in his mouth. Oral cares were not offered. NA-G then offered R106 an electric shaver and R106 began to shave his face independently. NA-G assisted R106 to complete shaving and wheeled him from the room and brought him to the dining room for breakfast.
-At 10:20 a.m. R106 had completed eating breakfast and was sleeping in his wheelchair at the table.
-At 11:00 a.m. NA-F and NA-G returned R106 to his room and checked and changed his incontinent brief. No oral cares were offered.

On 12/16/2015, at 11:06 a.m. NA-G stated residents should have oral cares twice a day. NA-G confirmed she had not offered R106 oral cares and should have.

On 12/17/2015, at 11:08:19 a.m. the DON stated morning cares included assisting residents to wash their face, hands, underarms and peri care as well as oral cares. The DON confirmed R106 should have been assisted to brush his teeth as directed on the care plan.

R113 was not offered assistance with

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F 282	Continued From page 13 repositioning and toileting as directed by R113's care plan. R113's Closet Care Plan (CPP), dated 8/2/15, directed staff to encourage and assist with repositioning and toileting every two hours and PRN. In addition, the CPP indicated R113 was a high fall risk and directed staff to offer toileting every two hours during the day. R113's care plan printed on 12/16/15, directed staff to encourage and assist with repositioning and toileting every two hours and PRN (as needed). R113's Order Summary Report dated 12/17/15, identified R113's diagnoses as history of stroke right side affect, anxiety, osteoarthritis and osteoporosis. On 12/16/15, at 7:23 a.m. NA-A was observed to provide R113 morning cares and toileting assistance. -At 7:51 a.m. NA-A was observed to assist R113 with transferring from the toilet to her wheel chair. NA-A applied R113's wheelchair foot rests and positioned R113's feet on the footrests. -At 8:51 a.m. NA-B was observed to feed R113 small bites of cheesecake, NA-B was not observed to offer or reposition R113. -At 10:20 a.m. LPN-A administered R113's medications and began R113's tube feeding administration. LPN-A was not observed to offer or reposition R113. -At 11:21 a.m. R113's call light was observed on.	F 282		

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F 282	Continued From page 14 -At 11:24 a.m. the social worker (SW) entered R113's room in which R113 stated the tube feeding was done and she needed to go to the bathroom. The SW continued to visit with R113 who loudly stated she still had to go to the bathroom. The SW informed R113 she would tell staff. -At 11:33 a.m. R113's call light was on again. Trained medication assistant (TMA)-A entered the room and proceeded to wheel R113 to the bathroom. -At 11:36 a.m. (3 hours and 45 minutes since last repositioned/toileted) R113 was assisted onto the toilet. R113's buttocks and gluteal folds were observed reddened with no open areas noted. R113 was observed to urinate and have a bowel movement during toileting. On 12/16/15, at 11:41 a.m. NA-A stated she thought R113 was to be repositioned and toileted per her request. NA-A was directed to review R113's CCP which was taped inside of R113's closet. NA-A checked R113's Closet Care Plan and verified it directed staff to encourage R113 to toilet and reposition every two hours and PRN. NA-A stated "I learn something new everyday." NA-A verified R113 had not been repositioned or offered toileting since she assisted her up at 7:23 a.m. On 12/16/15, at 11:47 a.m. R113 verified she had not been offered toileting or repositioning since she was assisted up. R113 stated her bottom got sore and staff had cream to apply when it got read.	F 282		

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F 282	Continued From page 15 On 12/16/2015, at 11:52 LPN-A verified R113 was not offered repositioning or toileting when R113 was connected to her feeding tube. On 12/16/15, at 1:35 p.m. the DON verified R113 was at risk for the development of a pressure ulcer and required assistance with transfers and toileting. The DON stated she expected staff to follow R113's CCP with regards to repositioning and toileting. The DON verified R113 should have been at least offered repositioning and toileting every two hours. R70 was not offered positioning and incontinence cares as directed by R70's care plan. R70's care plan, revision date 5/20/15, directed staff to see CCP dated 11/10/15, for urinary incontinence and repositioning care. R70's CCP dated 11/10/15, directed staff to transfer with assist of two and the mechanical lift, reposition R70 every two hours and encourage to sit on the toilet before and after meals. If R70 refused then to check and change incontinent brief. R70's offload/toileting form dated 12/16/15, directed staff to offload and toilet R70 every two hours. On 12/16/2015, at 7:13 a.m. R70 was observed in	F 282		

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F 282	Continued From page 16 bed, asleep. -At 8:36 a.m. NA-B and NA-A entered R70's room to get R70 up from bed. NA-A removed R70's blanket covering and R70 was observed to already be dressed. NA-A informed R70 they were getting her up as breakfast would soon be there. NA-A and NA-B assisted R70 up via the mechanical lift and positioned her into her wheelchair. After positioning the overbed table in front of R70, both NAs exited the room. R70 was not observed to be offered the commode or incontinent brief checked and changed. -At 8:49 a.m. R70 was observed independently eating breakfast. -At 9:24 a.m. R70 continued eating breakfast. -At 9:59 a.m. R70 remain seated in the wheelchair, in her room, looking out her room window. -At 11:33 a.m. NA-A was asked if R70 would be assisted with toileting. NA-A was observed to enter R70's room then stated R70 had refused to use the commode at this time as it was too close to lunch she would rather wait until after lunch. R70 was not observed to be checked and changed at this time. -At 11:35 a.m. NA-A verified she had assisted R70 to get dressed at 6:30 a.m. but had not gotten her out of bed. NA-A verified she had not checked nor changed R70 when she assisted her up at 8:36 a.m. NA-A verified she had not repositioned R70 since assisted up at 8:36 a.m. -At 11:55 a.m. R70 remained in the wheelchair, eating lunch. -At 1:06 p.m. NA-B and NA-C were observed to enter R70's room. Both NAs were observed to transfer R70 into bed via a mechanical lift. Once in bed, a strong offensive urine odor was noted. NA-B removed R70's incontinence brief which was observed saturated with urine. R70's	F 282		

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F 282	Continued From page 17 buttocks were reddened with no open areas noted. R70's skin was observed wet with urine. NA-B and NA-C reapplied the mechanical lift sheet and proceeded to attempt to transfer R70 onto the commode via the mechanical lift. R70 refused to be transferred to the commode stating her leg and hip hurt too bad to have to be moved again. NA-B and NA-C obtained a clean brief from R70's closet and NA-C assisted with R70's positioning from side to side to place the clean brief under R70. R70 was not provided with peri care following the removal of the wet brief. Once the brief was applied, R70 was covered with a blanket, bed pillow adjusted under her head and call light was provided. Both NAs exited the room. On 12/16/15, at 1:06 p.m. NA-B verified R70's brief was saturated with urine and the urine odor was very strong. NA-B verified she had not offered or provided R70 repositioning or toileting since she was assisted up at 8:36 a.m. NA-B also verified R70 was not provided peri cares during the changing of her brief and should have been. On 12/16/2015, at 1:35 p.m. the DON stated R70 should have received cares for positioning and toileting needs as directed by her care plan and definitely should have received pericare's after the incontinent episode. The DON stated it was her expectation staff would follow R70's care plan in regards to toileting and repositioning. The Care Planning and Conferences policy dated 6/23/04, indicated the purpose was to ensure that each resident received the care and services most appropriate to meet his/her needs. The	F 282		

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F 282	Continued From page 18 policy also indicated the Unit coordinator and social services were responsible for seeing the overall plan of care was implemented.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary care and services related to the removal of facial hair for 1 of 5 residents (R38) who were reviewed for activity of daily living (ADL) and required grooming assistance. The facility also failed to provide oral care for 1 of 3 residents (R106) who required assistance with oral care. Findings include: R38 was not provided assistance with the removal of facial hair. R38's Diagnosis Report dated 12/17/15, indicated R38's diagnoses included depression, anxiety and malaise. R38's activities of daily living (ADL) care plan	F 312	F312 - ADL Care Provided for Dependent Residents CRMC strives to provide care and services to residents to maintain their health, wellbeing and comfort. The policy for daily cares was reviewed and revised by the interdisciplinary team. R38's care plan has been reviewed and revised to include her choice for facial hair removal, via tweezer removal. The TAR for R38 has been updated to include weekly checks for need for plucking of facial hair by licensed staff. R38's facial hair on chin and near corner of lip was removed by tweezer, per R38's choice. R38 did not want facial hair directly above upper lip removed. R106□s care plan was reviewed and remains appropriate for brushing of upper dentures, partial lower and need for staff	1/26/16

