### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					AND TRANSMITTAL	ID: PWYO
1. MEDICARE/MEDICAID PROVIDE (L1) 245232 2.STATE VENDOR OR MEDICAID N (L2) 535845101	ER NO.	3. NAME AND ADI	DRESS OF FACILIT A REGIONA F MAIN STR	Y L MEI	E SURVEY AGENCY DICAL CENTER (L6) 56441	
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SUP 01 Hospital	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY <b>1</b> 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Oth		02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 03/31
<ul> <li>11LTC PERIOD OF CERTIFICATION</li> <li>From (a):</li> <li>To (b):</li> <li>12.Total Facility Beds</li> <li>13.Total Certified Beds</li> <li>14. LTC CERTIFIED BED BREAKDO</li> </ul>	117 (L18) 117 (L17)	B. Not in Comp	ce With quirements	'aivers:	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: A* 15. FACILITY MEETS	6. Scope of Services Limit 7. Medical Director
18 SNF 18/19 SI 11^ (L37) (L38)	7	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)
17. SURVEYOR SIGNATURE	n, HFE NE II part II - to		5/2014 <b>d by hcfa re</b> 4	(L19) GIONAI	18. STATE SURVEY AGENCY AI Kate JohnsTon, Enf	Forcement Specialist 1/12/2015
<ol> <li>DETERMINATION OF ELIGIBII</li> <li>_X1. Facility is Eligible to</li> <li>2. Facility is not Eligib</li> </ol>	Participate		PLIANCE WITH CI ITS ACT:	VIL	<ol> <li>Statement of Finant</li> <li>Ownership/Control</li> <li>Both of the Above :</li> </ol>	Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 02/01/1980 (L24)	23. LTC AGREEM BEGINNING (L41)		<ol> <li>LTC AGREEMEN ENDING DATE (L25)</li> </ol>	ΝT	26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>0</u> 01-Merger, Closure         02-Dissatisfaction W/ Reimbursement	05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C. 03001	(L45) ARRIER NO.	(L31)	30. REMARKS Posted 01/12/	/2015 Co.
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION C 12/02/2014	DF APPROVAL DATI	E (L33)	DETERMINATION APPRO	DVAL



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 245232

December 2, 2014

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 November 7, 2014 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 beds.

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

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

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

Sincerely,

## Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900 Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesota Department of Health • Compliance Monitoring • General Information: 651-201-5000 • Toll-free: 888-345-0823 http://www.health.state.mn.us An equal opportunity employer



#### Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered December 2, 2014

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

RE: Project Number S5368025

Dear Ms. Stratman:

On October 21, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 16, 2014. 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 December 1, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 16, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 7, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 16, 2014, effective November 7, 2014 and therefore remedies outlined in our letter to you dated October 21, 2014, 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 Division of Compliance Monitoring Email: mark.meath@state.mn.us

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

cc: Licensing and Certification File

5232r15

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245232	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 12/1/2014
Name	of Facility		Street Address, City, State, Zip Code	
CL	IYUNA 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).

(Y4)	ltem		(Y5)	Date	(Y4)	ltem		(Y5)	Date	(Y4)	ltem		(Y5)	Date
				Correction					Correction					Correction
				Completed					Completed					Completed
ID	Prefix	F0241		11/07/2014		ID Prefix	F0309		11/07/2014		ID Prefix	F0323		11/07/2014
F	-	483.15(a)				Reg. #	483.25				-	483.25(h)		
	LSC				<u> </u>	LSC					LSC			
				Correction					Correction					Correction
				Completed					Completed					Completed
ID	Prefix	F0328		11/07/2014		ID Prefix					ID Prefix			
F	Reg. #	483.25(k)				Reg. #					Reg. #			
	LSC					LSC					LSC			_
				Correction					Correction					Correction
				Completed					Completed					Completed
ID	Prefix					ID Prefix			Completed		ID Prefix			
F	Reg. #					Reg. #					Reg. #			
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F	Reg. # LSC					Reg. #					Reg. #			
	100					100					130			
				Correction					Correction					Correction
				Completed					Completed					Completed
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F	Reg. #					Reg. #					Reg. #			
	LSC				<u> </u>	LSC					LSC			_
Review	wed By		Reviewed E	Зу	Da	te:	Signature	of Surve	yor:				Date:	
State	Agency	,	LB/mr	n	1	2/02/20	014	28	3035				12/0	1/2014
Review	wed By	·	Reviewed B	Зу	Da	te:	Signature	of Surve	yor:				Date:	
CMS F	RO													
Follow	wup to	Survey Comp	leted on:					-				a Summary of		
		10/1	6/2014				Un	correcte	d Deficiencies	s (CMS	6-2567) Sent	to the Facility?	YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

December 2, 2014

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

Re: Reinspection Results - Project Number S5232021

Dear Ms. Stratman:

On December 1, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 16, 2014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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 Division of Compliance Monitoring Email: mark.meath@state.mn.us

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

5232r15licltr

#### State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00091	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 12/1/2014
Name of Facility			Street Address, City, State, Zip Code	
CU	YUNA REGIONAL MEDICAL CENTER		320 EAST MAIN STREET CROSBY, MN 56441	

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4)	Item	(Y5)	Date	(Y4)	ltem		(Y5) C	Date
			Correction				Correction					Correction
			Completed				Completed			04400		Completed
	20302		12/01/2014		ID Prefix		11/07/2014		ID Prefix			12/01/2014
Reg. # LSC	MN State Statute 14	44.6503			Reg. # LSC	MN Rule 4658.0520 Subp.	1		Reg. # LSC	MN St. Statute	144A.04 Sı	ıbd. 4
					LSC			<u> </u>	L30			-
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix	21805		11/07/2014		ID Prefix		-		ID Prefix			_
Reg. #	MN St. Statute 144.	651 Sub	d. £		Reg. #				Reg. #			
LSC					LSC				LSC	-		-
			Correction				Correction					Correction
ID Prefix			Completed		ID Prefix		Completed		ID Prefix			Completed
					Req. #		-					-
Reg. # LSC					0		-		Reg. # LSC			-
								+-				_
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix					ID Prefix		-		ID Prefix			_
Reg. #					Reg. #		-		Reg. #			_
LSC					LSC				LSC			-
			<b>a</b> "									<b>a</b> "
			Correction				Correction					Correction
ID Prefix			Completed		ID Prefix		Completed		ID Prefix			Completed
Reg. #					Reg. #				Reg. #			_
LSC					LSC				LSC			
				1-				+-				
Reviewed B	y Rev	iewed B	у	Da	ate:	Signature of Surve	eyor:				Date:	
State Agenc	y LI	3/mm	l	12/	/02/2014	4 28035					12/	01/2014
Reviewed B	y Rev	iewed B	y	Da	ate:	Signature of Surve	yor:				Date:	
CMS RO												
Followup to	Survey Completed	on:				Check for any	Uncorrected E	eficie	ncies. Was	a Summary of		
	10/16/20	14				-				to the Facility?	YES	NO
STATE FOR	M: REVISIT REPORT	(5/	'99)			Page 1 of 1				Event ID:	PWYO12	

