DEPARTMENT OF HEALTH

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered

June 8, 2022

Administrator
Cuyuna Regional Medical Center
320 East Main Street
Crosby, MN 56441

RE: CCN: 245232
Cycle Start Date: March 17, 2022

Dear Administrator:

On May 3, 2022, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

On June 3, 2022, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 17, 2022, did not go into effect. (42 CFR 488.417 (b))

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
March 31, 2022

Administrator
Cuyuna Regional Medical Center
320 East Main Street
Crosby, MN 56441

RE: CCN: 245232
Cycle Start Date: March 17, 2022

Dear Administrator:

On March 17, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 17, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 17, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. BUILDING ______ B. WING ______	C 03/17/2022

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
E 000	Initial Comments On 3/14/22, through 3/17/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/14/22, through 3/17/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED, however NO deficiencies were cited due to actions implemented by the facility prior to survey: H5232052C (MN78779) H5232053C (MN80015) AND The following complaint was found to be UNSUBSTANTIATED: H5232054C (MN81590). AND The following complaint was found to be	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/06/2022

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

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F 000	Continued From page 1 UNSUBSTANTIATED, however related deficiencies were cited. H5232051C (MN77779), with a deficiency cited at (F609). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		4/19/22

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F 550	Continued From page 2 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal intimate laundry was not left in a public area for 1 of 1 residents (R9) whose bras were observed sitting on top of the handrail outside her room door. Findings include: R9's Diagnosis Report dated 3/17/22, indicated R9's diagnoses included dementia, ataxia following cerebral infarction (impaired balance/coordination following stroke), depression, and chronic pain.	F 550	Cuyuna Regional Medical Center is committed to caring for all residents in a respectful manner and in an environment that maintains and enhances each resident's dignity, self-esteem, and self-worth with focus on quality of life. R9's care plan was reviewed on April 4, 2022, by the interdisciplinary team and remains appropriate with no changes needed. The Care Center's Privacy and Dignity Policy was reviewed and revised on April 3, 2022 by the Director of Nursing to	

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F 550	Continued From page 3 On 3/16/22, at 10:34 a.m. about six shirts on hangers were hanging on the hand railing outside R9's room. On top of the hangers were two bras. Registered nurse (RN)-D exited the room. RN-D stated she hadn't heard anyone knock on the door and confirmed personal laundry should not be left outside a resident's room. On 3/16/22, at 10:39 a.m. laundry aide (LA)-A stated she knocked on the resident's door and when no one answered she left the laundry hanging on the railing outside the resident's door. LA-A verified she should not have left personal laundry (resident's bras) outside the room where anyone walking by could see them. On 3/17/22, at 9:00 a.m. RN-C stated she would see clothing left outside of resident rooms about twice a week. RN-C verified this was not a dignified practice to leave personal clothing outside of resident rooms, especially if it was underclothes. On 3/17/22, at 9:45 a.m. RN-B verified it was not dignified for residents to have their personal clothing left in the hallway for anyone to see. RN-B stated she would expect staff to knock on the door and bring the clothing into the room to be put away. If no one answered the door the clothing should not have been left in the hallway. On 3/17/22, at 10:59 a.m. the director of nursing (DON) verified personal laundry should not be left in the hallway, staff should have knocked and brought the clothing into the room. If no one answered she would have expected the clothing to be delivered later. The DON confirmed it was not dignified to have personal clothing (especially bras) left in the hallway.	F 550	include resident's clean personal laundry will be delivered directly to the resident's room and placed in the dresser or closet, per resident preference. Resident's personal laundry is not to be left in the hallway. Education will be provided to all Care Center staff on the Care Center's revised Privacy and Dignity Policy during shift-to-shift huddles from April 7-18, 2022. The revised policy will also be reviewed at the Care Center's all staff meeting on April 14, 2022. Audits will be conducted to ensure personal laundry is handled in a dignified and respectful manner daily (Monday through Friday when laundry is delivered) x two weeks, then weekly x two weeks and then monthly for three months. Results of audits will be reviewed by the Facility's QAPI Committee for further recommendations	

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F 550	Continued From page 4 The facility policy titled Care Center Privacy and Dignity undated, directed staff to care for all residents in an approach that makes certain that each residents privacy and dignity was respected by staff.	F 550		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.	F 604		4/19/22

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F 604 Continued From page 5

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and document review, the facility failed to identify two full body pillows as a restraint for 1 of 1 resident (R1) who utilized two full body pillows and was unable to move them.