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F 312	Continued From page 19 revised on 8/5/15, indicated R38 required assistance with ADLs and maintaining of appearance related to impaired mobility. The plan directed staff to provide alternate rest periods with grooming activities, discuss with R38 portions of the task she would be willing to attempt and praise R38 for completed steps in personal hygiene for her appearance. The care plan further indicated R38 had the inability to focus on objects, discriminate color and adjust to changes in light and dark related to impaired vision due to macular degeneration. R38's Individual Care Plan dated 11/5/15, directed staff to set up R38 to wash her hands and face and staff was to assist for peri care. The care plan lacked direction for the removal of facial hair. R38's quarterly MDS dated 11/13/15, indicated R38 had moderately impaired cognition, did not have any behaviors or rejection of cares, had clear speech, had moderately impaired vision, wore glasses and required extensive assistance of one staff with dressing and personal hygiene. Throughout the survey on 12/14/15 11:30 a.m. until 8:00 p.m.; 12/15/15, from 8:00 a.m. until 4:30 p.m.; 12/16/15, from 7:00 a.m. until 3:30 p.m.; 12/17/15, from 8:00 a.m. until 11:30 a.m. R38 was observed to have several long hairs on her chin approximately three quarters of an inch long and several on her upper lip, at the corners of her mouth approximately a half an inch long and a few longer ones approximately an inch long on the right side under her jaw. Each day R38	F 312	assist with brushing of remaining lower teeth. R106's care plan will be reviewed with Lakeview team in huddles 1/15-1/21/16 on need for brushing of lower teeth with am/pm cares in addition to denture care. Staff education will be provided in daily team huddles from 1/8-1/15/16 on importance of providing good oral care and following the care plan. Education will also be provided at the all staff meeting on 1/22/16. Practice and adherence to correction will be monitored with random weekly audits of resident care for one month. If found to be in compliance with plan for correction, audits will be done monthly for 3 months, then quarterly thereafter for up to one year. Results of audits will be brought to the monthly QA meeting. Corrective action will be completed by 1/26/16.	

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F 312	Continued From page 20 was observed to have her hair done and was nicely dressed in a blouse, slacks and shoes. On 12/16/15, at 7:35 a.m. R38 stated she did not like the long facial hair. R38 stated she tried to get the staff to pluck them. R38 stated the staff had shaved and cut her facial hair with a scissors once but she did not like that and would not let them do that again. R38 stated she only wanted the facial hair plucked because "that's the only thing that works." R38 stated she had visited the beauty shop in which sometimes the hairs were plucked if they had time but "they don't like to do that." R38 stated she had poor vision and could not see them to do it herself. On 12/17/15, at 9:35 a.m. NA-E stated if he saw a female resident with facial hair he would trim it up. However, NA-E was assigned to R38's cares and had not offered or provided R38 with facial hair removal. On 12/17/15, at 10:30 a.m. registered nurse (RN)-C verified R38's care plan lacked direction for the removal of facial hair, however, stated R38's facial hair should have been removed. RN-C stated if a resident would not allow facial hair to be shaved then it should be trimmed. The staff could pluck facial hair if the resident's family allowed it. RN-C did not know if the beauty shop provided the plucking or waxing of facial hair. The facility's Daily Resident Care policy dated 10/92, indicated the purpose of the policy was to cleanse, refresh and groom residents. Ensure	F 312		

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F 312	Continued From page 21 adequate hygiene and grooming needs were met. The policy directed to assist with shaving as needed. R106 was not offered assistance with oral care on the morning of 12/16/15, as directed by the care plan. R106's significant change Minimum Data Set (MDS) dated 10/30/15, indicated R106 had severe cognitive impairment and required extensive assistance of two for bed mobility, was totally dependent on two staff for transfer and toileting and required extensive assistance of one for personal hygiene. The MDS also indicated R106 had no dental issues. R106's care plan dated 11/11/15, indicated R106 had a lower partial with his own teeth and an upper plate. The care plan directed staff to assist R106 with cleaning and placement of dentures daily and to provide set up and assistance to brush remaining lower teeth. R106's Individual Resident Care Plan dated 12/15/15, indicated R106 had upper dentures and lower partial and directed staff R106 required assist of 1 to clean dentures and set up for brushing of lower teeth. R106's Diagnosis Report dated 12/17/15, indicated R106 had diagnoses that included dementia, osteoarthritis, heart failure and fatigue.	F 312		

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F 312	Continued From page 22 On 12/16/2015, at 8:30 a.m. nursing assistant (NA)-F and NA-G were observed to assist R106 with morning cares. NA-G assisted R106 to wash and dry face and armpits and assisted R106 to apply deodorant. NA-G assisted R106 to donne a T-shirt and provided peri cares followed by the application of an incontinent brief and pants. NA-F and NA-G proceed to transfer R106 into the wheelchair via a mechanical lift into the wheelchair. NA-G assisted R106 into a sweatshirt. NA-G opened R106's dresser drawer to retrieve a hair brush. Toothpaste and a toothbrush were observed in the drawer. NA-G brushed R106's hair, offered him a hat and assisted R106 to put it on. NA-G washed R106's glasses and brought him his upper denture plate and lower partial plate and assisted him to put them in his mouth. Oral cares were not offered. NA-G offered R106 an electric shaver and R106 began to shave his face independently. NA-G assisted R106 to complete shaving and wheeled him from the room and brought him to the dining room for breakfast. -At 10:20 a.m. R106 had completed eating breakfast and was sleeping in his wheelchair at the table. -At 11:00 a.m. NA-F and NA-G returned R106 to his room and checked and changed his incontinent brief. No oral cares were offered. On 12/16/2015, at 11:06 a.m. NA-G stated residents should have oral cares twice a day. NA-G confirmed she had not offered R106 oral cares and should have done so.	F 312		

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F 312	Continued From page 23 On 12/17/2015, at 11:08:19 a.m. the director of nursing (DON) stated morning cares included assisting residents to wash their face, hands, underarms and peri care as well as oral cares. The DON confirmed R106 should have been assisted to brush his teeth as directed on the care plan. The A.M. Care Policy dated 10/1992, directed staff if resident had teeth to provide oral hygiene, if the resident had dentures soaking overnight, rinse thoroughly in cool water and have resident rinse mouth with water or mouthwash prior to dentures being inserted.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a repositioning program had been implemented for 2 of 2 residents (R113, R70) identified at risk for developing a pressure ulcer and did not receive timely repositioning assistance.	F 314	F314 - Treatment and Services to Prevent/Heal Pressure Sores CRMC□s policy for maintaining resident□s skin safety is to prevent or minimize pressure, by providing repositioning at least every two hours.	1/26/16

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F 314	Continued From page 24 Findings include: R113 was not offered timely assistance with positioning as directed by R113's care plan. R113's Closet Care Plan (CPP), print date 8/2/15, directed staff to encourage and assist R113 with repositioning every two hours and PRN. R113's quarterly MDS dated 10/26/15, indicated R113's cognition was intact and required extensive assist with bed mobility, transferring, toileting and personal hygiene. In addition, the MDS indicated R113 was occasionally incontinent of urine and was at risk for pressure ulcers. R113's Braden Scale for Predicting Pressure Sore Risk dated 10/26/15, indicated R113's ability to change and control body position was very limited and required moderate to maximum assistance in moving, frequently slid down in bed or chair and required frequent repositioning with maximum assist. R113's Tissue Tolerance Sitting Test dated 11/17/15, directed staff to reposition R113 every two hours. R113's care plan, printed on 12/16/15, directed staff to encourage and assist R113 with repositioning every two hours and PRN (as needed).	F 314	Resident□s care plans are developed through interdisciplinary process, to identify individual resident needs for maintaining health, wellbeing and comfort. R113□s and R70□s care plans have been reviewed by the interdisciplinary team. R113 and R70's care plan for toileting and repositioning will be reviewed in team huddles 1/15-1/21/16. Staff education will be provided in team huddles from 1/8- 1/15/16 on the importance and need for repositioning of all residents, per care plan. Education will also be provided at the all staff meeting on 1/22/16. Practice and adherence to correction will be monitored with random weekly audits of resident repositioning for one month. If found to be in compliance with plan for correction, audits will be done monthly for 3 months, then quarterly thereafter for up to one year. Results of audits will be brought to the monthly QA meeting. Corrective action will be completed by 1/26/16.	

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	245232	A. BUILDING _____ B. WING _____	12/17/2015

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F 314	Continued From page 25	F 314		

R113's Order Summary Report dated 12/17/15, identified R113's diagnoses as history of stroke, anxiety and osteoarthritis.