DEPARTMENT OF HEALTH A	MED	ICARE/MEDICA			CENTERS FOR ND TRANSMITTAL E SURVEY AGENCY		CAID SERVICES PWYO acility ID: 00091
1. MEDICARE/MEDICAID PROVIDER 1           (L1)         245232           2.STATE VENDOR OR MEDICAID NO.           (L2)         535845101		3. NAME AND AD (L3) CUYUNA (L4) EAST MA (L5) CROSBY	AREGIONAI AIN STREET	L MEDIC	CAL CENTER 320 (L6) 56441	<ol> <li>TYPE OF ACTION:</li> <li>Initial</li> <li>Termination</li> <li>Validation</li> </ol>	<u>2</u> (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9)	/NERSHIP	7. PROVIDER/SUI	·	Y 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Cor	9. Other nplaint
6. DATE OF SURVEY 10/7 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	<b>16/2014</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING 1 03/31	DATE: (L35)
<ul> <li>11LTC PERIOD OF CERTIFICATION</li> <li>From (a):</li> <li>To (b):</li> <li>12.Total Facility Beds</li> <li>13.Total Certified Beds</li> </ul>	117 (L18) 117 (L17)	X B. Not in Com	ace With equirements Based On: Acceptable POC	n	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: <b>B</b> *	6. Scope of Servic 7. Medical Directo	Dr
14. LTC CERTIFIED BED BREAKDOWN	N				15. FACILITY MEETS		
18 SNF 18/19 SNF 117	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMAR	(L39) KS (IF APPLICABLE S	(L42) HOW LTC CANCELI	(L43) ATION DATE):				
17. SURVEYOR SIGNATURE	NEII	Date :	11/04/2014	(L19)	18. STATE SURVEY AGENCY AP		Date: 12/02/2014 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAI	OFFICE OR SINGLE STAT	<b>TE AGENCY</b>	
<ol> <li>DETERMINATION OF ELIGIBILIT</li> <li>1. Facility is Eligible to Pa</li> <li>2. Facility is not Eligible</li> </ol>			IPLIANCE WITH ( HTS ACT:	CIVIL	<ol> <li>Statement of Financ</li> <li>Ownership/Control I</li> <li>Both of the Above :</li> </ol>	Interest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	24. LTC AGREEM	ENT	26. TERMINATION ACTION:	(L	.30)
OF PARTICIPATION <b>02/01/1980</b>	BEGINNING	DATE	ENDING DAT	Έ	VOLUNTARY 00 01-Merger, Closure	05-Fail to Me	et Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursemer 03-Risk of Involuntary Termination	ent 06-Fail to Me	et Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVI A. Suspension of				04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider S	Status Change
(L27)	B. Rescind Sus		(L44)			00-Active	
			(L45)				
28. TERMINATION DATE:	29	INTERMEDIARY/C	ARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)	Posted 12/02/2014	4 Co.	

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 21, 2014

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

RE: Project Number S5232022

Dear Ms. Stratman:

On October 16, 2014, 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.

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:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - 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, Supervisor Bemidji Survey Team Licensing and Certification Program Division of Compliance Monitoring 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 November 25, 2014, 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

Cuyuna Regional Medical Center October 21, 2014 Page 4

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 January 16, 2015 (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. Cuyuna Regional Medical Center October 21, 2014 Page 5

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 April 16, 2015 (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 Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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

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

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

Sincerely,

## Mark Meath

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

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB	3 NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3		SURVEY PLETED
		245232	B. WING			10/1	6/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	REGIONAL MEDICA				20 EAST MAIN STREET		
COTONA				С	ROSBY, MN 56441		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0	000			
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.					
F 241 SS=E	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with TAND RESPECT OF	F 2	241			11/7/14
	manner and in an e enhances each res	omote care for residents in a invironment that maintains or ident's dignity and respect in is or her individuality.					
	by: Based on observat review, the facility fa homelike dining exp (R53, R114, R65, R R142, R93, R87, R on trays in the Lake Findings include: On 10/13/14, at 5:1 the evening meal, 1 dinner meal, 12 res	NT is not met as evidenced tion, interview, and document ailed to provide a dignified perience for 12 of 16 residents (30, R129, R36, R112, R135, 150) who received their meals eview dining room. 0 p.m. during observation of 6 residents were served the idents, (R53, R114, R65, R30, R135, R142, R93, R87, R150)			CRMC strives to promote care for residents in a manner and in an environment that maintains or enhance each resident s dignity and respect in recognition of his or her individuality. The Lakeview Units dining experience was reviewed by the facility DON and Director of Nutritional Services on 10-21-14. All residents on the Dementia Care Lakeview unit will be served their mea on a place mat. Trays will be used only bring the meal to the table to serve the	n full e als ly to	
LABORATOR	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE	(	(X6) DATE

**Electronically Signed** 

10/29/2014

PRINTED: 11/04/2014

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.

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
		245232	B. WING _		10/	16/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
CUYUNA	REGIONAL MEDICA	L CENTER		320 EAST MAIN STREET CROSBY, MN 56441		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 241	Continued From pa	ge 1	F 24	41		
	Licensed practical n have always served trays were set up in dining room on a ca steam table in the o were observed to b directly on the table R93, R114, R129, F observed to eat the Residents R30, R8 seated next to them assistance from the Nursing assistant (I trays and stated, "I been served on tray here. During observation residents R36, R53 R135, and R142 at served on trays. R were assisted by at was assisted by a f think they have alw I don't know why." O Assistant Director of know why trays were stated, "I am not su you could ask nursi On 10/16/14, at 8:3 observed to be serv nurses (DON), inter a.m., stated, "I ask being served their n	ved on meal service trays. hurse (LPN)-B stated, "We d the meals on trays." The the kitchen, delivered to the art, and dished up from the dining room. Four residents e served with the place setting e. Residents R36, R53, R65, R135, and R142 were ir meals independently. 7, R112, were assisted by staff h. R150 ate with family e meal served on a tray. NA)-G was asked about the believe the meals have always ys as long as I have been on 10/15/14, at 8:15 a.m., f, R65, R93, R114, R129, e independently from meals tesidents R30, R87, R112, aff seated next to them. R150 amily member. LPN-A stated,"I ays served the meals on trays, Dn 10/15/14, at 11:27 a.m. the of Nutritional Services did not re used. The Culinary director tre why they do that like that, ng." 3 a.m. the meal was again yed on trays. The director of rviewed on 10/16/14, at 10:32 ed why the residents were neals on trays when I came o." The DON verified that the		residents. In the future, a requires a serving tray to independent eating and/o the individual s space w documented on their indi The facilities Dining Roor reviewed and revised on Revisions included using the meal only. Any reside serving tray to promote in eating and/or an awarene individual s space will ha documented on their indi plan. Mandatory Inservices we 14, 10-28-14 and 10-30-2 education including the s on the Lakeview unit, pro- manner and in an environ maintains or enhances e dignity and respect, reco individuality and promotir environment. The DON or designee wi weekly random audits for experience for 4 weeks a thereafter for 6 months o compliance has been rea these audits will be repor at the facilities monthly C Completion date: 11-7-14	promote or awareness of vill have this vidual care plan. m policy was 10-27-2014. trays for serving ent that requires a ndependent ess of the ave this vidualized care ere held on 10-27- 2014 with erving of meals omoting care in a nment that ach resident s gnizing ng a home like Il complete r dignified dining and quarterly or until ached. Results of ted and reviewed QAPI meetings.	

