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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: PWYO

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

Facility ID: 00091

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245232**

2.STATE VENDOR OR MEDICAID NO.
(L2) **535845101**

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

4. TYPE OF ACTION: **7** (L8)

| | |
|---|---|
| 1. Initial | 2. Recertification |
| 3. Termination | 4. CHOW |
| 5. Validation | 6. Complaint |
| 7. On-Site Visit | 9. Other |
| 8. Full Survey After Complaint | |

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/01/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
**03/31**

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

12.Total Facility Beds **117** (L18)

13.Total Certified Beds **117** (L17)

10.THE FACILITY IS CERTIFIED AS:

**X** A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 117 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE Date :
Eva Loch, HFE NE II 1/5/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 1/12/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS
Posted 01/12/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**12/02/2014**
(L33)

DETERMINATION APPROVAL

***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
MDH
DEPARTMENT OF HEALTH

***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

**Department of Health and Human Services**
**Centers for Medicare & Medicaid Services**

Form Approved
OMB NO. 0938-0390

**Post-Certification Revisit Report**



| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245232 | A. Building<br>B. Wing | 12/1/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| CUYUNA REGIONAL MEDICAL CENTER | 320 EAST MAIN STREET<br>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) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix **F0241**<br>Reg. # **483.15(a)**<br>LSC | Correction Completed **11/07/2014** | ID Prefix **F0309**<br>Reg. # **483.25**<br>LSC | Correction Completed **11/07/2014** | ID Prefix **F0323**<br>Reg. # **483.25(h)**<br>LSC | Correction Completed **11/07/2014** |
| ID Prefix **F0328**<br>Reg. # **483.25(k)**<br>LSC | Correction Completed **11/07/2014** | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By State Agency | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| | LB/mm | 12/02/2014 | 28035 | 12/01/2014 |
| **Reviewed By CMS RO** | **Reviewed By** | **Date:** | **Signature of Surveyor:** | **Date:** |
| | | | | |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? | YES | NO |
|---|---|---|---|
| 10/16/2014 | | | |

MINNESOTA MDH DEPARTMENT OF HEALTH

***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 | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 00091 | A. Building<br>B. Wing | 12/1/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| CUYUNA REGIONAL MEDICAL CENTER | 320 EAST MAIN STREET<br>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) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix **20302**<br>Reg. # **MN State Statute 144.6503**<br>LSC | Correction Completed **12/01/2014** | ID Prefix **20830**<br>Reg. # **MN Rule 4658.0520 Subp. 1**<br>LSC | Correction Completed **11/07/2014** | ID Prefix **21426**<br>Reg. # **MN St. Statute 144A.04 Subd. 4**<br>LSC | Correction Completed **12/01/2014** |
| ID Prefix **21805**<br>Reg. # **MN St. Statute 144.651 Subd. 5**<br>LSC | Correction Completed **11/07/2014** | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | LB/mm | 12/02/2014 | 28035 | 12/01/2014 |
| Reviewed By<br>CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

**Followup to Survey Completed on:** 10/16/2014

**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** YES NO

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: PWYO

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245232**

2.STATE VENDOR OR MEDICAID NO.
(L2) **535845101**

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

4. TYPE OF ACTION: **2** (L8)

| | |
|---|---|
| **1. Initial** | **2. Recertification** |
| **3. Termination** | **4. CHOW** |
| **5. Validation** | **6. Complaint** |
| **7. On-Site Visit** | **9. Other** |
| **8. Full Survey After Complaint** | |

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/16/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
**03/31**

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

12.Total Facility Beds **117** (L18)

13.Total Certified Beds **117** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

**X** B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 117 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE — Date :
Jane Aandal, HFE NEII — 11/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 12/02/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS
Posted 12/02/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*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

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.

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

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

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245232 | A. BUILDING _____ B. WING _____ | 10/16/2014 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 241 SS=E | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document 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.<br><br>Findings include:<br><br>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) | F 241 | CRMC strives to promote care for residents in a manner and in an environment that maintains or enhances each resident□s dignity and respect in full recognition of his or her individuality.<br>The Lakeview Units dining experience was reviewed by the facility DON and Director of Nutritional Services on 10-21-14.<br>All residents on the Dementia Care Lakeview unit will be served their meals on a place mat. Trays will be used only to bring the meal to the table to serve the | 11/7/14 |