Findings include:

R1's Diagnosis Report printed 3/17/22, indicated R1's diagnoses included vascular dementia, depression, anxiety, history of falling, and adult failure to thrive.

R1's quarterly Minimum Data Set (MDS) dated 3/7/22, indicated R1 was severely cognitively impaired, required extensive assistance with activities of daily living, and did not have restraints in use.

R1's care plan revised 9/14/21, indicated R1 was at risk for falls with a history falls and of crawling out of bed onto the fall mats. Interventions included the bed to be in the lowest position when staff were not in the room, call bell pinned to gown when in bed, and to not be left alone in her wheel chair in her room. In addition, a thick fall mat was to be placed next to the bed, then another fall mat next to the thick fall mat.

On 3/15/22, at 11:10 a.m. R1 was lying in her bed on her right side facing the wall, with two full length body pillows behind her back. The two body pillows were stacked one on top of the other and were about eight to 10 inches raised above her body. Next to R1's bed was a six to eight inch mat with a second mat about two inches thick next to the first mat.

F 604

It is the policy of Cuyuna Regional Medical Center, to respect a resident's right to be free from physical restraint and promote quality of life. Restraints will only be used as a last resort to treat a resident's medical symptoms, that place the resident at risk for injury to himself or others. When a restraint is necessary, the least restrictive device possible will be utilized.

The care plan for R1 was reviewed on April 4, 2022, by the interdisciplinary team. The body pillows used for position and comfort were discontinued on March 16, 2022, due to safety concerns. The remainder of the resident's care plan remains appropriate with no additional changes.

The policy for Care Center Restraint Free Environment was reviewed and revised on April 3, 2022, by the Director of Nursing to include the need to assess residents for safe use of body pillow when used for positioning, comfort or as a fall intervention. Body pillow assessment will be completed upon implementation of body pillow and reassessed quarterly and/or with significant change in condition thereafter.

A new assessment for body pillow use was implemented on March 25, 2022. Care Center RNs were provided training and education on the new body pillow assessment requirement on April 5, 2022.

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F 604

Continued From page 6

On 3/15/22, at 2:50 p.m. nursing assistant (NA)-E went into R1's room, R1 was lying in her bed on her right side with the two full body pillows behind her back and the fall mats next to her bed. NA-E stated R1 could move the pillows herself. NA-E checked R1's brief (it was dry) and then tucked both body pillows under the lift sheet.

On 3/16/22, at 9:19 a.m. NA-B stated the long body pillows on R1's bed were to keep R1 from rolling out of bed. NA-B stated the long body pillows were not a restraint. R1 was transferred from her wheelchair to her bed with a standing mechanical lift. When R1 was seated on the side of her bed she lifted her feet into the bed and lay down without staff assistance. NA-B tucked the long body pillows under the lift sheet, lowered the bed to the floor, and placed the thick mat next to the bed, then the second mat next to the thick mat.

On 3/17/22, at 8:24 a.m. NA-A entered R1's room, R1 was calling out, both long body pillows were tucked under her lift sheet. NA-A asked R1 if she could push her pillows away, R1 did not push the pillows away as requested. NA-A stated on previous occasions she had found R1's pillows pushed off her bed when she entered R1's room.

On 3/17/22, at 9:04 a.m. registered nurse (RN)-C entered R1's room. R1 was lying on her back in bed, the two body pillows were stacked one on top of the other on R1's left side. RN-C asked R1 to push the pillows off her bed. R1 smiled at RN-C and asked her for water. RN-C gave R1 some water to drink. R1 did not push the pillows off the bed.

F 604

Of the forty residents in the facility as of April 5, 2022, eight residents were identified using body pillows. The eight residents were assessed for safe use and/or continued need for body pillow use on April 6-7, 2022. One of eight residents discharged; four residents had body pillows discontinued from use; three residents were assessed as safe for body pillow use for positioning and comfort. Resident care plans were updated following assessment completion.