If continuation sheet Page 2 of 11

	-	AND HUMAN SERVICES & MEDICAID SERVICES		FOF	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3) E	ATE SURVEY OMPLETED
		245232	B. WING _		0/16/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CUYUNA	REGIONAL MEDICA	L CENTER		320 EAST MAIN STREET CROSBY, MN 56441	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From pa	ge 2	F 24	1	
F 309 SS=D	Room- Nursing servindicated: Resident: right to eat with digripleasurable experies are considered whet for the resident. Re admission as to which the resident's needs Dementia unit: Resident's needs National State (ADON) verified the be served on trays 483.25 PROVIDE Of HIGHEST WELL BI Each resident must provide the necessa or maintain the high mental, and psycho accordance with the and plan of care. This REQUIREMENT by: Based on observat review, the facility factors	16 a policy titled "Dining vice Reviewed 1/18/13 s in the Care Center have the nity and have each meal be a ence. Each resident's needs encreating a dining program sidents will be assessed on ich dining program will meet s and functional capacity. idents requiring a reduced or special behavior assistant director of nurses e policy did not direct meals to in the dementia care area. CARE/SERVICES FOR EING receive and the facility must ary care and services to attain nest practicable physical, social well-being, in e comprehensive assessment NT is not met as evidenced ion, interview, and document ailed to provide a bariatric of 1 resident (R69) who	F 30	9 CRMC strives to ensure each resident receives and is provided the necessary care and services to attain or maintain th highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment an plan of care. R69 has been on a weight loss program	t t

Event ID: PWYO11

Facility ID: 00091

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PRINTED: 11/04/2014

					FORM	APPROVE
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY PLETED
	245232	B. WING _			10/1	6/2014
PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REGIONAL MEDICA	L CENTER					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(		BE	(X5) COMPLETIC DATE
R69s admission Mi 12/24/13, indicated required total assis extensive assistance The activities of dat Assessment (CAA) had morbid obesity sustained a left ank with a walking boot attempted to work w was unable to prog as R69s ankle heat would be able to re for a prolonged stay independence with The quarterly MDS required total assis extensive assistance R69s PT progress R69s prognosis wa put weight on the left R69s PT progress R69 transferred fro table and to bed wir of 3. R69 was able then was able to state R69s PT progress	<ul> <li>inimum Data Set (MDS) dated R69 was cognitively intact, tance with transfers and ce with bed mobility.</li> <li>ily living (ADL) Care Area</li> <li>dated 12/29/13, indicated R69</li> <li>and had fallen at home. R69</li> <li>kle fracture and was treated</li> <li>Physical therapy (PT) had</li> <li>with R69 initially, however, R69</li> <li>ress in therapy. PT anticipated</li> <li>led and pain was less he</li> <li>sume therapy. R69 was at risk</li> <li>y to regain functional</li> <li>cares.</li> <li>dated 9/11/14, indicated R69</li> <li>tance with transfers and</li> <li>ce with bed mobility.</li> </ul> note dated 12/27/13, indicated note dated 2/27/14, indicated m wheelchair to the standing th a standing lift and the assist to stand for one minute and and for 2 minutes times 5.	F 3(	09	has had a 10% weight loss. The DON met with the Director of R on 10-23-14 to discuss communicat between Rehab and Nursing regard equipment needs for individual resic The DON met with the Physical The involved in R69 s care to discuss resident needs, improving communi processes and process for obtaining Capital Budget equipment needs or exploring grants for equipment purch These requests will no longer be ma e-mail, but discussed in person to e all equipment needs and processes understood by all parties. The DON, Physical Therapist and R primary physician met on 10-27-14 to discuss a trial use of a Bariatric Stant table. An order was received from t primary physician to trial a bariatric standing frame for weakness secon to polymyositis. The Bariatric Stand Frame was ordered for a 30 day tria 10-28-14 with an arrival date of 11-1 2014. If R69 is able to tolerate the standing frame at current weight, the Bariatric Standing Frame will be purchased. R69 is also working with CRMC s Bariatric Weight Loss pro- through the hospital as an outpatien well as the facility dietician. The DON or designee will complete monthly audits/meetings with the Re- Department to ensure on-going communication between departmen Results of this audits/meeting will be	ehab tion ling dents. erapist ication dication dication ding hases. ade by nsure are are c69 s to nding the dary ling d on 17- e n gram t as ehab	
	RS FOR MEDICARE OF DEFICIENCIES DF CORRECTION PROVIDER OR SUPPLIER A REGIONAL MEDICA SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From pa R69s admission Mi 12/24/13, indicated required total assis extensive assistand The activities of da Assessment (CAA) had morbid obesity sustained a left anl with a walking boot attempted to work was unable to prog as R69s ankle hea would be able to re for a prolonged sta independence with The quarterly MDS required total assis extensive assistand R69s PT progress R69s prognosis wa put weight on the left R69s PT progress R69 transferred fro table and to bed wi of 3. R69 was able then was able to st R69s PT progress R69s PT progress R69 transferred fro table and to bed wi of 3. R69 was able then was able to st	OF CORRECTION       IDENTIFICATION NUMBER:         245232         PROVIDER OR SUPPLIER         A REGIONAL MEDICAL CENTER         SUMMARY STATEMENT OF DEFICIENCIES         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         REGULATORY OR LSC IDENTIFYING INFORMATION)	RS FOR MEDICARE & MEDICAID SERVICES         FOF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULT A. BUILDI         245232       B. WING         PROVIDER OR SUPPLIER       245232         A REGIONAL MEDICAL CENTER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       pp PREFID TAG         Continued From page 3       F 3         R69s admission Minimum Data Set (MDS) dated 12/24/13, indicated R69 was cognitively intact, required total assistance with transfers and extensive assistance with bed mobility.       F 3         The activities of daily living (ADL) Care Area Assessment (CAA) dated 12/29/13, indicated R69 had morbid obesity and had fallen at home. R69 sustained a left ankle fracture and was treated with a walking boot. Physical therapy (PT) had attempted to work with R69 initially, however, R69 was unable to progress in therapy. PT anticipated as R69s ankle healed and pain was lees he would be able to resume therapy. R69 was at risk for a prolonged stay to regain functional independence with cares.         The quarterly MDS dated 9/11/14, indicated R69 required total assistance with bed mobility.         R69s PT progress note dated 12/27/13, indicated R69s prognosis was limited until R69 was able to put weight on the left lower extremity to stand.         R69s PT progress note dated 2/27/14, indicated R69 transferred from wheelchair to the standing table and to bed with a standing lift and the assist of 3. R69 was able to stand for 2 minutes times 5.         R69s PT progress note dated 8/4/14, by physical	RS FOR MEDICARE & MEDICAID SERVICES         FOF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPL A. BUILDING.         245232       B. WING         PROVIDER OR SUPPLIER       33 (C)         REGIONAL MEDICAL CENTER       33 (C)         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG         Continued From page 3 R69s admission Minimum Data Set (MDS) dated 12/24/13, indicated R69 was cognitively intact, required total assistance with transfers and extensive assistance with bed mobility.       F 309         The activities of daily living (ADL) Care Area Assessment (CAA) dated 12/29/13, indicated R69 had morbid obesity and had fallen at home. R69 sustained a left ankle fracture and was treated with a walking boot. Physical therapy (PT) had attempted to work with R69 initially, however, R69 was unable to progress in therapy. PT anticipated as R69s ankle healed and pain was less he would be able to resume therapy. R69 was at risk for a prolonged stay to regain functional independence with cares.         The quarterly MDS dated 9/11/14, indicated R69 required total assistance with transfers and extensive assistance with bed mobility.         R69s PT progress note dated 12/27/13, indicated R69s PT progress note dated 12/27/14, indicated R69 transferred from wheelchair to the standing table and to bed with a standing lift and the assist of 3. R69 was able to stand for 2 minutes times 5.         R69s PT progress note dated 8/4/14, by physical therapist (PT)-A indicated R69 was not currently a	TMENT OF HEALTH AND HUMAN SERVICES       ON         RS FOR MEDICARE & MEDICAID SERVICES       ON         FOR DEDICARE SERVICES       ON         PROVIDER OR SUPPLIER       X         AREGIONAL MEDICAL CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE         SECAN MEDICAL CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE         REGUNAL MEDICAL CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE         SECAN MEDICAL CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE         SECAN MEDICAL CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE         REGUNAL MEDICAL CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE         SEQULATORY OR LSCIDENTFYING INFORMATION)       PROVIDERS PLAN OF CORRECTIVE ACTION PLOUD         REGULATORY OR LSCIDENTFYING INFORMATION)       PROVIDERS         Continued From page 3       F 309         R69s admission Minimum Data Set (MDS) dated       F 309         Integuined total assistance with transfers and       F 309         sutained a lef ankle fracture and was treated       The DON met with the Physical The         wold be able to resume therapy. PT anticipated       as R69s ankle healed and pain was less for         R69s PT progress note dated 12/27/13, indicated       R69         R69s PT progress note dated 12/27/14, indicated       R69         R69s PT progress note dated 12/27/14, indicated	RS FOR MEDICARE & MEDICAID SERVICES         OND NO.           COP DEFICIENCIES         (X) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER:         (X) DRATE         (X) DRATE           245232         B. WING         10/1           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZP CODE         320 EAST MAIN STREET           CONTINUER         STREET ADDRESS, CITY, STATE, ZP CODE         320 EAST MAIN STREET           REGIONAL MEDICAL CENTER         PROVIDER: PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION)         PROVIDER: PLAN OF CORRECTION FAG           Continued From page 3 R69s admission Minimum Data Set (MDS) dated 12/24/13, indicated R69 was cognitively intact, required total assistance with transfers and extensive assistance with transfers and extensive assistance with transfers and extensive assistance with reargy. R69 was a trisk for a prolonged stay to regain functional independence with cares.         F 309         Strice admission in January, 2014. R69 has had a 10% weight loss.           The QUN met with he Director of Rehab as R69s ankle healed and pain was less he would be ab to resume therapy. R69 was a trisk for a prolonged stay to regain functional independence with cares.         F 309         Strice admission in January, 2014. R69 sprimary physician therapy traitigated as R69s PT progress note dated 12/27/13, indicated R69 PT progress note dated 12/27/14, indicated R69 PT progress note dated 8/4/14, by physical therapist (PT)-A indicated R69 was not currently a         The DON rodesi