On 12/16/15, at 7:23 a.m. NA-A was observed to provide R113 morning cares and toileting assistance.
-At 7:51 a.m. NA-A was observed to assist R113 to transfer from the toilet to her wheelchair. NA-A applied R113's foot rests to the wheelchair and positioned R113's feet on the footrests. R113 was positioned in room to face the room exit door.
- At 8:51 a.m. NA-B was observed to feed R113 small bites of cheesecake, NA-B was not observed to offer or reposition R113.
-At 10:20 a.m. licensed practical nurse (LPN)-A, administered R113's medications and began R113's tube feeding administration.
-At 11:21 a.m. R113's call light was on.
-At 11:24 a.m. the social worker (SW) entered R113's room and turned off the call light. R113 stated to SW that the tube feeding was done and she needed to go to the bathroom. The SW continued to visit with R113 who loudly stated she still had to go to the bathroom. The SW informed R113 she would tell staff.
-At 11:33 a.m. R113's call light was observed on again. Trained medication assistant (TMA)-A entered the room and began to unplug R113's feeding tube machine from the electrical outlet and pushed R113's wheelchair to the bathroom.
-At 11:36 a.m. R113 was assisted to transfer from the wheelchair to the toilet. R113's buttocks and gluteal folds were observed reddened with no open areas noted. R113 was observed to urinate and have a bowel movement during toileting. (3

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F 314	Continued From page 26 hours and 45 minutes since R113 had been last repositioned). On 12/16/15, at 11:41 a.m. NA-A stated R113 was to be repositioned and toileted per her request as directed by the Skyview unit's offload/toilet times form. NA-A was asked if R113's Closet Care Plan was followed. NA-A reviewed R113's Closet Care Plan which was taped to the inside of R113's closet door. NA-A verified the plan directed staff to encourage and assist R113 with repositioning every two hours and PRN. NA-A stated "I learn something new everyday." NA-A stated she thought R113 was repositioned only per request. NA-A verified R113 had not been repositioned since she assisted her up at 7:51 a.m. On 12/16/15, at 11:47 a.m. R113 verified she had not been offered toileting or repositioning since she was assisted up this morning. R113 stated when she got hooked up to the tube feeding, she had to wait to move until it was done. R113 verified her bottom got sore waiting for assistance however staff had cream they could apply when her bottom was red. On 12/16/2015, at 11:52 LPN-A verified R113 was not offered repositioning when R113 was connected to her tube feeding. On 12/16/15, at 1:35 p.m. the DON verified R113 was at risk for the development of a pressure ulcer and required assistance with transfers and repositioning. The DON stated she expected staff to follow R113's CCP with regards to repositioning	F 314		

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F 314	Continued From page 27 and that the Skyview offload/toilet times form was utilized for the NAs to document what time resident tasks / cares were completed. The DON verified R113's offload/toilet form was inaccurate and R113 should have been at least offered repositioning every two hours. R70 was at risk for pressure ulcers and was not provided timely positioning assistance as directed by R70's care plan. R70's care plan, revision date 5/20/15, directed staff to see CCP of 11/10/15, for repositioning directive. R70's Quarterly MDS dated 11/2/15 indicated R70 was cognitively intact, required extensive assist of two staff for bed mobility, was totally dependent on staff for transfers, was frequently incontinent of bowel and bladder and was at risk for pressure ulcers. R70's Braden Scale dated 11/2/15, indicated R70 was at high risk for pressure ulcers, could not bear own weight and/or must be assisted into chair or wheelchair, mobility was very limited and was unable to make frequent or significant changes independently. R70's CCP dated 11/10/15, directed staff to transfer R70 with assist of two staff and the mechanical lift and to reposition R70 every two hours.	F 314		

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F 314	Continued From page 28 R70's Tissue Tolerance Testing dated 11/17/15, indicated R70 could tolerate an every two hour repositioning program and directed staff to offload (relief pressure) every two hours. R70's offload/toileting form dated 12/16/15, directed staff to off load R70 every two hours. R70's Order Summary Report dated 12/17/15, identified, R70 diagnoses as neuropathy and edema. On 12/16/2015, at 7:13 a.m. R70 was observed in bed, asleep. -At 8:36 a.m. NA-B and NA-A entered R70's room to assist R70 up from bed. NA-A was observed to remove the blanket covering R70 who was observed to be already dressed. NA-A informed R70 they getting her up now as breakfast would be here soon. NA-A and NA-B utilized a mechanical lift and transferred R70 from bed into the wheelchair. R70's wheelchair seat had a pressure redistribution pad on it. R70's bedside table was positioned next to her. -At 8:49 a.m. R70 remained in her room, seated in the wheelchair independently eating breakfast. -At 9:24 a.m. R70 continued eating breakfast. -At 9:59 a.m. R70 remained in the wheelchair, in her room, looking out the window. -At 11:33 a.m. NA-A was asked if R70 would be toileted. NA-A entered R70's room and stated R70 refused to use the commode at this time as it was too close to lunch and she would rather wait until after lunch. R70 was not observed to be checked and changed at this time.	F 314		

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F 314	Continued From page 29 -At 11:35 a.m. NA-A verified at 6:30 a.m. she had assisted R70 to get dressed but did not get her out of bed. NA-A verified she had not repositioned R70 since she got her up at 8:36 a.m. -At 11:55 a.m. R70 remained in the wheelchair, eating her lunch. -At 1:06 p.m. NA-B and NA-C were observed to enter R70's room and proceed to transfer R70 from the wheelchair into bed via the mechanical lift. Once in bed, NA-B and NA-C assisted R70 in turning from side to side in order to remove R70's incontinent brief. NA-B removed the brief which was observed saturated with urine. R70's buttocks were observed reddened with no open areas noted. NA-B and NA-C applied a clean brief, covered R70 with a blanket, adjusted her bed pillow, provided R70 the call light and exited the room. On 12/16/15, at 1:06 p.m. NA-B verified she had not offered or provided R70 repositioning assistance since she was assisted up at 8:36 a.m. On 12/16/2015, at 1:35 p.m. the DON verified R70 was at risk for pressure ulcers and R70 should have received positioning assistance as directed by the care plan. The DON stated it was her expectation that staff followed R70's care plan in regards to repositioning needs. The facility Skin Safety Plan/Pressure ulcer and Skin Injury Prevention /Interpretation policy dated 8/29/14, directed staff to minimize pressure and reposition at a minimum of every two hours.	F 314		

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F 314	Continued From page 30 The Care Planning and Conferences policy dated 6/23/04, indicated the purpose was to ensure that each resident received the care and services most appropriate to meet his/her needs. The policy also indicated the Unit coordinator and social services were responsible for seeing the overall plan of care was implemented.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely toileting assistance according to the individualized assessed need for 2 of 3 residents (R113, R70) who required assistance with toileting. Findings include: R113 was not provided toileting assistance for three hours and 45 minutes on 12/16/15.	F 315	F315 - No catheter, Prevent UTI, Restore Bladder CRMC□s bowel and bladder policy is for each resident to be assessed for toileting needs. An individualized care plan is developed to meet the needs of each resident, to maintain resident dignity and reduce the risk for UTI and skin break down. The bowel and bladder program policy was reviewed by the interdisciplinary team.	1/26/16

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F 315	Continued From page 31 R113's Closet Care Plan (CPP), dated 8/2/15, directed staff to offer and assist R113 with toileting every two hours and PRN (as needed). In addition, the CPP indicated R113 was at high risk for falls and directed staff to offer toileting every two hours during the day. R113's Bladder Assessment Form, dated 8/11/15, indicated R113 had urge and stress incontinence, was currently incontinent of bladder, had impaired mobility/ambulation and a schedule toileting plan was indicated. R113's quarterly Minimum Data Set (MDS) dated 10/26/15, indicated R113's cognition was intact, required extensive assist with bed mobility, transferring, toileting and personal hygiene. In addition, the MDS indicated R113 was occasionally incontinent of urine and was at risk for pressure ulcers. R113's Braden Scale for Predicting Pressure Sore Risk dated 10/26/15, indicated R113's ability to change and control body position was very limited and required moderate to maximum assistance in moving, transfers and toileting. R113's care plan, print date 12/16/15, directed staff to offer and assist R113 with toileting every 2 hours and PRN (as needed). R113's Order Summary Report dated 12/17/15,	F 315	R113□s and R70□s care plan has been reviewed and revised by the interdisciplinary team. Both require toileting assistance every 2 hours. R113 and R70's care plan for toileting and repositioning will be reviewed in team huddles 1/15-1/21/16. Staff education will be provided in team huddles from 1/8- 1/15/16 on importance of following the care plan for all resident toileting needs, to maintain resident dignity and reduce risk for UTI□s and skin breakdown. Education will also be provided at the all staff meeting on 1/22/16. Practice and adherence to correction will be monitored with random weekly audits of resident toileting per care plan, for one month. If found to be in compliance with plan for correction, audits will be done monthly for 3 months, then quarterly thereafter for up to 1 year. Results of audits will be brought to the monthly QA meeting. Corrective action will be completed by 1/26/16.	