Education will be provided to Care Center staff on the revised Care Center Restraint Free Environment Policy during shift-to-shift huddles from April 7-18, 2022. The revised policy will also be reviewed at the Care Center's all staff meeting on April 14, 2022.

Audits will be conducted for the eight residents previously identified with body pillows including R1, as well as random audit of other residents in the facility, to ensure body pillows are used appropriately, according to the plan of care. Audit schedule will follow daily audit for two weeks, then (if compliance is achieved), weekly for two weeks, then monthly for three months.

Results of audits will be reviewed by the Facility's QAPI Committee for further recommendations.

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F 604	Continued From page 7	F 604		

On 3/17/22, at 9:49 a.m. RN-B stated she had occasionally found R1's long body pillows at the foot of the bed. RN-B stated on 6/6/21, R1 had moved the pillows out of the way to get her shoes but then had a fall out of bed.

On 3/17/22, at 10:11 a.m. NA-D stated about two weeks ago she found the long body pillows on the fall mat. NA-D verified when the pillows were tucked under the lift sheet R1 would not be able to get at them and move them.

On 3/17/22, at 10:20 a.m. RN-B stated the MDS nurse looked at restraints each quarter. RN-B verified no one was having R1 demonstrate at those reviews if she could move the pillows.

On 3/17/22, at 10:26 a.m. the director of nursing (DON) stated the long body pillows were for positioning and comfort. The DON went to R1's room, R1 was lying on her back in bed with the two long body pillows stacked one on top of the other on lying next to her on the bed and not tucked under the lift sheet. The DON asked R1 to push the pillows away, R1 did not push the pillows away. The DON stated the pillows were a "safety risk" and removed the pillows from R1's room. The DON verified the long body pillows were a "safety risk" because R1 could no longer move the pillows out of her way.

The facility policy titled Care Center Restraint Free Environment undated, defined a restraint as any manual method, physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body.

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 ______	C 03/17/2022

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 609	Continued From page 8	F 609		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported immediately (within two hours) to the administrator and State Agency (SA) for 1 of 4 residents (R11) reviewed for abuse.	F 609	Cuyuna Medical Regional Center strives to provide a safe living environment for all residents of the facility, ensuring all residents will be protected from abuse, neglect, exploitation, and maltreatment. Any allegation of abuse, neglect,	4/19/22

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F 609	Continued From page 9 Finding include: R11's Transfer/Discharge Report printed 3/17/22, indicated R11's diagnoses included anxiety disorder, depressive disorder, acquired absence of right leg below knee, Alzheimer's disease, dementia, low back pain, and Diabetes Mellitus. R11's care plan initiated 8/12/16, indicated R11 had cognitive impairments and dementia with behaviors (swearing, hitting, kicking and refusals of care), with a need for assistance with activities of daily living (ADLs) and mobility. In addition, R11's care plan indicated R11 had verbal outbursts (swearing, name calling [whores], delusions/physical aggression [hitting, biting, kicking, and refusal of cares], cognitive impairment [major depression with psychotic symptoms such as paranoia and hallucinations]) A facility incident report submitted to the SA on 10/19/21, at 4:35 a.m. indicated on 10/17/21, at 4:49 a.m. R11 was yelling out during cares to "call the doctor, the doctor had raped her". On 3/16/22, at 1:08 p.m. the director of nursing (DON) stated she was unsure of when she first learned of the allegation. The DON verified she would have expected staff to report an allegation of rape immediately to the charge nurse who then should have called her or the administrator at that time. The DON verified the allegation was not reported timely. The facility policy titled Abuse Prevention Freedom from Abuse, Neglect And Exploitation, undated, directed all staff to report to their immediate supervisor any suspected maltreatment of a vulnerable adult at the time of	F 609	exploitation, and maltreatment will be reported within 2 hours to the state agency, if allegation involves abuse or results in serious bodily harm; and no later than 24 hours if allegation does not involve abuse or result in bodily harm. The facility policy for Abuse Prevention was reviewed by the interdisciplinary team on April 5, 2022 and remains appropriate with no changes. The care plan for R11 was reviewed on April 4, 2022, by the interdisciplinary team and remains appropriate. Education on Abuse Prevention Policy and reporting requirements will be provided to Care Center staff during shift-to-shift huddles from April 7-18, 2022. Training content will include review of the definitions of abuse, neglect, exploitation, and maltreatment; how to protect residents when abuse is suspected, who to report concerns to and need for immediate reporting to the facility’s Administrator (or designee) and within 2 hours to the state licensing agency. Abuse Prevention Policy and reporting requirements will also be reviewed at the Care Center’s all staff meeting on April 14, 2022. Random audits will be conducted to assess staff’s knowledge of definitions of abuse and timely reporting requirements daily x two weeks, then weekly x 2 weeks or until compliance is achieved and then	