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

Electronically Signed | 10/29/2014

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| F 241 | Continued From page 1<br>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.<br><br>During observation on 10/15/14, at 8:15 a.m., residents R36, R53, R65, R93, R114, R129, R135, and R142 ate independently from meals served on trays. Residents R30, R87, R112, were assisted by staff seated next to them. R150 was assisted by a family member. LPN-A stated,"I think they have always served the meals on trays, I don't know why." On 10/15/14, at 11:27 a.m. the Assistant Director of Nutritional Services did not know why trays were used. The Culinary director stated, "I am not sure why they do that like that, you could ask nursing."<br><br>On 10/16/14, at 8:33 a.m. the meal was again observed to be served on trays. The director of nurses (DON), interviewed on 10/16/14, at 10:32 a.m., stated, "I asked why the residents were being served their meals on trays when I came here eight years ago." The DON verified that the process did not provide a homelike dining experience. | F 241 | residents. In the future, any resident that requires a serving tray to promote independent eating and/or awareness of the individual□s space will have this documented on their individual care plan.<br>The facilities Dining Room policy was reviewed and revised on 10-27-2014. Revisions included using trays for serving the meal only. Any resident that requires a serving tray to promote independent eating and/or an awareness of the individual□s space will have this documented on their individualized care plan.<br>Mandatory Inservices were held on 10-27-14, 10-28-14 and 10-30-2014 with education including the serving of meals on the Lakeview unit, promoting care in a manner and in an environment that maintains or enhances each resident□s dignity and respect, recognizing individuality and promoting a home like environment.<br>The DON or designee will complete weekly random audits for dignified dining experience for 4 weeks and quarterly thereafter for 6 months or until compliance has been reached. Results of these audits will be reported and reviewed at the facilities monthly QAPI meetings.<br>Completion date: 11-7-14 | |

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| F 241 | Continued From page 2<br><br>On 10/16/14, at 10:16 a policy titled "Dining Room- Nursing service Reviewed 1/18/13 indicated: Residents in the Care Center have the right to eat with dignity and have each meal be a pleasurable experience. Each resident's needs are considered when creating a dining program for the resident. Residents will be assessed on admission as to which dining program will meet the resident's needs and functional capacity. Dementia unit: Residents requiring a reduced stimuli environment or special behavior interventions. The assistant director of nurses (ADON) verified the policy did not direct meals to be served on trays in the dementia care area. | F 241 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to provide a bariatric standing table for 1 of 1 resident (R69) who required the table.<br><br>Findings include: | F 309 | CRMC strives to ensure each resident receives and is provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br>R69 has been on a weight loss program | 11/7/14 |

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| F 309 | Continued From page 3<br>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.<br><br>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.<br><br>The quarterly MDS dated 9/11/14, indicated R69 required total assistance with transfers and extensive assistance with bed mobility.<br><br>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.<br><br>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 one minute and then was able to stand for 2 minutes times 5.<br><br>R69s PT progress note dated 8/4/14, by physical therapist (PT)-A indicated R69 was not currently a candidate for skilled PT secondary to inability to | F 309 | since admission in January, 2014. R69 has had a 10% weight loss.<br>The DON met with the Director of Rehab on 10-23-14 to discuss communication between Rehab and Nursing regarding equipment needs for individual residents.<br>The DON met with the Physical Therapist involved in R69□s care to discuss resident needs, improving communication processes and process for obtaining Capital Budget equipment needs or exploring grants for equipment purchases. These requests will no longer be made by e-mail, but discussed in person to ensure all equipment needs and processes are understood by all parties.<br>The DON, Physical Therapist and R69□s primary physician met on 10-27-14 to discuss a trial use of a Bariatric Standing table. An order was received from the primary physician to trial a bariatric standing frame for weakness secondary to polymyositis. The Bariatric Standing Frame was ordered for a 30 day trial on 10-28-14 with an arrival date of 11-17-2014. 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 program through the hospital as an outpatient as well as the facility dietician.<br>The DON or designee will complete monthly audits/meetings with the Rehab Department to ensure on-going communication between departments. Results of this audits/meeting will be reported and reviewed at monthly QAPI meetings. | |