Facility ID: 00091

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		AND HUMAN SERVICES				FORM	11/04/2014 APPROVED 0938-0391
STATEMENT	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245232	B. WING	i		10/ <sup>,</sup>	16/2014
NAME OF !	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CUYUNA	A REGIONAL MEDICA	L CENTER			20 EAST MAIN STREET ROSBY, MN 56441		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	transfer safely onto inability to wheel the table for safe positi demonstrate function been no other signi warrant continued the benefit from a baria increase lower extra and ambulation. The R69's neurologist to plan could allow R60 living. PT-A recommediate director of nursing (Control and the R69s care plan reviewed or stated his goal was getting any PT. On was observed up in stated he was walk fell which caused the he had an underlying muscle and joint we frustrated, "Its like I be here." On 10/16/14, at 9:5 (PT)-A stated R69 I uncommon inflammed muscle weakness a body. It can make in	o the tilt table. There was an e mechanical lift under the tilt oning. R69 was unable to onal progress and there had ificant functional change to therapy. PT-A felt R69 would atric standing frame to emity strength for transfers he plan was to confer with o determine if the proposed 59 to return to independent mended the equipment to the (DON) and the administrator.		309	Completion date: 11-7-14		

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		& MEDICAID SERVICES			MB NO	APPROVEI . 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		e survey IPleted
		245232	B. WING _		10/	16/2014
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
CUYUNA	REGIONAL MEDICA	L CENTER		320 EAST MAIN STREET CROSBY, MN 56441		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309 F 323 SS=D	strength to stand. F assisted onto the life would would buckle PT-A stated the we from the DON and bariatric standing fr frame cost \$7,000 would work. PT-A state authorization from the and still had not red stated she had call with no return call On 10/16/14, at 11: had received an en could get the table purchase the table administrator. The miscommunication There was no polic 483.25(h) FREE OI HAZARDS/SUPER The facility must er environment remai as is possible; and adequate supervisi prevent accidents.	ated R69 did not have the leg PT-A stated R69 could be ft table to stand straight, but e if standing without support. administration to order the rame. PT-A stated the standing and they did not know if it stated the company provided a ly a \$200 fee for return red she had asked for the DON over a month ago ceived a response. PT-A ed the neurologist three times and they could unless it was approved by the DON stated there had been between PT and herself. ry regarding the issue. F ACCIDENT	F 3(			11/7/14

If continuation sheet Page 6 of 11

STATEMEN	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		BERTHIO, THOR HOWBER.		G	00111	
		245232	B. WING _		10/1	6/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 320 EAST MAIN STREET		
CUYUNA	REGIONAL MEDICA	L CENTER		CROSBY, MN 56441		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE
F 323	Based on observat review, the facility fi effectiveness of a p when a resident sta R37) reviewed with Findings include: R52 was observed, lying in bed awake pillow. The alarm cl sheet instead of the R52's quarterly Min 8/5/14, indicated dia due to cardiovascul osteoporosis. The I extensive assist for dressing, toilet use, non-ambulatory. The 11/25/13, signi Assessment (CAA) for falls due to med impaired balance. T Assessment indicat for additional falls. Nursing progress n R52's last fall. R52 the activity room. R52's care plan dat at risk for falls relat impaired balance, a	tion, interview and document ailed to determine the bersonal clip alarm to alert staff ands for 2 of 4 residents (R52, clip alarms. on 10/15/14, at 6:30 a.m., with an alarm box next to her lip was attached to the bed a bed frame. imum Data Set (MDS) dated agnoses that included aphasia lar disease, hemiplegia, and MDS indicated R52 required bed mobility, transfers, personal hygiene, and was ficant change Fall Care Area indicated R52 was at high risk lication use, wandering and The 7/30/14 Fall Risk ted R52 remained at high risk otes on 9/6/14, described fell out of the wheel chair in ted 8/6/14, indicated R52 was ed to history of falls/injury, and poor coordination. The use of a clip alarm while in	F 32	CRMC strives to ensure that the r environment remains free of accid hazards as is possible; and each r receives adequate supervision and assistance devices to prevent acci R52 and R37 s clip alarms were a to the bed frame on 10-16-14. All residents in the facility who hav alarms have had the alarm attache bed frame. Mandatory In-services were held of 10-27-14, 10-28-14 and 10-30-201 education including the need to att clip alarms to the bed frame when resident is in bed. The DON or designee will complet weekly random audits for proper attachment of clip alarms to the be for 4 weeks and quarterly thereafte months or until compliance has be reached. Results of these audits w reported at the facility QAPI meetin Completion date: 11-7-14	ent esident dents. affixed e clip ed to the n 4 with ach all the e ed frame er for 6 en rill be	