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F 609	Continued From page 10 the suspicion. The supervisor would then report the incident immediately to the administrator.	F 609	monthly for three months. Audits will vary to cover all shifts. Results of audits will be reviewed by the Facility's QAPI Committee for further recommendations.	
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting	F 888		4/19/22

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F 888	Continued From page 11	F 888		

and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an

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F 888	Continued From page 12 exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and	F 888		

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F 888

Continued From page 13

(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure COVID-19 vaccination policies and procedures included a process that all staff, including contracted staff, had received the COVID-19 vaccination or were granted an religious and/or medical exemption. This resulted in less than 100% staff vaccination rate which increases the potential of spreading COVID to residents who resided at the facility.

Findings include:

A Human Resources email dated 3/15/22, identified dietary aide (DA)-A did not receive a vaccine upon hire (2/21/22) and was granted 30 days "to make a decision" from her hire date. Human Resources was scheduled to follow up with DA-A on 3/21/22, but DA-A was suspended and was most likely not going to return.

The facility COVID-19 Staff Vaccination Status for Providers undated, identified DA-A was a dietary employee assigned to the kitchen. The form also identified DA-A was unvaccinated and did not

F 888

Cuyuna Regional Medical Center requires all staff be fully vaccinated as a term and condition of employment or have a valid exemption on file, per CMS mandate for the protection of residents residing within the facility.

The policy for CMS COVID-19 Health Care Staff Vaccination Final Rule Mandate Policy for Cuyuna Regional Medical Center was review on April 4, 2022, by the Director of Nursing and Facility Administrator. No changes were made to the policy which outlines mandate requirements for vaccination as a condition of employment before a new employee can start in orientation.

On March 25, 2022, Employee Health Nurse provided training on the vaccine mandate policy to Human Resources Staff, including that no new team member can begin orientation until vaccine mandate requirements are met.

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F 888	Continued From page 14	F 888		

have a medical or non-medical exemption.

The dietary staff schedule dated 2/21/22-3/20/22, identified DA-A worked 2/22/22, 2/23/22, 2/24/22, 2/25/22, 2/28/22, 3/3/22, 3/4/22, 3/5/22, 3/6/22, and 3/14/22.

During an interview on 3/15/22, at 2:55 p.m. registered nurse (RN)-A stated she was responsible for tracking the employee vaccination matrix for the long-term care center, but employee health and human resources were responsible for employee vaccination and/or exemptions. RN-A was responsible for unvaccinated employee COVID testing. DA-A was listed on the provided Staff Vaccination Matrix, however, the matrix identified she was unvaccinated and had no medical or non-medical exemption. At that time, RN-A stated she needed to reach out to Human Resources for clarification.

During an interview on 3/16/22, at 1:39 p.m. the administrator and RN-A provided a printed email from human resources which identified DA-A was unvaccinated and did not have a medical or non-medical exemption due to DA-A having a 30-day delay. The administrator stated Human Resources had no documentation regarding DA-A's 30-day delay besides an email dated 3/15/22, which stated DA-A "did not receive a vaccine upon hire and was granted 30 days to 'make a decision' from her hire date which was 2/21/22." The administrator further stated this was identified at the beginning of survey and DA-A had been suspended from employment at that time. Additionally, Human Resource employees were educated on the vaccine mandate and the requirements that must be followed.