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| F 309 | Continued From page 4<br>transfer safely onto the tilt table. There was an inability to wheel the mechanical lift under the tilt table for safe positioning. R69 was unable to demonstrate functional progress and there had been no other significant functional change to warrant continued therapy. PT-A felt R69 would benefit from a bariatric standing frame to increase lower extremity strength for transfers and ambulation. The plan was to confer with R69's neurologist to determine if the proposed plan could allow R69 to return to independent living. PT-A recommended the equipment to the director of nursing (DON) and the administrator.<br><br>R69s care plan revised 9/23/14, indicated R69 was transferred with the assist of 3 and a mechanical lift. Physical therapy evaluation for change in functional status.<br><br>R69, interviewed on 10/14/14, at 9:49 a.m., stated his goal was to walk again but was not getting any PT. On 10/15/14, a 7:05 a.m. R69 was observed up in the electric wheelchair. R69 stated he was walking with a walker at home and fell which caused the fractured ankle. R69 stated he had an underlying health condition that caused muscle and joint weakness. R69 stated he was frustrated, "Its like I live here and I don't want to be here."<br><br>On 10/16/14, at 9:52 a.m. physical therapist (PT)-A stated R69 had polymyositis (an uncommon inflammatory disease that causes muscle weakness affecting both sides of the body. It can make it difficult to climb stairs, rise from a seated position, lift objects or reach | F 309 | Completion date: 11-7-14 | |

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| F 309 | Continued From page 5<br>overhead). PT-A stated R69 did not have the leg strength to stand. PT-A stated R69 could be assisted onto the lift table to stand straight, but would would buckle if standing without support. PT-A stated the were waiting for authorization from the DON and administration to order the bariatric standing frame. PT-A stated the standing frame cost $7,000 and they did not know if it would work. PT-A stated the company provided a 30 day trial with only a $200 fee for return shipping. PT-A stated she had asked for authorization from the DON over a month ago and still had not received a response. PT-A stated she had called the neurologist three times with no return call<br><br>On 10/16/14, at 11:20 a.m. the DON stated she had received an email from PT-A and replied they could get the table on a trial basis but they could purchase the table unless it was approved by the administrator. The DON stated there had been miscommunication between PT and herself. There was no policy regarding the issue. | F 309 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by: | F 323 | | 11/7/14 |

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| F 323 | Continued From page 6<br>Based on observation, interview and document review, the facility failed to determine the effectiveness of a personal clip alarm to alert staff when a resident stands for 2 of 4 residents (R52, R37) reviewed with clip alarms.<br><br>Findings include:<br><br>R52 was observed, on 10/15/14, at 6:30 a.m., lying in bed awake with an alarm box next to her pillow. The alarm clip was attached to the bed sheet instead of the bed frame.<br><br>R52's quarterly Minimum Data Set (MDS) dated 8/5/14, indicated diagnoses that included aphasia due to cardiovascular disease, hemiplegia, and osteoporosis. The MDS indicated R52 required extensive assist for bed mobility, transfers, dressing, toilet use, personal hygiene, and was non-ambulatory.<br><br>The 11/25/13, significant change Fall Care Area Assessment (CAA) indicated R52 was at high risk for falls due to medication use, wandering and impaired balance. The 7/30/14 Fall Risk Assessment indicated R52 remained at high risk for additional falls.<br><br>Nursing progress notes on 9/6/14, described R52's last fall. R52 fell out of the wheel chair in the activity room.<br><br>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. | F 323 | CRMC strives to ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br>R52 and R37□s clip alarms were affixed to the bed frame on 10-16-14.<br>All residents in the facility who have clip alarms have had the alarm attached to the bed frame.<br>Mandatory In-services were held on 10-27-14, 10-28-14 and 10-30-2014 with education including the need to attach all clip alarms to the bed frame when the resident is in bed.<br>The DON or designee will complete weekly random audits for proper attachment of clip alarms to the bed frame for 4 weeks and quarterly thereafter for 6 months or until compliance has been reached. Results of these audits will be reported at the facility QAPI meetings.<br><br>Completion date: 11-7-14 | |

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| F 323 | Continued From page 7<br>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.<br><br>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.<br><br>R37 was observed, on 10/15/14, at 7:50 a.m. during transfer out of bed with a mechanical lift and assistance of NA-E and NA-F assisted R37 out of bed with a mechanical lift. NA-E unclipped the alarm from R37's bed sheet and applied the clip alarm with a Velcro strap on to the arm of the wheel chair. NA-E stated R37 did not have side rails so they clipped the alarm to the bed sheet.<br><br>The 5/16/14 Fall Comprehensive Assessment indicated R37 was at risk for falls due to incontinence, physical and cognitive deficits. The 5/21/14, annual MDS Fall CAA indicated R37 had balance problems.<br><br>R37's 8/14/14, quarterly MDS indicated diagnoses that included cardiovascular attack (CVA) and dementia. The MDS indicated R37 required total assist for bed mobility, transfers, dressing, toilet use, personal hygiene, and was non-ambulatory.<br><br>R37's care plan dated 8/17/14, indicated a risk for falls due to history of falls and impaired communication. The care plan directed a clip | F 323 | | |