If continuation sheet Page 7 of 11

		AND HUMAN SERVICES				FORM	11/04/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245232	B. WING			10/ <sup>,</sup>	16/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CUYUNA	REGIONAL MEDICA	L CENTER		-	20 EAST MAIN STREET ROSBY, MN 56441		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	<ul> <li>(NA)-D stated staff the bed sheet with a used and usually the with a strap to the stand clip alarm was secu- clip due to no side in clip alarm should be the bed sheet.</li> <li>R37 was observed, during transfer out a and assistance of N out of bed with a m the alarm from R37 clip alarm with a Ve wheel chair. NA-E stails so they clipped The 5/16/14 Fall Co indicated R37 was incontinence, physi 5/21/14, annual MD balance problems.</li> <li>R37's 8/14/14, quant diagnoses that inclu (CVA) and dementi required total assist</li> </ul>	88 a.m. nursing assistant secured the clip alarm box to a clip due to no side rails were he clip alarms were secured	F 3	223			
	falls due to history of	ted 8/17/14, indicated a risk for of falls and impaired le care plan directed a clip					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245232	B. WING _		10/	16/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CUYUNA	REGIONAL MEDICA	L CENTER		320 EAST MAIN STREET CROSBY, MN 56441		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323 F 328 SS=D	R37's last fall was f At 8:50 a.m. RN-Av secured to the shee side rails used. RN- should be affixed to The facility policy, F 11/7/2012, indicated be initiated to aid in potential. The undated manuf indicated the clip al- wheel chair or bed. 483.25(k) TREATM NEEDS The facility must en proper treatment ar special services: Injections; Parenteral and enter Colostomy, ureteros Tracheostomy care; Foot care; and Prostheses. This REQUIREMEN by: Based on observat	and wheelchair. otes dated 9/20/14, indicated rom the bed on 9/20/14. verified the clip alarm was et on bed with a clip due to no A verified the clip alarm o a secure object. Fall Prevention dated d appropriate interventions will the decrease of falls facturer's direction for usage arm was to be attached to a ENT/CARE FOR SPECIAL sure that residents receive nd care for the following eral fluids; stomy, or ileostomy care;	F 32	3		11/7/14
				receive proper treatment and care	ior	

Facility ID: 00091

If continuation sheet Page 9 of 11

PRINTED: 11/04/2014

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · · ·	E SURVEY PLETED	
		245232	B. WING		— 10/*	16/2014	
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CUYUNA	REGIONAL MEDICA	L CENTER		320 EAST MAIN STREET CROSBY, MN 56441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIATE ICIENCY)	(X5) COMPLETIC DATE	
F 328	Continued From pa	ae 9	F3	28			
	monitoring a person their blood) for 1 of for respiratory servi Findings include: R206's admission M dated 10/7/14, indic impairment and chr (lung) disease (CO R206's physician's indicated oxygen th cannula (oxygen de flow rate of 2 liters) dated 10/2/14, did r R206's treatment m record (MAR) indica on evenings and nig documented evider provided on 10/1/14 The treatment MAR was unable to be lo treatment MAR for indicated PO was e ordered by the physic	Minimum Data Set (MDS) cated severe cognitive ronic obstructive pulmonary PD). orders dated 10/1/14, herapy at 2 liters per nasal elivered through the nose at a . The temporary care plan not address oxygen therapy. hedication administration ated R206 required PO checks ghts. There was no nee that PO checks were 4. & for 10/2/14, through 10/8/14, ocated by facility staff. The 10/9/14, through 10/15/14, evaluated only 12 of 21 times		up on 10-16-14 to b during the day and The DON met with establish perimeters completing pulse or oxygen saturation le acute and chronic of resident is acute an on a routine basis, of levels will be obtain signs. Residents or stable or on chronic oxygen saturation le there is a change in are physician orders saturation levels ab percentage such as saturation levels ab oximetry will be obta These guidelines has the facility procedur Oximetry for Acute use. Mandatory Inservice 10-27-14, 10-28-14 education on the gu Pulse oximetry for a oxygen use. The DON or design	the Medical Director to s and guidelines for kimetry to monitor evels in the blood for oxygen use. When a id requiring vital signs oxygen saturation ed as part of the vital oxygen who are coxygen who are coxygen will have evels checked when or condition. When there is to maintain oxygen ove a certain s, keep oxygen ove 92%, pulse ained every shift. ave been included in re for obtaining Pulse and Chronic Oxygen es were held on and 10-30-2014 with uidelines for obtaining acute and chronic		
	cannula. On 10/15/14, at 7:2 bed with the oxyger face instead of into	h oxygen at 2 liters per nasal 1 a.m. R206 was observed in n cannula off to the side of the the nares. R206 wanted to get :23 a.m. nursing assistant		for 4 weeks and qua months or until com	per facility guidelines arterly thereafter for 6 apliance has been these audits will be ity QAPI meetings.		

Facility ID: 00091

If continuation sheet Page 10 of 11

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/04/2014 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(X3) DAT	E SURVEY IPLETED
		245232	B. WING	;		10/	/16/2014
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CUYUNA	A REGIONAL MEDICA	L CENTER			320 EAST MAIN STREET CROSBY, MN 56441		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 328	(NA)-I was informed At 7:29 a.m. NA-I c a.m. cares for R206 At 7:34 a.m. NA-I re cannula when R206 stated she was dizz edge of the bed. At transferred to the c licensed practical n 7:37 a.m. NA-I app liters. At 11:35 a.m. wheelchair with her LPN-D, interviewed stated they do not c the past the PO wa respiratory disease Registered nurse (f 10/16/14, at 9:28 a. resident was admitt would automatically the POs every shift the PO levels were on the treatment M. On 10/16/14, at 10: (NP) stated she wo times during the da The Oxygen Delive 11/29/95, indicated should be evaluated	d that R206 wanted to get up. came to the room to provide 6. emoved R206's oxygen 6 washed her face. R206 zy when she was seated on the c 7:35 a.m. R206 was commode with the assist of hurse (LPN)-C and NA-I. At lied the oxygen to R206 at 2 . R206 was up in the r oxygen on. d on 10/16/14, at 9:27 a.m., check R206's PO because in as 92-93 % (normal for chronic e was above 90%). RN)-B, was interviewed on .m. and stated that when ted with oxygen orders, they y write on the MAR to check the to check d as directed AR. :29 a.m. the nurse practitioner build like the PO checked 2-3 ay and once at night for R206. ery System policy dated the following parameters d with oxygen therapy and e oximetry (should be above		328			

If continuation sheet Page 11 of 11

	MENT OF HEALTH			-	F5232025	FORM	10/17/2014 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			PLE CONSTRUCTION G 01 - NURSING HOME	(X3) DATE SU COMPLE	
		245232		B. WING		10/15	6/2014
	ROVIDER OR SUPPLIER			RESS, CITY, S	STATE, ZIP CODE		
001017				BY, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000		= = =	
	FIRE SAFETY 01 Main Building						
	Minnesota Departm time of this survey ( Center C&NC 01 M substantial complia participation in Med Subpart 483.70(a), 2000 edition of Nati Association (NFPA)	Survey was conduct ent of Public Safety. Cuyuna Regional Me ain Building was fou nce with the requirer icare/Medicaid at 42 Life Safety from Fire onal Fire Protection Standard 101, Life S er 19 Existing Health	At the dical nd in nents for CFR, , and the Safety				
	1-story building with building was constru- hospital, separated and was determined construction. The m east of the existing determined to be of with additions to the room) and south win II (111) construction dayroom addition w west wing, was dete construction and se barrier. The building compartments by 30 barriers.	edical Center C&NC a basement. The or ucted in 1962, attach with a 2-hour fire rat d to be of Type II (00 ajor addition was co building in 1982, was Type II (000) constru- main entrance area ng (dayroom) in 1996 . In 2007 a 10 feet b as constructed to the ermined to be Type II parated with a 2-hour b divided into 7 sm 0 minute and 2- hour	riginal ed to a ed barrier 0) nstructed suction (dining 6 of Type y 30 feet e north (111) rr fire oke fire				
	automatic fire sprink accordance with NF Installation of Sprink The facility has a fire detection throughou	der Systems 1999 ed a alarm system with t the corridor system	in dition. smoke ı, in				
LABORATOF	RY DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESE	NTATIVE'S SIGN	ATURE	TITLE	(2	X6) DATE

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.