Pre-employment onboarding includes meeting with employee health nurse, where paperwork for vaccine mandate will be completed, prior to start date.

Audits will be conducted weekly for four weeks, then monthly for three months by Employee Health Nurse (or designee), to ensure all new hires have met the vaccine mandate requirements, prior to start date.

Results of audits will be reviewed by the Facility's QAPI Committee for further recommendations.

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F 888	Continued From page 15 The facility policy CMS COVID-19 Health Care Staff Vaccination Interim Final Rule Mandate Policy for Cuyuna Regional Medical Center Staff and Providers undated, identified the policy applied to all staff and all new staff were required to comply with the CMS vaccination requirements outlined in this policy as a condition of employment. Potential candidates for employment would be notified of the requirements of this policy prior to the start of employment. All new staff must show proof of COVID-19 full vaccination or approved exemption prior to orientation.	F 888		

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
March 31, 2022

Administrator
Cuyuna Regional Medical Center
320 East Main Street
Crosby, MN 56441

Re: State Nursing Home Licensing Orders
Event ID: IJKG11

Dear Administrator:

The above facility was surveyed on March 14, 2022 through March 17, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00091	A. BUILDING: ______ B. WING ______	C 03/17/2022

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2 000	Initial Comments	2 000		

Initial Comments

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
On 3/14/22, through 3/17/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed

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2 000	Continued From page 1	2 000		

these orders and identify the date when they will be completed.

The following complaints were found to be SUBSTANTIATED, however NO deficiencies were cited due to actions implemented by the facility prior to survey:

H5232052C (MN78779)
H5232053C (MN80015)

AND

The following complaint was found to be UNSUBSTANTIATED: H5232054C (MN81590).

AND

The following complaint was found to be UNSUBSTANTIATED, however a related Federal deficiency was cited.

H5232051C (MN77779), with a deficiency cited at (F609); no State deficiency.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

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2 000	Continued From page 2 You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 510	MN Rule 4658.0300 Subp. 2 Use of Restraints Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 510	Corrected	4/19/22

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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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review, the facility failed to identify two full body pillows as a restraint for 1 of 1 resident (R1) who utilized two full body pillows and was unable to move them.

Findings include:

R1's Diagnosis Report printed 3/17/22, indicated R1's diagnoses included vascular dementia, depression, anxiety, history of falling, and adult failure to thrive.

R1's quarterly Minimum Data Set (MDS) dated 3/7/22, indicated R1 was severely cognitively impaired, required extensive assistance with activities of daily living, and did not have restraints in use.

R1's care plan revised 9/14/21, indicated R1 was at risk for falls with a history falls and of crawling out of bed onto the fall mats. Interventions included the bed to be in the lowest position when staff were not in the room, call bell pinned to gown when in bed, and to not be left alone in her wheel chair in her room. In addition, a thick fall mat was to be placed next to the bed, then another fall mat next to the thick fall mat.

On 3/15/22, at 11:10 a.m. R1 was lying in her bed on her right side facing the wall, with two full length body pillows behind her back. The two body pillows were stacked one on top of the other and were about eight to 10 inches raised above her body. Next to R1's bed was a six to eight inch mat with a second mat about two inches thick next to the first mat.

On 3/15/22, at 2:50 p.m. nursing assistant (NA)-E went into R1's room, R1 was lying in her bed on her right side with the two full body pillows behind

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2 510	Continued From page 4	2 510		

her back and the fall mats next to her bed. NA-E stated R1 could move the pillows herself. NA-E checked R1's brief (it was dry) and then tucked both body pillows under the lift sheet.

On 3/16/22, at 9:19 a.m. NA-B stated the long body pillows on R1's bed were to keep R1 from rolling out of bed. NA-B stated the long body pillows were not a restraint. R1 was transferred from her wheelchair to her bed with a standing mechanical lift. When R1 was seated on the side of her bed she lifted her feet into the bed and lay down without staff assistance. NA-B tucked the long body pillows under the lift sheet, lowered the bed to the floor, and placed the thick mat next to the bed, then the second mat next to the thick mat.