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| F 323 | Continued From page 8<br>alarm while in bed and wheelchair.<br><br>Nursing progress notes dated 9/20/14, indicated R37's last fall was from the bed on 9/20/14.<br><br>At 8:50 a.m. 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.<br><br>The facility policy, Fall Prevention dated 11/7/2012, indicated appropriate interventions will be initiated to aid in the decrease of falls potential.<br><br>The undated manufacturer's direction for usage indicated the clip alarm was to be attached to a wheel chair or bed. | F 323 | | |
| F 328 SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to consistently monitor | F 328 | CRMC strives to ensure that residents receive proper treatment and care for | 11/7/14 |

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| F 328 | Continued From page 9<br>pulse oximetry (PO) (non-invasive method for monitoring a person's oxygen saturation level in their blood) for 1 of 1 resident (R206) reviewed for respiratory services.<br><br>Findings include:<br><br>R206's admission Minimum Data Set (MDS) dated 10/7/14, indicated severe cognitive impairment and chronic obstructive pulmonary (lung) disease (COPD).<br><br>R206's physician's orders dated 10/1/14, indicated oxygen therapy at 2 liters per nasal cannula (oxygen delivered through the nose at a flow rate of 2 liters). The temporary care plan dated 10/2/14, did not address oxygen therapy.<br><br>R206's treatment medication administration record (MAR) indicated R206 required PO checks on evenings and nights. There was no documented evidence that PO checks were provided on 10/1/14.<br><br>The treatment MAR for 10/2/14, through 10/8/14, was unable to be located by facility staff. The treatment MAR for 10/9/14, through 10/15/14, indicated PO was evaluated only 12 of 21 times ordered by the physician.<br><br>On 10/14/14, at 9:12 a.m. R206 was observed on her back in bed with oxygen at 2 liters per nasal cannula.<br><br>On 10/15/14, at 7:21 a.m. R206 was observed in bed with the oxygen cannula off to the side of the face instead of into the nares. R206 wanted to get up for the day. At 7:23 a.m. nursing assistant | F 328 | special services.<br>R206 oxygen saturation levels were set up on 10-16-14 to be checked three times during the day and once at night.<br>The DON met with the Medical Director to establish perimeters and guidelines for completing pulse oximetry to monitor oxygen saturation levels in the blood for acute and chronic oxygen use. When a resident is acute and requiring vital signs on a routine basis, oxygen saturation levels will be obtained as part of the vital signs. Residents on oxygen who are stable or on chronic oxygen will have oxygen saturation levels checked when there is a change in condition. When there are physician orders to maintain oxygen saturation levels above a certain percentage such as, keep oxygen saturation levels above 92%, pulse oximetry will be obtained every shift. These guidelines have been included in the facility procedure for obtaining Pulse Oximetry for Acute and Chronic Oxygen use.<br>Mandatory Inservices were held on 10-27-14, 10-28-14 and 10-30-2014 with education on the guidelines for obtaining Pulse oximetry for acute and chronic oxygen use.<br>The DON or designee will complete weekly random audits for compliance with obtaining Pulse oximetry for acute and chronic oxygen use per facility guidelines for 4 weeks and quarterly thereafter for 6 months or until compliance has been reached. Results of these audits will be reported at the facility QAPI meetings.<br>Completion date: 11-7-14 | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 328 | Continued From page 10<br>(NA)-I was informed that R206 wanted to get up. At 7:29 a.m. NA-I came to the room to provide a.m. cares for R206.<br>At 7:34 a.m. NA-I removed R206's oxygen cannula when R206 washed her face. R206 stated she was dizzy when she was seated on the edge of the bed. At 7:35 a.m. R206 was transferred to the commode with the assist of licensed practical nurse (LPN)-C and NA-I. At 7:37 a.m. NA-I applied the oxygen to R206 at 2 liters. At 11:35 a.m. R206 was up in the wheelchair with her oxygen on.<br><br>LPN-D, interviewed on 10/16/14, at 9:27 a.m., stated they do not check R206's PO because in the past the PO was 92-93 % (normal for chronic respiratory disease was above 90%).<br><br>Registered nurse (RN)-B, was interviewed on 10/16/14, at 9:28 a.m. and stated that when resident was admitted with oxygen orders, they would automatically write on the MAR to check the POs every shift. At 10:45 a.m. RN-B verified the PO levels were not documented as directed on the treatment MAR.<br><br>On 10/16/14, at 10:29 a.m. the nurse practitioner (NP) stated she would like the PO checked 2-3 times during the day and once at night for R206.<br><br>The Oxygen Delivery System policy dated 11/29/95, indicated the following parameters should be evaluated with oxygen therapy and documented, pulse oximetry (should be above 90% with chronic respiratory disease). | F 328 | | |