	MENT OF HEALTH					FORM	: 10/17/2014 APPROVED ). 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA		PLE CONSTRUCTION	(X3) DATE S COMPL	URVEY
		245232		B. WING		10/1	5/2014
	ROVIDER OR SUPPLIER	CAL CENTER	320 EA	DRESS, CITY, S ST MAIN S BY, MN 564			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI T BE PRECEDED BY FULL INTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	accordance with NF Alarm Code" 1999 is monitored for aut notification. Hazard detection in accord Fire Code 2007 edi The facility has a ca census of 109 at th The facility was sur 01 main building an as existing. The 200	I hazardous areas in FPA 72 "The Nationa edition. The fire alari tomatic fire departme lous areas have auto ance with the Minnes	I Fire m system ent omatic fire sota State and had a gs. The 5 additions	K 000			
FORM CMS-	2567(02-99) Previous Vei	rsions Obsolete			PWY021	If continuation	sheet Page 2 of 2

	MENT OF HEALTH				F52.32025	FOR	: 10/17/2014 MAPPROVED D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			PLE CONSTRUCTION G <b>02 - 2007 DAYROOM</b>	(X3) DATE S COMPL	
		245232		B. WING		10/*	15/2014
	ROVIDER OR SUPPLIER			RESS, CITY, S	STATE, ZIP CODE		
COTONA		ALGENTER		BY, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000			
	FIRE SAFETY						
	02 2007 Addition						
	Minnesota Departm time of this survey, Center C&NC 02 20 substantial complia participation in Med Subpart 483.70(a), 2000 edition of Nati Association (NFPA) Code (LSC), Chapte	Survey was conductor tent of Public Safety. Cuyuna Regional Me 007 Addition was fou nce with the requirer icare/Medicaid at 42 Life Safety from Fire onal Fire Protection Standard 101, Life S er 18 New Health Ca ledical Center C&NC	At the edical nd in nents for CFR, , and the Safety ire.		×		
	building was constru- hospital, separated and was determined construction. The m east of the existing determined to be of with additions to the room) and south wit II (111) construction dayroom addition w west wing, was dete construction and se barrier. The building compartments by 30 barriers.	a basement. The or ucted in 1962, attach with a 2-hour fire rat d to be of Type II (00 hajor addition was co building in 1982, was Type II (000) constru- main entrance area ng (dayroom) in 1990. In 2007 a 10 feet b as constructed to the ermined to be Type II parated with a 2-hour g is divided into 7 sm 0 minute and 2- hour s protected with a co kler system installed	ed to a ed barrier 0) nstructed s uction (dining 6 of Type y 30 feet e north (111) r fire oke fire				
-	accordance with NF Installation of Sprin The facility has a fin detection throughou	PA 13 Standard for kler Systems 1999 er e alarm system with it the corridor system	dition. smoke ı, in				
LABORATOR	RY DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESE	NTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

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.

	MENT OF HEALTH					FOR	: 10/17/201 MAPPROVEI ). 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			LE CONSTRUCTION 6 02 - 2007 DAYROOM	(X3) DATE S COMPL	
		245232		B. WING		10/*	15/2014
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
CUYUNA	A REGIONAL MEDIC	CAL CENTER	1	ST MAIN S BY, MN 564			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCII BE PRECEDED BY FULL INTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	accordance with NF Alarm Code" 1999 of is monitored for aut notification. Hazard detection in accorda Fire Code 2007 edi The facility has a ca census of 105 at the The facility was sur 01 main building an as existing. The 200	I hazardous areas in FPA 72 "The Nationa edition. The fire alarr comatic fire departme ous areas have auto ance with the Minnes	I Fire m system ent omatic fire sota State and had a gs. The 5 additions	K 000			
ORM CMS-	2567(02-99) Previous Ver	sions Obsolete			PWYO21	If continuation	sheet Page 2 of :



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted October 21, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5232022

Dear Ms. Stratman:

The above facility was surveyed on October 13, 2014 through October 16, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us.

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.

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 Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

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

5232s15lic

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00091	B. WING		10/1	6/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CUYUNA	REGIONAL MEDICA	I CENTER	MAIN STRE , MN 56441	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
_ABORATOR`	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 10/29/14

Electronically Signed

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00091	B. WING		10/	16/2014
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
CUYUNA	REGIONAL MEDICA		T MAIN STREE Y, MN 56441	T		
(X4) ID	SUMMARY STA		ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.				
	<ul> <li>Minnesota Department of Health.</li> <li>On 10/13/14, 10/14/14, 10/15/14, and 10/16/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date whe they will be completed.</li> <li>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.</li> </ul>	n				
	column entitled "IC statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are in after the statement evidence by." Follo	number appears in the far left O Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMN "PROVIDER'S PLA	ARD THE HEADING OF THE N WHICH STATES, NN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	( )	CONSTRUCTION		E SURVEY PLETED				
		00091	B. WING		10/	16/2014				
NAME OF F	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, ST	ADDRESS, CITY, STATE, ZIP CODE						
CUYUNA	REGIONAL MEDICA		EAST MAIN STREE SBY, MN 56441	ΞT						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE				
2 000	Continued From pa	age 2	2 000							
	THIS WILL APPEA	AR ON EACH PAGE.								
	PLAN OF CORRE	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS TE STATUTES/RULES.								
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train		se 2 302			11/7/14				
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144									
	Alzheimer's disease or related segregated or gen care staff	ility serves persons with disorders, whether in a eral unit, the facility's direct ors must be trained in deme								
	<ul> <li>(1) an explanation related disorders;</li> <li>(2) assistance with</li> <li>(3) problem solving and</li> <li>(4) communication</li> <li>(c) The facility shal written or electroni training program, ti trained, the frequent topics covered.</li> </ul>	activities of daily living; g with challenging behaviors	s; s ic							
	This MN Requirem	nent is not met as evidence	ed							

STATE FORM

PWYO11

If continuation sheet 3 of 17

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00091	B. WING		10/	16/2014
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	•	
CUYUNA	REGIONAL MEDICA		T MAIN STRE Y, MN 56441	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 302	Continued From pa	age 3	2 302			
	facility failed to ensitive facility failed to ensitive formation on a determining program, the trained, the frequent topics covered at the potential to affect a	and document review, the sure that consumers received escription of the Alzheimer's ne categories of employees ncy of training, and the basic ne facility. This had the anted to review the information		Corrected		
	Findings include:					
	packet indicated th	nal Medical Center admission ere was a specialized gram with special staff training				
	(DON) stated they	55 a.m. the director of nursing were not being specific ission packet about what the program contained.	1			
	SUGGESTED MET	THOD OF CORRECTION:				
	the admission pack information for con training in the facili and assurance con	sing or designee could update ket to include all the required sumers regarding dementia ty. The quality assessment nmittee could review the to ensure compliance.				
	TIME PERIOD FO Twenty-one (21) da					
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			11/7/14