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F 315	Continued From page 32 identified R113's diagnoses as history of stroke, anxiety and osteoarthritis. On 12/16/15, at 7:23 a.m., nursing assistant (NA)-A was observed to provide morning cares and toileting assistance to R113. -At 7:51 a.m. NA-A was observed to assist R113 to transfer from the toilet to her wheelchair. NA-A applied R113's foot rests to the wheelchair positioned R113's feet on the footrests. R113 was positioned in the room to face the room exit door. NA-A exited the room. -At 8:51 a.m. NA-B was observed to feed R113 small bites of cheesecake, NA-B was not observed to offer toileting assistant to R113. -At 10:20 a.m. licensed practical nurse (LPN)-A, administered R113's medications and began R113's tube feeding administration. -At 11:21 a.m. R113's call light was on. -At 11:24 a.m. the social worker (SW) entered R113's room and turned off the call light. R113 stated her tube feeding was done and she needed to go to the bathroom. The SW continued to visit with R113 who loudly stated she still had to go to the bathroom. The SW informed R113 she would tell staff. -At 11:33 a.m. R113's call light was on again. Trained medication assistant (TMA)-A entered the room and proceeded to push R113's wheelchair towards the bathroom. -At 11:36 a.m. (3 hours and 45 minutes since R113 had last been offered toileting) R113 was assisted to transfer onto the toilet. R113's buttocks and gluteal folds were observed reddened with no open areas noted. R113 urinated and had a bowel movement during toileting.	F 315		

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F 315	Continued From page 33 On 12/16/15, at 11:41 a.m. NA-A stated R113 was to be toileted per her request as indicated on the Skyview offload/toilet times form. NA-A was asked if R113 Closet Care Plan was followed. NA-A reviewed R113's Closet Care Plan which was taped to the inside of R113's closet door. NA-A verified the CCP directed staff to offer and assist with toileting every two hours and PRN. NA-A stated "I learn something new everyday." NA-A stated she thought R113 was to be toileted per her request. NA-A verified R113 had not been offered toileting since 7:23 a.m. and she should have offered toileting every two hours. On 12/16/15, at 11:47 a.m. R113 verified she had not been offered toileting assistance since she got up this morning. R113 stated when she was connected to the tube feeding she had to wait until the feeding was done in order to go the bathroom as staff did not like taking her while the feeding machine was hooked up. R113 stated she tried to wait until the feeding was done but there had been times she could not wait. R113 stated her bottom got sore and staff had cream they could put on it when it was red. On 12/16/2015, at 11:52 a.m. LPN-A verified R113 was not offered toileting when R113 was connected to her tube feeding. On 12/16/15, at 1:35 p.m. the director of nursing (DON) verified R113 was at risk for the development of a pressure ulcer and required assistance with transfers and toileting. The DON stated she expected staff to follow R113's CCP	F 315		

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F 315	Continued From page 34 with regards to toileting and that the Skyview offload/toilet times form was utilized for the NAs to document when tasks / cares were completed. The DON verified R113's offload/toilet form was inaccurate and R113 should have been at least offered toileting every two hours. R70 was not offered timely toileting assistance as directed by R70's care plan. R70's care plan, revision date 5/20/15, directed staff to see CCP of 11/10/15, for urinary incontinence. R70's Quarterly MDS dated 11/2/15, indicated R70 was cognitively intact, required extensive assist of two for toileting and bed mobility, was totally dependent on staff for transfers and was frequently incontinent of bladder. R70's Bladder Assessment dated 11/10/15, indicated R70 rarely felt the urge to void in time to remain continent, transferred with a mechanical lift and assist of two and benefited from scheduled toileting to reduce incontinence, prevention of urinary tract infections and prevent skin breakdown. R70's CCP dated 11/10/15, directed staff to transfer with assist of two using mechanical lift, encourage R70 to sit on the toilet before and after meals, if refused check and change incontinent brief.	F 315		

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F 315	Continued From page 35 R70's offload/toileting form dated 12/16/15, directed staff to toilet R70 every two hours. R70's Order Summary Report dated 12/17/15, indicated R70 was diagnosed with neuropathy, edema and had a history of urinary tract infections (UTI). On 12/16/2015, at 7:13 a.m. R70 was observed in bed, asleep. -At 8:36 a.m. NA-B and NA-A entered R70's room to get R70 up from bed. NA-A was observed to remove R70's blanket covering and R70 was observed to be fully dressed. NA-A informed R70 they were getting her up now as breakfast would be here soon. NA-A and NA-B assisted R70 from bed into the wheelchair via a mechanical lift. R70's bedside table was positioned next to her and both NAs exited the room. R70 was not observed to be offered the commode or incontinent brief checked and changed. A strong, offensive urine odor was noted in R70's room. -At 8:49 a.m. R70 remained seated in the wheelchair, eating breakfast independently. -At 9:24 a.m. R70 continued to eat breakfast. -At 9:59 a.m. R70 remained in the wheelchair, in her room, looking out her window. -At 11:33 a.m. NA-A was asked if R70 would be toileted. NA-A entered R70's room and stated R70 refused to use the commode at this time as it was too close to lunch and would rather wait until after lunch. R70 was not observed to be checked and changed at this time. -At 11:35 a.m. NA-A verified she had assisted R70 to dress at 6:30 a.m. but did not get her out of bed. NA-A verified she did not offer the	F 315		

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F 315	Continued From page 36	F 315		

commode or check and change R70's incontinent brief when she assisted R70 up at 8:36 a.m. NA-A verified she had not provided toileting or check and change for R70 since 6:30 a.m. this morning.
-At 11:55 a.m. R70 remained in the wheelchair, eating lunch.
-At 1:06 p.m. NA-B and NA-C were observed to enter R70's room and proceed to transfer R70 from the wheelchair and in to bed. A strong urine odor was detected. NA-B removed R70's incontinent brief which was observed to be saturated with urine and had an offensive strong urine odor noted. R70's buttocks were observed with no open areas noted. R70's peri area, abdominal skin and buttocks were observed wet with urine. NA-B and NA-C attempted to utilize the mechanical lift in order to transfer R70 onto the commode but R70 refused. NA-B obtained a clean incontinent brief and proceeded to apply it without providing peri area cleansing following the incontinent episode. NA-B proceeded to cover R70 with a blanket, adjust the bed pillow, provide R70 the call light and exited the room.

On 12/16/15, at 1:06 p.m. NA-B verified R70's brief was saturated with urine and the urine odor was very strong. NA-B verified she had not offered or provided R70 toileting assistance since she was assisted up at 8:30 a.m. NA-B confirmed urine smell was very strong in R70's room. Both NA-A and NA-B verified R70 was not provided peri cares during the changing of her incontinent brief and should have received peri area cleansing.

On 12/16/2015, at 1:35 p.m. the DON verified

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CUYUNA REGIONAL MEDICAL CENTER	320 EAST MAIN STREET CROSBY, MN 56441

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F 315	Continued From page 37 R70 had a history of UTI's and R70 should have received timely toileting cares as directed by her care plan and definitely should have received pericare's following the incontinent episode. The DON it was her expectation for staff to follow R70's care plan in regards to toileting. The DON confirmed R70's care plan was not followed. The Bowel and Bladder Program Policy dated 10/6/2004, directed staff to follow the bowel and bladder schedule for assessed toileting needs and the nursing assistants were responsible for following the schedule. In addition, the charge nurses/team leaders were responsible to ensure the daily plan was followed.	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		1/26/16

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F 322	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication was administered as directed by facility policy for 1 of 1 resident (R113) observed to recieve a cocktail of medications via a percutaneous endoscopic gastrostomy (PEG) tube (tube placed into the stomach for feeding). Findings include: During the medication administration observation on 12/15/15, at 10:07 a.m. R113 was observed to receive a mixture of medications administered together via a PEG tube. R113's Medical Diagnosis report printed 12/16/15, identified R113's diagnoses as dysphagia (difficulty swallowing), cerebrovascular disease (stroke), anxiety, depression, osteoarthritis, hyperlipidemia (abnormally elevated lipid levels in the blood) and heart disease. R113's quarterly Minimum Data Set (MDS) dated 10/26/15, indicated R113 had a feeding tube and was on a mechanical altered diet. R113's dehydration/fluid maintenance Care Area Assessment (CAA) dated 8/12/15, indicated R113's feeding tube was to be flushed with 30	F 322	F322 - NG Treatment/Services for Restoring Eating Skills CRMC strives to provide safe standards of nursing practice and care to the residents, to maintain their health, wellbeing and comfort. CRMC has developed a new policy for Enteral Tube Medication Administration. R113's care plan and physician orders have been reviewed and revised by the interdisciplinary team. The primary physician and pharmacy consultant have reviewed and given further direction and clarification for crushing and administration of R113's medications; orders are now for delivery of all meds via cocktail for R113 with clinical direction provided in Enteral Tube Medication Administration policy. CRMC's Clinical Education Department will provide education and competency training for staff nurses on enteral medication administration standards, in learning stations the week of 1/19-1/22/16. The new policy for Enteral Medication Administration will be reviewed by nurses during the educational sessions. Also, CRMC's Consultant Pharmacist will provide further education to nurses on 1/26/16, on medication administration via tube and rights of medication administration. Physician orders have been reviewed and revised, as appropriate, for all residents	

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F 322	Continued From page 39 cubic centimeters (cc) before and after medication administration. R113's Order Summary report dated 12/15/15, directed staff to flush R113's feeding tube with 30 cc's before and after medication administration, however lacked an order and justification for cocktailing (mixture of liquid and crushed medications) the medications. On 12/15/15, at 9:36 a.m. licensed practical nurse (LPN)-B was observed to prepare the following medications for administration: -crushed one tablet of Lexapro 20 milligrams (mg) (antidepressant); one tablet of Norvasc 2.5 mg (high blood pressure medication) and acetaminophen 650 mg (two 325 mg tablets) - combined the Lexapro, Norvasc, and acetaminophen crushed tablets and placed the powdered mixture into a three ounce Dixie cup -donned a pair of gloves and took the gabapentin (pain medication) 300 mg capsule apart and placed the contents of the capsule into another three ounce Dixie cup - used a sterile needle and poked a hole into the cholecalciferol tablet 2000 units (vitamin D) capsule and squeezed the liquid contents out of the capsule into the Dixie cup which had the gabapentin - poured out 5 cc's (1250 mg) of calcium carbonate suspension and placed it into a clear plastic measuring cup - poured 20 cc's of tap water into the Dixie cup which held the crushed Lexapro, Norvasc and acetaminophen mixture - entered R113's room, donned a pair of gloves, gathered supplies which included a graduate and	F 322	receiving medication via enteral tube. The physician and pharmacy consultant have reviewed individual resident medications and given guidance for crushing and administering mediations together, in a cocktail, as appropriate. Practice and adherence to correction will be monitored with random weekly audits of enteral medication administration for one month. If found to be in compliance with plan for correction, audits will be done monthly for 3 months, then quarterly thereafter for up to one year. Results of audits will be brought to the monthly QA meeting. Corrective action will be completed by 1/26/16.	