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|---|---|---|---|
| | 245232 | A. BUILDING **01 - NURSING HOME** B. WING _____ | **10/15/2014** |

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

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>01 Main Building<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Cuyuna Regional Medical Center C&NC 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.<br><br>Cuyuna Regional Medical Center C&NC is a 1-story building with a basement. The original building was constructed in 1962, attached to a hospital, separated with a 2-hour fire rated barrier and was determined to be of Type II (000) construction. The major addition was constructed east of the existing building in 1982, was determined to be of Type II (000) construction with additions to the main entrance area (dining room) and south wing (dayroom) in 1996 of Type II (111) construction. In 2007 a 10 feet by 30 feet dayroom addition was constructed to the north west wing, was determined to be Type II (111) construction and separated with a 2-hour fire barrier. The building is divided into 7 smoke compartments by 30 minute and 2- hour fire barriers.<br><br>The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection throughout the corridor system, in | K 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

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| K 000 | Continued From page 1<br>common areas and hazardous areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition.<br><br>The facility has a capacity of 117 beds and had a census of 109 at the time of the survey.<br><br>The facility was surveyed as two buildings. The 01 main building and the 1982 and 1996 additions as existing. The 2007 dayroom as new.<br><br>The requirement at 42 CFR, Subpart 485.623 (d) is MET. | K 000 | | |

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245232 | A. BUILDING **02 - 2007 DAYROOM** B. WING _____ | **10/15/2014** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>02 2007 Addition<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Cuyuna Regional Medical Center C&NC 02 2007 Addition was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care.<br><br>Cuyuna Regional Medical Center C&NC is a 1-story building with a basement. The original building was constructed in 1962, attached to a hospital, separated with a 2-hour fire rated barrier and was determined to be of Type II (000) construction. The major addition was constructed east of the existing building in 1982, was determined to be of Type II (000) construction with additions to the main entrance area (dining room) and south wing (dayroom) in 1996 of Type II (111) construction. In 2007 a 10 feet by 30 feet dayroom addition was constructed to the north west wing, was determined to be Type II (111) construction and separated with a 2-hour fire barrier. The building is divided into 7 smoke compartments by 30 minute and 2- hour fire barriers.<br><br>The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection throughout the corridor system, in | K 000 | | |

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| K 000 | Continued From page 1<br>common areas and hazardous areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition.<br><br>The facility has a capacity of 117 beds and had a census of 105 at the time of the survey.<br><br>The facility was surveyed as two buildings. The 01 main building and the 1982 and 1996 additions as existing. The 2007 dayroom as new.<br><br>The requirement at 42 CFR, Subpart 485.623 (d) is MET: | K 000 | | |

*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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00091 | A. BUILDING: _____ B. WING _____ | 10/16/2014 |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>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.<br><br>INITIAL COMMENTS:<br>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 | 2 000 | | |

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| 2 000 | Continued From page 1<br><br>Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.<br><br>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 when they will be completed.<br><br>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.<br><br>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. | 2 000 | | |

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| 2 000 | Continued From page 2<br>THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |
| 2 302 | MN State Statute 144.6503 Alzheimer's disease or related disorder train<br><br>ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING:<br>MN St. Statute 144.6503<br><br>(a) If a nursing facility serves persons with Alzheimer's<br>disease or related disorders, whether in a segregated or general unit, the facility's direct care staff<br>and their supervisors must be trained in dementia care.<br><br>(b) Areas of required training include:<br>(1) an explanation of Alzheimer's disease and related disorders;<br>(2) assistance with activities of daily living;<br>(3) problem solving with challenging behaviors; and<br>(4) communication skills.<br>(c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.<br>(d) The facility shall document compliance with this section.<br><br>This MN Requirement is not met as evidenced | 2 302 | | 11/7/14 |