On 3/17/22, at 8:24 a.m. NA-A entered R1's room, R1 was calling out, both long body pillows were tucked under her lift sheet. NA-A asked R1 if she could push her pillows away, R1 did not push the pillows away as requested. NA-A stated on previous occasions she had found R1's pillows pushed off her bed when she entered R1's room.

On 3/17/22, at 9:04 a.m. registered nurse (RN)-C entered R1's room. R1 was lying on her back in bed, the two body pillows were stacked one on top of the other on R1's left side. RN-C asked R1 to push the pillows off her bed. R1 smiled at RN-C and asked her for water. RN-C gave R1 some water to drink. R1 did not push the pillows off the bed.

On 3/17/22, at 9:49 a.m. RN-B stated she had occasionally found R1's long body pillows at the foot of the bed. RN-B stated on 6/6/21, R1 had moved the pillows out of the way to get her shoes but then had a fall out of bed.

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On 3/17/22, at 10:11 a.m. NA-D stated about two weeks ago she found the long body pillows on the fall mat. NA-D verified when the pillows were tucked under the lift sheet R1 would not be able to get at them and move them.

On 3/17/22, at 10:20 a.m. RN-B stated the MDS nurse looked at restraints each quarter. RN-B verified no one was having R1 demonstrate at those reviews if she could move the pillows.

On 3/17/22, at 10:26 a.m. the director of nursing (DON) stated the long body pillows were for positioning and comfort. The DON went to R1's room, R1 was lying on her back in bed with the two long body pillows stacked one on top of the other on lying next to her on the bed and not tucked under the lift sheet. The DON asked R1 to push the pillows away, R1 did not push the pillows away. The DON stated the pillows were a "safety risk" and removed the pillows from R1's room. The DON verified the long body pillows were a "safety risk" because R1 could no longer move the pillows out of her way.

The facility policy titled Care Center Restraint Free Environment undated, defined a restraint as any manual method, physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee could ensure potential restraint use is identified. Those residents utilizing potential restraints could be comprehensively assessed and the information brought to the interdisciplinary team to ensure it is

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2 510	Continued From page 6 the least restrictive alternative for each individual. The information could be shared with the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 510		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal intimate laundry was not left in a public area for 1 of 1 residents (R9) whose bras were observed sitting on top of the handrail outside her room door. Findings include: R9's Diagnosis Report dated 3/17/22, indicated R9's diagnoses included dementia, ataxia following cerebral infarction (impaired balance/coordination following stroke), depression, and chronic pain. On 3/16/22, at 10:34 a.m. about six shirts on hangers were hanging on the hand railing outside R9's room. On top of the hangers were two bras. Registered nurse (RN)-D exited the room. RN-D stated she hadn't heard anyone knock on the	21805	Corrected	4/19/22

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21805	Continued From page 7 door and confirmed personal laundry should not be left outside a resident's room. On 3/16/22, at 10:39 a.m. laundry aide (LA)-A stated she knocked on the resident's door and when no one answered she left the laundry hanging on the railing outside the resident's door. LA-A verified she should not have left personal laundry (resident's bras) outside the room where anyone walking by could see them. On 3/17/22, at 9:00 a.m. RN-C stated she would see clothing left outside of resident rooms about twice a week. RN-C verified this was not a dignified practice to leave personal clothing outside of resident rooms, especially if it was underclothes. On 3/17/22, at 9:45 a.m. RN-B verified it was not dignified for residents to have their personal clothing left in the hallway for anyone to see. RN-B stated she would expect staff to knock on the door and bring the clothing into the room to be put away. If no one answered the door the clothing should not have been left in the hallway. On 3/17/22, at 10:59 a.m. the director of nursing (DON) verified personal laundry should not be left in the hallway, staff should have knocked and brought the clothing into the room. If no one answered she would have expected the clothing to be delivered later. The DON confirmed it was not dignified to have personal clothing (especially bras) left in the hallway. The facility policy titled Care Center Privacy and Dignity undated, directed staff to care for all residents in an approach that makes certain that each residents privacy and dignity was respected by staff.	21805		

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21805	Continued From page 8 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff regarding ensuring resident personal laundry items are not stored in public areas and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21805		