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F 322	Continued From page 40 60 cc syringe - At 10:07 a.m. LPN-B exposed R113's PEG tube, unclamped and removed the plug on the end of the PEG tube, connected the syringe to the PEG tube and checked the placement of the PEG tube by injecting 10 cc's of air into the PEG tube using a 60 cc syringe and a stethoscope to auscultate the abdomen - LPN-B removed the plunger of the 60 cc syringe and poured in 30 cc's of tap water into the open ended syringe allowing the water to be administered by gravity - LPN-B placed the mixture of 20 cc's of tap water, crushed Lexapro, Norvasc and acetaminophen into the open ended syringe allowing the mixture of medications to be administered by gravity - flushed the PEG tube with 10 cc's of tap water - placed the 5 cc's of liquid calcium carbonate suspension into the open ended syringe and allowed the suspension to be administered by gravity - flushed with 10 cc's of tap water - poured approximately 10 cc's of tap water into the gabapentin and vitamin D mixture - placed the mixture of 10 cc's of tap water, gabapentin and vitamin D mixture into the open ended syringe allowing the mixture of medication to be administered by gravity - followed with a tap water flush of a total of 30 cc's - unattached the open ended syringe from the PEG tube and hooked up the feeding tube pump and started the tube feedings using a calibrated pump On 12/15/15, at 1:35 p.m. LPN-B stated she thought R113 had an order to crush and mix all of	F 322		

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F 322	Continued From page 41 R113's medications and give them through the PEG tube. However, LPN-B reviewed R113's current medication administration record (MAR) and was unable to find an order to cocktail R113's medications. The facility's Guidelines for Clinical Procedures in the Care Center - Feeding Tube: Medication Administration policy dated 3/16/11, directed staff to prepare tablet medications by crushing them individually into a fine powder and then to mix each medication with 30 cc's of water. In addition, when administering more than one medication, each medication should be administered separately and flushed between medications with at least 15 cc's of water. On 12/16/15, at 12:55 p.m. the director of nursing (DON) confirmed she expected staff to follow the current standards of practice which was outlined in the facility's policy to flush the feeding tube before and after each individual medication. On 12/16/15, at 1:24 p.m. the consulting pharmacist (CP) stated staff should have followed the facility's policy for medication administration via a feeding tube.	F 322		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		1/26/16

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F 332	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure it was free of medication error rate of 5% or less. A medication error rate of 15.3% was observed during 2 of 7 (R58, R113) medication pass observations. Findings include: R58 received Flomax 0.4 milligrams (mg) (medication for urinary retention) at the incorrect time. On 12/14/15, at 5:20 p.m. licensed practical nurse (LPN)-D was observed to administer medications to R58. LPN-D administered Coumadin 3 mg (an anticoagulation medication used to eliminate or reduce the risk of blood clots), potassium 40 milli-equivalents (mEq), and Flomax 0.4 mg. At the time of administration, R58 had just taken bites of her evening meal. R58's Clinical Physician Orders, with the order date of 4/8/13, directed staff to give Flomax 0.4 mg ½ hour after supper. R58's medication administration record (MAR) directed staff to give Flomax 0.4 mg by mouth one time a day ½ hour after supper. On 12/15/15, at 3:42 p.m. LPN-D confirmed she had given the Flomax at 5:22 p.m. on 12/14/15, while R58 was still eating her supper. LPN-D confirmed the Flomax should have been given ½ hour after supper and it had been given while R58 was eating. R113 received medications cocktailed (mixture of	F 332	F332 - Free of Medication Error Rates of 5% or More CRMC strives to provide safe standards of nursing practice and care for the residents, to maintain their health, wellbeing and comfort. CRMC has developed a new policy for Medication Administration, effective 1/7/16 and a new policy on Medication Error Point System on 1/11/16. R58's physician orders were reviewed and revised by the physician and pharmacy consultant. The physician provided clarification for timing for the administration of Flomax and discontinued parameter for medication to be given in correlation with meal. R113's care plan and physician orders have been reviewed and revised by the interdisciplinary. The primary physician and pharmacy consultant have reviewed and given direction and clarification for crushing and administration of R113's medications via enteral tube. CRMC's Clinical Education Department will provide education and competency training for staff nurse on the rights of medication administration, in learning modules, the week of 1/19- 1/22/16. The new policies for Medication Administration and Medication Error Point System will be reviewed by nurses during the educational sessions. Also, CRMC's Consultant Pharmacist will provide further education to nurses on 1/26/16, on rights of medication administration. Practice and adherence to correction will	

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F 332	Continued From page 43 liquid and crushed medications) via a percutaneous endoscopic gastrostomy (PEG) tube (tube placed into the stomach for feeding) without an order or justification for cocktailing (mixture of liquid and crushed medications); Lexapro 20 mg (antidepressant) was given the incorrect route then ordered; and nitroglycerine patch 24 hour 0.4 mg/hour (medication used to prevent chest pain) was applied over two hours later than scheduled. On 12/15/15, at 9:36 a.m. licensed practical nurse (LPN)-B was observed to prepare the following medications for administration: -crushed one tablet of Lexapro 20 milligrams (mg) (antidepressant); one tablet of Norvasc 2.5 mg (high blood pressure medication) and acetaminophen 650 mg (two 325 mg tablets) - combined the Lexapro, Norvasc, and acetaminophen crushed tablets and placed the powdered mixture in a three ounce Dixie cup -donned a pair of gloves and took the gabapentin (pain medication) 300 mg capsule apart and placed the contents of the capsule into another three ounce Dixie cup - used a sterile needle and poked a hole into the cholecalciferol tablet 2000 units (vitamin D) capsule and squeezed the liquid contents out of the capsule into the Dixie cup which had the gabapentin - poured out 5 cc's (1250 mg) of calcium carbonate suspension and placed it into a clear plastic measuring cup - poured 20 cc's of tap water into the Dixie cup which held the crushed Lexapro, Norvasc and acetaminophen mixture - entered R113's room, donned a pair of gloves, gathered supplies which included a graduate and 60 cc syringe	F 332	be monitored with random weekly audits of medication administration pass for one month. If found to be in compliance with plan for correction, audits will be done monthly for 3 months, then quarterly thereafter for up to 1 year. Results of audits will be brought to the monthly QA meeting. Corrective action will be completed by 1/26/16.	

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F 332	Continued From page 44 - at 10:07 a.m. LPN-B exposed R113's PEG tube, unclamped and removed the plug on the end of the PEG tube, connected the syringe to the PEG tube and checked the placement of the PEG tube by injecting 10 cc's of air into the PEG tube using a 60 cc syringe and a stethoscope to auscultate the abdomen - LPN-B removed the plunger of the 60 cc syringe and poured in 30 cc's of tap water into the open ended syringe allowing the water to be administered by gravity - LPN-B then placed the mixture of 20 cc's of tap water, crushed Lexapro, Norvasc and acetaminophen into the open ended syringe allowing the mixture of medications to be administered by gravity - flushed the PEG tube with 10 cc's of tap water - placed the 5 cc's of liquid calcium carbonate suspension into the open ended syringe and allowed the suspension to be administered by gravity - flushed with 10 cc's of tap water - poured approximately 10 cc's of tap water into the gabapentin and vitamin D mixture - placed the mixture of 10 cc's of tap water, gabapentin and vitamin D mixture into the open ended syringe allowing the mixture of medication to be administered by gravity - followed with a tap water flush of a total of 30 cc's - at 10:12 a.m. LPN-B applied the nitroglycerine patch 0.4 mg/hour to R113's right collar bone area (two hours and 12 minutes past the prescribed administration time). R113's Order Summary Report printed 12/15/15, directed staff to: - flush R113's feeding tube with 30 cc's before and after medication administration, however	F 332		