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00091	B. WING	B. WING		10/16/2014	
IAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE			
UYUNA				EET			
(X4) ID	SUMMARY ST		Y, MN 56441	PROVIDER'S PLAN OF CO		(XE)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE	
2 830	Continued From pa	age 4	2 830				
	receive nursing can custodial care, and individual needs an the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from t	a general. A resident must re and treatment, personal an a supervision based on and preferences as identified in a resident assessment and scribed in parts 4658.0400 an sing home resident must be ou possible unless there is a the attending physician that the ain in bed or the resident n bed.	ıd ıt				
	by: Based on observat review, the facility f	tion, interview, and document failed to provide a bariatric I of 1 resident (R69) who		Corrected			
	12/24/13, indicated required total assis	inimum Data Set (MDS) dated I R69 was cognitively intact, stance with transfers and ce with bed mobility.	ť				
	Assessment (CAA) had morbid obesity sustained a left and with a walking boot attempted to work was unable to prog as R69s ankle hea	ily living (ADL) Care Area ) dated 12/29/13, indicated R6 v and had fallen at home. R69 kle fracture and was treated t. Physical therapy (PT) had with R69 initially, however, R6 gress in therapy. PT anticipate led and pain was less he esume therapy. R69 was at ris	59 d				

	ta Department of Here Tor Deficiencies OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00091	B. WING		10/	16/2014
AME OF F	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
UYUNA	REGIONAL MEDICA		ST MAIN STREI SY, MN 56441	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 5	2 830			
	for a prolonged sta independence with	ay to regain functional a cares.				
	required total assis	6 dated 9/11/14, indicated R69 stance with transfers and ce with bed mobility.				
	R69s prognosis wa	note dated 12/27/13, indicate as limited until R69 was able to eft lower extremity to stand.				
	R69 transferred fro table and to bed w of 3. R69 was able	note dated 2/27/14, indicated om wheelchair to the standing ith a standing lift and the assis to stand for one minute and tand for 2 minutes times 5.				
	therapist (PT)-A inc candidate for skille transfer safely onto inability to wheel th table for safe posit demonstrate functi been no other sign warrant continued benefit from a baria increase lower ext and ambulation. Th R69's neurologist to plan could allow Re living. PT-A recom	note dated 8/4/14, by physica dicated R69 was not currently ed PT secondary to inability to b the tilt table. There was an ne mechanical lift under the tilt ioning. R69 was unable to ional progress and there had ificant functional change to therapy. PT-A felt R69 would atric standing frame to remity strength for transfers he plan was to confer with to determine if the proposed 69 to return to independent mended the equipment to the (DON) and the administrator.	a			
	R69s care plan revented by the second	vised 9/23/14, indicated R69				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			B. WING				
		00091	B. WING		10/	/16/2014	
IAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST <b>T MAIN STREE</b>				
CUYUNA	REGIONAL MEDICA		, MN 56441	- 1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	ige 6	2 830				
		h the assist of 3 and a /sical therapy evaluation for al status.					
	stated his goal was getting any PT. On was observed up in stated he was walk fell which caused th he had an underlyin muscle and joint wa	n 10/14/14, at 9:49 a.m., to walk again but was not 10/15/14, a 7:05 a.m. R69 in the electric wheelchair. R69 ing with a walker at home and he fractured ankle. R69 stated ing health condition that caused eakness. R69 stated he was I live here and I don't want to					
	(PT)-A stated R69 uncommon inflamm muscle weakness a body. It can make i from a seated positi overhead). PT-A st strength to stand. F assisted onto the lift would would buckle PT-A stated the we from the DON and bariatric standing fr frame cost \$7,000 would work. PT-A st 30 day trial with onl shipping. PT-A stat authorization from the and still had not recommonder	52 a.m. physical therapist had polymyositis (an natory disease that causes affecting both sides of the t difficult to climb stairs, rise tion, lift objects or reach ated R69 did not have the leg PT-A stated R69 could be ft table to stand straight, but e if standing without support. re waiting for authorization administration to order the rame. PT-A stated the standing and they did not know if it stated the company provided a ly a \$200 fee for return ed she had asked for the DON over a month ago ceived a response. PT-A ed the neurologist three times					

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		00091	B. WING	B. WING		10/16/2014	
AME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
		320 FAS	T MAIN STREE				
UTUNA	REGIONAL MEDICA	CROSE	ί, MN 56441				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 830	Continued From pa	ige 7	2 830				
	had received an en could get the table purchase the table administrator. Ther issue. Based on observa	20 a.m. the DON stated she nail from PT-A and replied they on a trial basis but they could unless it was approved by the e was no policy regarding the tion, interview and document					
	effectiveness of a p when a resident sta R37) reviewed with	ailed to determine the personal clip alarm to alert staf ands for 2 of 4 residents (R52, clip alarms.					
	Findings include:						
	lying in bed awake	, on 10/15/14, at 6:30 a.m., with an alarm box next to her lip was attached to the bed a bed frame.					
	8/5/14, indicated di due to cardiovascu osteoporosis. The l extensive assist for	imum Data Set (MDS) dated agnoses that included aphasia lar disease, hemiplegia, and MDS indicated R52 required bed mobility, transfers, , personal hygiene, and was					
	Assessment (CAA) for falls due to med impaired balance.	ficant change Fall Care Area indicated R52 was at high risl lication use, wandering and The 7/30/14 Fall Risk ted R52 remained at high risk	<				
		otes on 9/6/14, described fell out of the wheel chair in					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00091	B. WING		10/	16/2014
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
UYUNA	REGIONAL MEDICA	AL CENTER	T MAIN STREE (, MN 56441	ΞT		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 8	2 830			
2 830	R52's care plan dated 8/6/14, indicated R52 was at risk for falls related to history of falls/injury, impaired balance, and poor coordination. The care plan indicated use of a clip alarm while in bed and wheelchair. On 10/16/14, at 8:38 a.m. nursing assistant (NA)-D stated staff secured the clip alarm box to the bed sheet with a clip due to no side rails were used and usually the clip alarms were secured with a strap to the side rail. At 8:50 a.m. registered nurse (RN)-A verified the clip alarm was secured to the sheet on bed with a clip due to no side rails used. RN-A verified the clip alarm should be affixed to a secure object vs. the bed sheet.		a			
	during transfer out and assistance of out of bed with a m the alarm from R3 clip alarm with a V wheel chair. NA-E rails so they clippe The 5/16/14 Fall C indicated R37 was incontinence, phys	I, on 10/15/14, at 7:50 a.m. of bed with a mechanical lift NA-E and NA-F assisted R37 nechanical lift. NA-E unclipped 7's bed sheet and applied the elcro strap on to the arm of the stated R37 did not have side d the alarm to the bed sheet. omprehensive Assessment at risk for falls due to ical and cognitive deficits. The DS Fall CAA indicated R37 had				
	R37's 8/14/14, qua diagnoses that incl (CVA) and dement required total assis	arterly MDS indicated luded cardiovascular attack ia. The MDS indicated R37 st for bed mobility, transfers, e, personal hygiene, and was				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00091	B. WING		10/	16/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
CUYUNA	REGIONAL MEDICA		T MAIN STREE Y, MN 56441	ET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 830	Continued From pa	age 9	2 830				
	Based on observa review, the facility to pulse oximetry (PC monitoring a perso	tion, interview, and document failed to consistently monitor 0) (non-invasive method for n's oxygen saturation level in f 1 resident (R206) reviewed rices.					
	dated 10/7/14, indi	Minimum Data Set (MDS) cated severe cognitive ronic obstructive pulmonary PD).					
	indicated oxygen th cannula (oxygen do flow rate of 2 liters)	orders dated 10/1/14, herapy at 2 liters per nasal elivered through the nose at a ). The temporary care plan not address oxygen therapy.					
	record (MAR) indic on evenings and n	nedication administration ated R206 required PO check ights. There was no nce that PO checks were 4.	s				
	was unable to be lo treatment MAR for	R for 10/2/14, through 10/8/14, ocated by facility staff. The 10/9/14, through 10/15/14, evaluated only 12 of 21 times sician.					
		I2 a.m. R206 was observed or h oxygen at 2 liters per nasal					
	On 10/15/14, at 7:2	21 a.m. R206 was observed in					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. DOILDING			
		00091	B. WING		10/16/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CUYUNA	REGIONAL MEDICA		T MAIN STREE (, MN 56441	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 10	2 830			
	face instead of into up for the day. At 7 (NA)-I was informe At 7:29 a.m. NA-I of a.m. cares for R200 At 7:34 a.m. NA-I r cannula when R200 stated she was dizz edge of the bed. At transferred to the of licensed practical n 7:37 a.m. NA-I app liters. At 11:35 a.m. wheelchair with her LPN-D, interviewed stated they do not of	emoved R206's oxygen 6 washed her face. R206 zy when she was seated on the 7:35 a.m. R206 was ommode with the assist of purse (LPN)-C and NA-I. At lied the oxygen to R206 at 2 . R206 was up in the	t e			
	10/16/14, at 9:28 a resident was admit would automatically the POs every shift the PO levels were on the treatment M On 10/16/14, at 10 (NP) stated she wo	RN)-B, was interviewed on .m. and stated that when ted with oxygen orders, they y write on the MAR to check . At 10:45 a.m. RN-B verified not documented as directed AR. :29 a.m. the nurse practitioner buld like the PO checked 2-3				
	The Oxygen Delive 11/29/95, indicated should be evaluate documented, pulse	ay and once at night for R206. The following parameters d with oxygen therapy and oximetry (should be above espiratory disease).				