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F 332	Continued From page 45 lacked an order and justification for cocktailing medications - give Lexapro 20 mg by mouth one time a day - nitroglycerine patch 24 0.4 mg/hour to be applied at 8:00 a.m. and removed at 8:00 p.m. R113's MAR directed staff to: -flush R113's feeding tube with 30 cc's before and after medication administration -give Lexapro 20 mg by mouth one time a day -nitroglycerine patch 24 0.4 mg/hour to be applied at 8:00 a.m. and removed at 8:00 p.m. On 12/15/15, at 1:35 p.m. LPN-B stated she thought R113 had an order to crush and mix all of R113's medications and give them through the PEG tube. However, LPN-B reviewed R113's current MAR and was unable to find an order to cocktail R113's medications. On 12/15/15, at 12:53 p.m. LPN-C verified the order dated 7/31/15, to crush all oral medications and give via the feeding tube had not been transcribed correctly onto the current physician orders dated 12/15/15. LPN-B verified the current order directed staff to administer the Lexapro 20 mg by mouth, and the directions on the Lexapro blister pack (retail packaging in which a clear plastic or metal-foil seal holds the tablet against a cardboard sheet) and the MAR also directed staff to administer the Lexapro 20 mg by mouth. LPN-B confirmed she had crushed the Lexapro 20 mg and had administered it via the PEG tube with the Norvasc and acetaminophen. In addition, LPN-B verified the nitroglycerine patch 0.4 mg/hour should have	F 332		

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F 332	Continued From page 46 been placed on R113 at 8:00 a.m. as ordered. LPN-B stated she thought she had a grace period to administer timed medications of one hour before or after they were scheduled. LPN-B confirmed the nitroglycerine patch had been applied over two hours past the scheduled time. On 12/16/15, at 12:55 p.m. the director of nursing (DON) confirmed she expected staff to follow the current standards of practice for administering medications via a feeding tube. The DON confirmed the facility policy directed staff to flush the feeding tube before and after each individual medication. The DON verified staff had a window of one hour before or one hour after to administer a scheduled medication. The DON confirmed R113's patch had been applied beyond this one hour window. In addition, the DON verified medications should be administered by the correct route and when the order was for a medication to be given after the meal, it should be given after the meal. On 12/16/15, at 1:24 p.m. the consulting pharmacist (CP) stated staff should have followed the facility's policy for medication administration via a feeding tube. In addition, medications should be administered using the correct route and scheduled times. Guidelines for Clinical Procedures in the Care Center - Feeding Tube: Medication Administration policy dated 3/16/11, directed staff to prepare tablet medications by crushing them individually into a fine powder and then to mix each medication with 30 cc's of water. In addition,	F 332		

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F 332	Continued From page 47 when administering more than one medication, each medication should be administered separately and flushed between medications with at least 15 cc's of water. Pharmaceutical Services Policy dated 9/10/95, directed staff to cross check the label of the medication container with the medication order on the MAR to identify the correct dose to be administered and correct time of administration. In addition, medications are to be given at the time ordered or within 60 minutes before or after the time designated.	F 332		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide 1 of 2 residents (R58) with the recommended inner lipped plate adaptive eating equipment in the Lakeview dining room as directed. Findings include: R58's Medical Diagnosis report printed 12/16/15, identified R58's diagnoses as poliomyelitis (polio virus on the spinal cord with characteristics of paralysis), dementia, fatigue and cataracts.	F 369	F369 - Assistive Devices- Eating Equipment/Utensils CRMC strives to provide residents with a pleasurable dining experience, by developing individualized care plans, to support and maintain a resident□s functional ability and promote dignity and self-worth. The interdisciplinary team reviewed and revised the Dining Room policy on 1/8/16. R58□s care plan has been reviewed by the Interdisciplinary team with the continued recommendation of a lip plate in order to maintain ability to feed self and	1/26/16

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F 369	Continued From page 48 R58's quarterly Minimum Data Set (MDS) dated 10/19/15, indicated R58 had severe cognitive impairment, required extensive assist with eating, had range of motion impairment on one side of her upper extremities and was on a mechanical altered diet. R58's activities of daily living (ADL) Care Area Assessment (CAA) dated 7/29/15, indicated R58 had declined in her condition and required more support for eating. R58's care plan dated 9/11/15, directed staff to serve R58's meals on an inner lipped plate. R58's Occupational Therapy Plan of Care dated 3/2/15, indicated R58 was able to feed herself but staff had noted an increased difficulty with this task. Several different adaptive equipment had been trialed and those found to be effective included the built-up handled spoons and forks and the inner lip plate. R58's Clinical Physician Orders dated 9/28/15, directed staff to provide R58 with the inner lipped plate with her meals. On 12/14/15, at 5:20 p.m. R58 was observed seated in a wheelchair at a dining room table. R58's place setting included two handled cups with lids, a curved fork and spoon with raised handles, a regular plate (a non-inner lipped plate) and dycem (a nonslip mat) attached to the bottom of R58's plate. -At 5:38 p.m. R58 used her fork and pushed the	F 369	promote dignity. Culinary team has revised the procedure for setting up the resident□s trays for meal service in the Lakeview dining area. All adaptive equipment will be pre-set by culinary staff on the trays within the enclosed cart. Culinary Director is replacing the current resident dietary tickets with a new ticket system. The new ticket system has a defined area for adaptive equipment. This will make communication of adaptive equipment needs clear to culinary and nursing staff. The new dietary ticket system and updated dining policy will be reviewed with nursing and culinary staff during team huddles the week of 1/18-1/22/16 and at the all staff meeting on 1/22/16. Practice and adherence to correction will be monitored with random weekly audits of dining service, to ensure adaptive equipment is in place for R58 and other residents with adaptive equipment needs. If found to be in compliance with plan for correction, audits will be done monthly for 3 months, then quarterly thereafter for up to one year. Results of audits will be brought to the monthly QA meeting. Corrective action will be completed by 1/26/16.	

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F 369	Continued From page 49 shepards pie across the plate with some of the shepards pie falling off the rim of the plate and onto the table and R58's clothing protector and pants. R58 remained eating this way, spilling food over the plate onto the table and her clothing with some of the food falling around her on the floor. -At 5:45 p.m. R58 used her fingers and scooped up the shepards pie, pushed it across the plate and brought it to her mouth. -At 6:00 p.m. R58 had finished her meal. Clumps of shepards pie and pieces of chocolate bar surrounded R58's plate, down the front of R58's clothing protector, on R58's pants and the floor surrounding her wheelchair. On 12/14/15, at 5:54 p.m. licensed practical nurse (LPN)-D confirmed R58's meal had been served on a regular dinner plate (non-inner lipped). LPN-D stated the inner lipped plates where a bit deeper and had a ledge around the rim of the plate. On 12/14/15, at 6:10 p.m. registered nurse (RN)-C verified R58 had not been served her meal on an inner lipped plate and that R58's meal ticket was not available to review. On 12/15/15, at 8:15 a.m. RN-C provided a sample meal ticket for R58. This meal ticket directed staff to serve R58's meals on an inner lipped plate. RN-C confirmed R58's evening meal on 12/14/15, had not been served on an inner lipped plate, as directed.	F 369		

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F 369	Continued From page 50 On 12/16/15, at 8:51 a.m. dietary aide (DA)-A stated the special silverware and other equipment a resident needed was listed on the resident's meal ticket. On 12/16/15, at 1:04 p.m. the director of nursing (DON) stated she expected staff to follow each resident's plan of care as it related to adaptive eating equipment. Meal Tray Identification Care Center policy dated 1/1/14, indicated a meal card would be provided for each resident to ensure the meal conformed to the physician diet order and individual special needs of the resident such as adaptive devices	F 369		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		1/26/16

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F 431	Continued From page 51 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to properly date eye drop bottles with a when opened date for 5 of 5 (North Transitional Care unit, Lakeview, Skyview, Parkview, Woodview) medication carts reviewed. Findings include: On 12/16/15, at 9:10 a.m. the North Transitional Care unit (TCU) medication cart was reviewed with registered nurse (RN)-D. RN-D confirmed the one eye bottle solution in the medication cart lacked a when opened date. RN-D stated the eye drop bottles should be labeled with a date when they are opened. Licensed practical nurse (LPN)-E confirmed eye drop bottles should be dated when they are opened.	F 431	F431 - Drug Records, Label/Store Drugs & Biologicals CRMC strives to adhere to safe standards of nursing practice for maintaining safety and storage of medications, including eye drops. CRMC revised the procedure for Eye Drop Administration to include dating the eye drops when the bottle is opened. The eye drops and ointments on all units were re-ordered, replaced as appropriate and dated when opened, per policy. The expiration for Xalantan is 42 days (6 weeks) when kept at room temperature. All other eye drops expire per product expiration date, per Medication Expiration Dating guidelines provided by Pharmacy Consultants, Inc. 9/15. Education was provided to nurses in huddles in Dec. 2015 – Jan. 2016, on need to date all eye drops upon opening.	

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F 431	Continued From page 52 On 12/16/15, at 12:18 p.m. the Lakeview medication cart was reviewed with RN-C. RN-C confirmed five of the seven opened eye bottle solutions in the medication cart lacked a when opened date. RN-C verified the eye bottles or the box they were stored in should have been labeled with the date they are opened. On 12/16/15, at 12:29 p.m. the Skyview medication cart was reviewed with trained medication aide (TMA)-A. TMA-A confirmed all 16 opened eye bottle solutions in the medication cart lacked a when opened date. TMA-A verified they should have been marked with the date the bottles were opened. On 12/16/15, at 12:33 p.m. the Parkview medication cart was reviewed with LPN-C. LPN-C verified all eight opened eye bottle solutions in the medication cart lacked a when opened date. On 12/16/15, at 12:38 p.m. the Woodview medication cart was reviewed with LPN-A. LPN-A verified all seven opened eye bottle solutions in the medication cart lacked a when opened date. LPN-A confirmed all seven bottles should have been labeled with the date the bottle were opened. On 12/16/15, at 12:52 p.m. the director of nursing (DON) verified medications such as eye drops should have been dated when opened. The DON stated staff were supposed to write the date the bottle was opened on the eye drop bottle itself or	F 431	Revised procedure for eye drop administration will be reviewed with nurses the week of 1/19-1/22/16 at nurse learning stations and at all staff meeting on 1/22/16. Also, Pharmacy Consultants will provide additional training to nurses on 1/26/16 to include need for dating of eye drops. Practice and adherence to correction will be monitored with random weekly audits of medication cart, to ensure eye drops are dated, for one month. If found to be in compliance with plan for correction, audits will be done monthly for 3 months, then quarterly thereafter for up to 1 year. Results of audits will be brought to the monthly QA meeting. Corrective action will be completed by 1/26/16.	

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F 431	Continued From page 53 the box the eye drop solution was stored. On 12/16/15, at 1:24 p.m. the consulting pharmacist (CS)-A stated the facility should follow their practice with dating eye drop solutions when opened as some eye drop solutions were time sensitive for expiration. No policy related to the dating of eye drop solutions was provided. The American Society of Ophthalmic Registered Nurses (ASORN) recommended ophthalmic bottles or tubes be labeled with the date they were originally opened and the expiration date should not exceed 28 days once opened.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		1/26/16

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F 441	Continued From page 54 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to prevent cross contamination of soiled resident care equipment to personal belongings for 1 of 3 residents (R70) observed to be transferred utilizing a wet, soiled mechanical lift which was placed on the residents personal property. Findings include: On 12/16/2015, at 7:13 a.m. R70 was observed in bed, asleep. -At 8:36 a.m. nursing assistant (NA)-B and NA-A were observed to enter R70's room to get R70 up from bed. R70 was observed to be fully dressed	F 441	F441 - Infection Control, Prevent Spread, Linens It is CRMC's policy to handle linens in a safe manner, to prevent the spread of infection to residents and others within the facility. The Policy for Linen Care and Handling was reviewed by the interdisciplinary team. R70's care plan has been reviewed by interdisciplinary team. Staff education will be provided in team huddles 1/13-1/19/16 on need to launder slings weekly, on bath day and prn, if they come in contact with soiling or contaminated skin. Education will also include measures for staff to use for	

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F 441	Continued From page 55 with a blue mechanical lift sheet positioned under her. NA-A and NA-B connected the lift sheet to the mechanical lift and transferred R70 from the bed and into the wheelchair. NA-A and NA-B removed the blue lift sheet from under R70 and placed it on the blue fabric recliner in the room. R70's bedside table was positioned next to her and both NAs exited the room. R70's lift sheet and blue fabric recliner was detected to have a strong offensive urine odor, -At 11:33 a.m. NA-A was asked if R70 would be toileted. NA-A entered R70's room and exited it. NA-A stated R70 refused to use the commode at this time as it was too close to lunch and would wait until after lunch. -1:06 p.m. NA-B and NA-C were observed to enter R70's room. R70's lift sheet was placed under her. The lift sheet was then attached to the Hoyer lift and R70 was transferred into her bed. R70 was detected to have a strong offensive urine odor. NA-B removed R70's incontinent brief which was observed saturated with urine and a strong offensive urine odor was detected. R70's peri area, abdomen and buttocks were observed wet with urine. R70's lift sheet remained under her during the removal of the saturated incontinent brief. R70 was observed to lay on the lift sheet with skin wet from urine. NA-B and NA-C then reattached the sheet to the mechanical lift in order to transfer R70 onto the commode, however, R70 refused. NA-B and NA-C proceeded to turn R70 from side to side to remove the lift sheet from under R70. NA-B tossed the wet lift sheet onto the upper back of R70's fabric covered recliner which was next to R70's bed. A blue sweater, a newspaper and a blanket throw were also observed on the seat of the recliner and the lift sheet landed on the recliner fabric and on top of the blanket. NA-B	F 441	infection control prevention, to prevent cross contamination of resident personal belongings. Education will also be provided at the all staff meeting on 1/22/16. Practice and adherence to correction will be monitored with random weekly audits of resident care for one month. If found to be in compliance with plan for correction, audits will be done monthly for 3 months, then quarterly thereafter for up to one year. Results of audits will be brought to the monthly QA meeting. Corrective action will be completed by 1/26/16.	

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F 441	Continued From page 56 obtained a clean brief and both NAs placed the incontinent brief on R70. No pads or protective covering was placed beneath R70 or the lift sheet. R70 was covered with a blanket, bed pillow was adjusted and call light was provided and both NAs exited the room. On 12/16/15, at 1:06 p.m. NA-B verified R70's brief was saturated with urine and the urine odor was very strong. NA-B verified R70's lift sheet was wet with urine and also had a strong urine odor and should not have been placed on the blue fabric recliner. NA-B obtained a plastic bag and placed the lift sheet into the bag. NA-B stated staff usually change out the lift sheet every couple of days because when we send the lift sheets to laundry we don't always get them back when we need them. Both NA-A and NA-B verified the placement of the soiled lift sheet onto the recliner and reusing the soiled lift sheet would be and infection control concern. On 12/16/2015, at 1:35 p.m. the director of nursing (DON) stated staff should never have placed the soiled lift sheet on the recliner or reused it after being soiled from urine. The DON stated it was an infection control concern with soiled linen and put R70 at risk of infections. The DON stated the facility had ample lift sheets available for use at all times and there was not reason not to send the lift sheet to the laundry for cleaning. The facility policy, Linen care and Handling, revised date 8/6/10, indicated guidelines for soiled linen- all linen is considered potentially	F 441		

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F 441	Continued From page 57 infectious, and as such is handled in a manner to reduce the transmission of infection. Soiled linen should be handled as little as possible and in a manner which avoids agitation and to place soiled linen in impervious linen bags as close to the point of use as possible.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain R70's room in a clean, sanitary and odor free manner which had the potential to affect all residents, staff and the public who visited the room and the unit. The facility also failed to maintain resident care equipment, rooms and furnishings in good repair. Findings include: R70's room had a strong offensive urine odor and the facility failed to reduce/eliminate the odor. On 12/14/15, at 6:19 p.m. a strong offensive urine odor was noted outside R70's room. On 12/16/16, at 7:21 a.m. the same strong	F 465	F465 - Clean, sanitary, odor free environment It is the policy of CRMC to provide a clean, sanitary environment that is free from odors. Resident 70 and roommate were temporarily relocated during survey to a vacant room on the same wing so that a thorough cleaning and renovation could be done of the room including stripping and waxing floors, painting, and insulating and sheet rocking outside walls. R70 was referred to her physician regarding strong urine odor; bed and mattress have been replaced; wheelchair cushion has been replaced; chair removed. R21: padded tray table has been replaced as of 1/12/16. R116: parts no longer available for this type of specialized chair. OT screen was	1/26/16

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F 465	Continued From page 58 offensive urine odor remained outside of R70's room and was overpowering when entering the room. Several staff and residents were observed going back and forth past R70's room. No staff acknowledged R70's room needed to be cleaned. On 12/16/2015, at 8:42:a.m. nursing assistant (NA)-A stated the urine smell in R70's room had always been there. NA-A stated she had tried a lot of things such as changing the bedding, wiping down the bed and changing out the linen but the urine odor remained. NA-A stated she made sure to take out the soiled briefs right away and provide good cares. NA-A stated if R70 had gotten wet from urine she would independently remove her shirts/clothing and stick them in a drawer or somewhere else so we try to make sure those were removed out of the room as well. NA-A verified R70's recliner which was positioned next to R70's bed also smelled urine but she had not cleaned it. On 12/16/2015, at 10:24 a.m. the environmental service (ES) director confirmed R70's room had a strong urine odor and stated R70's bed needed to be cleaned or changed out. The ES also stated R70's room floor was dirty and the whole area smelled of urine. The ES stated it could be from the recliner, the commode, the bed, the floor or the wheelchair. The ES verified R70's room needed to be cleaned. On 12/16/2015, at 11:55 a.m. Housekeeper (H)-A verified R70's room, bed, wheelchair and recliner had a strong offensive urine odor which had been there for quite a while. H-A stated she was told nursing staff would clean with R70's bed as it was an air mattress. H-A stated she had tried all kinds of products including bleach to try and remove	F 465	sent on 1/13/16 to evaluate resident for appropriate wheelchair need. New wheelchair will be issued based on results of screen. R33: wheelchair armrest has been replaced 1/12/16. R68: wheelchair has been replaced 1/13/16. Room 202-1: adhesive will be removed from the floor the week of 1/18/16 Room 214-1: areas of scraped paint will be repainted the week of 1/18/16 Room 508-1: scrape in floor will be burnished the week of 1/18/16 been filled; ceiling tiles have been replaced Room 603-1: red material has been removed; radiator has been repainted Room 604-1: over bed table was disposed of and replaced Room 610-1: wall will be repainted the week of 1/18/16 Room 610-2: wall will be repainted the week of 1/18/16 Room 703-2: anti-skid strips have been replaced and sticky residue from glue removed; scuffs will be removed week of 1/18/16 Staff will receive training at the all staff meeting on 1/22/16 regarding the policy and process of submission of work orders for equipment maintenance needs, odors and damage to the facility. Education will include the responsibility of all staff to submit all needs noted. EVS Director will perform weekly checks of each wing for one month to assess the needs. Once compliance is met monthly checks will be continued. Plans are in place to do	