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00091	B. WING		10/16/20 <sup>-</sup>	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CUYUNA	REGIONAL MEDICA		T MAIN STREE Y, MN 56441	ET		
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2 830	Continued From pa	age 11	2 830			
	SUGGESTED MET	THOD OF CORRECTION:				
	system for on-goin could provide educ proper use of clip a movement. The DC for the licensed nu checking pulse oxit the DON could revi policy. The quality committee could es oxygen documenta	y department to develop a g communication. The DON ation to the staff regarding the alarms to alert staff of resident DN could schedule a meeting rses to establish a system for metry on residents. In addition iew and revise the oxygen use assessment and assurance stablish systems to audit ation, clip alarm use for munication between	,			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one	e			
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 4 Tuberculosis ntrol	21426			11/5/14
	maintain a compre- infection control pro- current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Mort This program must infection control pla unpaid employees, residents, and volu Health shall provide	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). t include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of e technical assistance ntation of the guidelines.				

Minnesc	ota Department of He	alth				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00091	B. WING		10/1	6/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CUYUNA	A REGIONAL MEDICA	I CENTER	MAIN STRE MN 56441	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426		ance with this subdivision must	21426			
Minnesota D	by: Based on interview facility failed to com assessment accord Disease Control (C the transmission of residents (R78) rev addition, screening not provided for 1 of for TB screening. Findings include: R78 was admitted t Review of the Care Screening Tool for I revealed R78's sym and history and risk A hand written note eligible has hx [hist R136 was admitted Review of the unda Screening Tool for I symptoms of active blank. The residen section indicated R test on 4/7/14, how history and risk fact	ent is not met as evidenced and document review, the plete a tuberculosis (TB) risk ling to the current Centers for DC) guidelines for preventing tuberculosis for 1 of 5 iewed for TB screening. In for active TB symptoms was of 5 residents (R136) reviewed to the facility on 9/4/14. Center Baseline TB Residents dated 9/4/14, optoms of active TB disease a factors sections were blank. on the form read, "*not ory] of exposure". to the facility on 5/23/14. ted Care Center Baseline TB Residents revealed R136's TB disease section was t's history and risk factors 136 had a negative TB skin ever, the remainder of the tors questions were blank. 6 p.m. the assistant director of		Corrected		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	•	
UYUNA	REGIONAL MEDICA		T MAIN STRE (, MN 56441	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	ge 13	21426			
	history and risk fact symptoms of active	nfirmed assessments for tors and screening for TB disease had not been mission to the facility for R78				
	dated 8/3/13 directer resident for signs a admission. The po complete the Care	rculosis Screening policy ed staff to assess each nd symptoms of TB upon licy also directed staff to Center Baseline TB Screening ent for all new admissions.	9			
	SUGGESTED MET	HOD OF CORRECTION:				
	education to staff t tuberculosis monito assessment and as	sing or designee could provide o address the importance of oring for residents. The quality sourance committee could to audit tuberculosis screening ce.	,			
	TIME PERIOD FOR Twenty-one (21) da					
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			11/5/14
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by:	ent is not met as evidenced				
	Based on observati	on, interview, and document		Corrected		

STATE FORM

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00091	B. WING		10/	16/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
CUYUNA	REGIONAL MEDICA	I CENTER	T MAIN STREE ′, MN 56441	ET		
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
21805	Continued From pa	ige 14	21805			
	review, the facility failed to provide a dignified homelike dining experience for 12 of 16 residents (R53, R114, R65, R30, R129, R36, R112, R135, R142, R93, R87, R150) who received their meals on trays in the Lakeview dining room.					
	Findings include:					
	On 10/13/14, at 5:10 p.m. during observation of the evening meal, 16 residents were served the dinner meal, 12 residents, (R53, R114, R65, R30, R129, R36, R112, R135, R142, R93, R87, R150) had their meals served on meal service trays. Licensed practical nurse (LPN)-B stated, "We have always served the meals on trays." The trays were set up in the kitchen, delivered to the dining room on a cart, and dished up from the steam table in the dining room. Four residents were observed to be served with the place setting directly on the table. Residents R36, R53, R65, R93, R114, R129, R135, and R142 were observed to eat their meals independently. Residents R30, R87, R112, were assisted by staff seated next to them. R150 ate with family assistance from the meal served on a tray. Nursing assistant (NA)-G was asked about the trays and stated, "I believe the meals have always been served on trays as long as I have been here.					
	residents R36, R53 R135, and R142 at served on trays. R were assisted by st	on 10/15/14, at 8:15 a.m., b, R65, R93, R114, R129, e independently from meals desidents R30, R87, R112, aff seated next to them. R150 amily member. LPN-A stated,"				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED <b>10/16/2014</b>	
		00091				
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CUYUNA	REGIONAL MEDICA		T MAIN STREE ′, MN 56441	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE	
21805	stated, "I am not su you could ask nursi On 10/16/14, at 8:3 observed to be serv nurses (DON), inter a.m., stated, "I aske being served their r here eight years ag	re why they do that like that,	21805			
	Room- Nursing serrindicated: Resident right to eat with diguing pleasurable experies are considered when for the resident. Re admission as to which resident's need Dementia unit: Resistimuli environment interventions. The (ADON) verified the	16 a policy titled "Dining vice Reviewed 1/18/13 s in the Care Center have the nity and have each meal be a ence. Each resident's needs en creating a dining program sidents will be assessed on ich dining program will meet s and functional capacity. idents requiring a reduced t or special behavior assistant director of nurses e policy did not direct meals to in the dementia care area.				
	The director of nurs nutritional services system for a dignifie Lakeview unit. The to staff to address dining for all resider	HOD OF CORRECTION: sing (DON )and the director of could meet and develop a ed dining experience on the DON could provide education the importance of dignity with ints. The quality assessment mittee could establish a ensure compliance.				

Minnesota Department of Health           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLI.           IDENTIFICATION NUMBER         00091		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00091	B. WING		10/16/2014	
AME OF F	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE			
UYUNA	REGIONAL MEDICA	AL CENTER	ST MAIN STREE Y, MN 56441	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLE THE APPROPRIATE DATE	
21805	Continued From pa	age 16	21805			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.					