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F 465	Continued From page 59 the odor but had been unable to get rid of the smell. On 12/16/15, at 1:06 p.m. NA-B verified the urine odor was very strong in R70's room and stated R70's wheelchair cushion was saturated with a urine odor. NA-B stated staff had been dealing with the odor for a long time but it did not get fixed. NA-B stated she had reported the odor to her supervisors but she did not know what was done about it. NA-B stated, "apparently nothing, because the odor is still here." NA-B stated staff had wiped down the furnishings and the things in R70's room. On 12/16/2015, at 1:35 p.m. the director of nursing (DON) was present in R70's room and verified the room, bed, recliner and wheelchair had a strong offensive urine odor and stated interventions would be immediately put into place to take care of it. The DON verified R70's room should be odor free and clean and it was not. On 12/16/15, at 3:28 p.m. the DON stated R70 was temporarily relocated to another room so that cleaning and planned remodeling could take place. The DON stated when R70's bed was moved away from the wall, a large puddle of dried urine was noted. On 12/17/15, at 8:35 a.m. the facility's manager (FM), stated he had not been previously notified of room odor. The FM said he had inspected R70's room the evening of 12/16/15, and stated the room flooring was "nasty" with an offensive urine odor which was detectable in the hallway as well. The FM stated the problem would be addressed right away.	F 465	extensive room renovations. Results of audits will be brought to the monthly QA meeting. Corrective action will be completed by 1/26/16.	

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 _____	12/17/2015

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 465	Continued From page 60 The Work Orders and Preventative Maintenance policy dated 1/6/14 indicated all employees were responsible for notifying Facilities Management when maintenance was required on equipment or when damage to the facility was observed. On 12/17/2015, at 10:21 a.m. a tour of the facility was completed with the Facilities Director (FD). the FD stated they planned to remodel residents' rooms, however, had not discussed which wing was next and the project would not be completed for approximately two years. During the tour the following concerns were identified and confirmed by FD: Care Equipment: R21's 1/4 padded tray table on the left arm of the wheelchair had a worn area approximately 2 inches (") in diameter on the corner which exposed the foam padding. R116's wheelchair metal sides and rungs were covered with dust, dirt and what appeared to be food debris. The rear edge of the right arm was covered with black electrical tape. R33's left wheelchair armrest had cracks and chips in the vinyl covering that exposed the white foam padding. R68's wheelchair had food debris stains on the bottom rungs and metal side parts. The right	F 465		

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 _____	12/17/2015

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 465	Continued From page 61 armrest's vinyl covering had cracks that exposed the foam padding and the seat had cracks exposing gray foam. Rooms and furnishings: 202-1: The floor next to the bed had an area approximately 3 feet (ft) x 2 ft with long black strips of adhesive stuck to the floor. In front of the toilet in the shared bathroom there was an area approximately 3" x 10" of dark gray adhesive stuck to the floor. 214-1: The wall next to the bed had three areas of scraped paint approximately 4 inches in diameter. 508-1: The wall by the head of the bed had an approximate 5" gouge that exposed the sheetrock. The floor by the foot of the bed had an approximate 2 foot scrape in the tile. The wall above the baseboard directly to the left of the shared sink had an approximate 14" gouge through the paint and into the sheetrock. There were also several 3/4" holes in the ceiling tiles by the curtain tracks. 603-1: The radiator had a red felt looking material stuck in the opening at the bottom of the radiator. The radiator also had an area approximately 2" x 24" of paint chipped off down to the metal.	F 465		

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 _____	12/17/2015

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 465	Continued From page 62 604-1: The over the bed table had an approximately 2" chip in the corner and the surface of the table was covered with black permanent marker. 610 -1: The wall by the bed had an area approximately 1 ft x 2 ft of black scuff marks by bed. 610-2: The wall by the bed had an area approximately 2 ft x 3 ft of black scuff marks by the bed. 703-2: The anti-skid strips on the floor next to the bed were curling up at the ends. The wall by the sink had an area approximately 1 ft long of black scuff marks. The bathroom door also had black scuffs marks. The FD indicated the facility had a computer work order system and stated his expectation would be that these issues with the rooms and furnishings would have been reported and addressed. The FD also indicated the facility repaired and maintained wheelchairs belonging to the facility. The FD indicated the wheelchairs used by R21, R116 and R68 were owned by the facility and the issues should have been reported and addressed. The FD indicated R33's wheelchair belonged to R33 and would not be repaired by the facility. On 12/17/15, at 11:04 a.m. the licensed social worker (LSW) stated she was responsible to	F 465		

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 _____	12/17/2015

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 465	Continued From page 63 assist R33 with any repairs or maintenance required for her wheelchair but had been unaware there was an issue. The LSW confirmed the repair need should have been reported. The Work Orders and Preventative Maintenance policy dated 1/6/14, indicated all employees were responsible for notifying Facilities Management when maintenance was required on equipment or when damage to the facility was observed.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. BUILDING **01 - NURSING HOME** B. WING _____	**12/17/2015**

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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K 000	INITIAL COMMENTS	K 000		

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 substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

EPOC

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
445 MINNESOTA STREET, SUITE 145

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/14/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. BUILDING **01 - NURSING HOME** B. WING _____	**12/17/2015**

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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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us or 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. The facility was surveyed as two buildings: 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. BUILDING **01 - NURSING HOME** B. WING _____	**12/17/2015**

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
K 000	Continued From page 2 The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection throughout the corridor system, in common areas and hazardous areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. 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 2007 edition. The facility has a capacity of 117 beds and had a census of 93 at the time of the survey. The requirement at 42 CFR, Subpart 485.623 (d) is NOT MET.	K 000		
K 017 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017		1/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. BUILDING **01 - NURSING HOME** B. WING _____	**12/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 017	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility had penetrations located in the ceiling tile located in the facility that are not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the residents, visitors, and staff members of the facility. Findings include: On facility tour between 10:00 PM to 2:00 PM on 12/17/2015, observations revealed, that there was a penetration in the ceiling tiles located in the lower level corridor by the dish room. This deficient condition was verified by a Director of Facilities Management (DH).	K 017	Ceiling tiles replaced on December 28, 2015. Facility Manager is responsible to prevent reoccurrence.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		1/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. BUILDING **01 - NURSING HOME** B. WING _____	**12/17/2015**

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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K 029	Continued From page 4	K 029		
	This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors. Findings include: On facility tour between 10:00 PM to 2:00 PM on 12/17/2015, observation revealed, that there was a vertical penetration in the ceiling of the mechanical room that is located across from the maintenance shop. This deficient condition was verified by a Director of Facilities Management (DH).		Vertical penetration in the ceiling patched on December 28, 2015. Facility Manager is responsible to prevent reoccurrence.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water	K 056		1/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. BUILDING **01 - NURSING HOME** B. WING _____	**12/17/2015**

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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K 056	Continued From page 5 supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors, and staff members of the facility. Findings include: On facility tour between 10:00 PM to 2:00 PM on 12/17/2015, observations have revealed that there are standard type of sprinkler heads mixed in with quick response sprinkler heads in the same compartment located in the TCU between the nurses station and the corridor. This deficient condition was verified by a Director of Facilities Management (DH).	K 056	All sprinkler heads replaced to standard type on December 28, 2015. Facility Manager is responsible to prevent reoccurrence.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than	K 076		1/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. BUILDING **01 - NURSING HOME** B. WING _____	**12/17/2015**

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K 076	Continued From page 6 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, that the oxygen storage room was not maintained in accordance with NFPA 99 Standards for Health Care Facilities (1999 edition). This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively affect residents, staff, and visitors in the event of an emergency. Findings include: On facility tour between 10:00 PM to 2:00 PM on 12/17/2015, observations revealed that the oxygen storage room door leading to the corridor was not equipped with a self-closing device. This deficient condition was verified by a Director of Facilities Management (DH).	K 076	Self-closing door closure installed on December 28, 2015. Facility Manager is responsible to prevent reoccurrence.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. BUILDING **02 - 2007 DAYROOM** B. WING	**12/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

02 2007 Addition

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 02 2007 Addition was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care.

The facility was surveyed as two buildings.

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.

The entire building is protected with a complete automatic fire sprinkler system installed in

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/14/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. BUILDING **02 - 2007 DAYROOM** B. WING _____	**12/17/2015**

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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K 000	Continued From page 1 accordance with NFPA 13 Standard for Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection throughout the corridor system, in common areas and hazardous areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. 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 2007 edition. The facility has a capacity of 117 beds and had a census of 93 at the time of the survey. The requirement at 42 CFR, Subpart 485.623 (d) is MET:	K 000		