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| 2 302 | Continued From page 3<br>by:<br>Based on interview and document review, the facility failed to ensure that consumers received information on a description of the Alzheimer's training program, the categories of employees trained, the frequency of training, and the basic topics covered at the facility. This had the potential to affect all 102 residents and any consumers who wanted to review the information.<br><br>Findings include:<br><br>The Cuyuna Regional Medical Center admission packet indicated there was a specialized dementia care program with special staff training for dementia care.<br><br>On 10/16/14, at 11:55 a.m. the director of nursing (DON) stated they were not being specific enough in the admission packet about what the dementia training program contained.<br><br>SUGGESTED METHOD OF CORRECTION:<br><br>The director of nursing or designee could update the admission packet to include all the required information for consumers regarding dementia training in the facility. The quality assessment and assurance committee could review the revised document to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-one (21) days. | 2 302 | Corrected | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General | 2 830 | | 11/7/14 |

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| 2 830 | Continued From page 4<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to provide a bariatric standing table for 1 of 1 resident (R69) who required the table.<br><br>Findings include:<br><br>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.<br><br>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 | 2 830 | Corrected | |

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| 2 830 | Continued From page 5<br>for a prolonged stay to regain functional independence with cares.<br><br>The quarterly MDS dated 9/11/14, indicated R69 required total assistance with transfers and extensive assistance with bed mobility.<br><br>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.<br><br>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 one minute and then was able to stand for 2 minutes times 5.<br><br>R69s PT progress note dated 8/4/14, by physical therapist (PT)-A indicated R69 was not currently a candidate for skilled PT secondary to inability to transfer safely onto the tilt table. There was an inability to wheel the mechanical lift under the tilt table for safe positioning. R69 was unable to demonstrate functional progress and there had been no other significant functional change to warrant continued therapy. PT-A felt R69 would benefit from a bariatric standing frame to increase lower extremity strength for transfers and ambulation. The plan was to confer with R69's neurologist to determine if the proposed plan could allow R69 to return to independent living. PT-A recommended the equipment to the director of nursing (DON) and the administrator.<br><br>R69s care plan revised 9/23/14, indicated R69 | 2 830 | | |

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| 2 830 | Continued From page 6<br>was transferred with the assist of 3 and a mechanical lift. Physical therapy evaluation for change in functional status.<br><br>R69, interviewed on 10/14/14, at 9:49 a.m., stated his goal was to walk again but was not getting any PT. On 10/15/14, a 7:05 a.m. R69 was observed up in the electric wheelchair. R69 stated he was walking with a walker at home and fell which caused the fractured ankle. R69 stated he had an underlying health condition that caused muscle and joint weakness. R69 stated he was frustrated, "Its like I live here and I don't want to be here."<br><br>On 10/16/14, at 9:52 a.m. physical therapist (PT)-A stated R69 had polymyositis (an uncommon inflammatory disease that causes muscle weakness affecting both sides of the body. It can make it difficult to climb stairs, rise from a seated position, lift objects or reach overhead). PT-A stated R69 did not have the leg strength to stand. PT-A stated R69 could be assisted onto the lift table to stand straight, but would would buckle if standing without support. PT-A stated the were waiting for authorization from the DON and administration to order the bariatric standing frame. PT-A stated the standing frame cost $7,000 and they did not know if it would work. PT-A stated the company provided a 30 day trial with only a $200 fee for return shipping. PT-A stated she had asked for authorization from the DON over a month ago and still had not received a response. PT-A stated she had called the neurologist three times with no return call | 2 830 | | |

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| 2 830 | Continued From page 7<br><br>On 10/16/14, at 11:20 a.m. the DON stated she had received an email from PT-A and replied they could get the table on a trial basis but they could purchase the table unless it was approved by the administrator. There was no policy regarding the issue.<br><br>Based on observation, interview and document review, the facility failed to determine the effectiveness of a personal clip alarm to alert staff when a resident stands for 2 of 4 residents (R52, R37) reviewed with clip alarms.<br><br>Findings include:<br><br>R52 was observed, on 10/15/14, at 6:30 a.m., lying in bed awake with an alarm box next to her pillow. The alarm clip was attached to the bed sheet instead of the bed frame.<br><br>R52's quarterly Minimum Data Set (MDS) dated 8/5/14, indicated diagnoses that included aphasia due to cardiovascular disease, hemiplegia, and osteoporosis. The MDS indicated R52 required extensive assist for bed mobility, transfers, dressing, toilet use, personal hygiene, and was non-ambulatory.<br><br>The 11/25/13, significant change Fall Care Area Assessment (CAA) indicated R52 was at high risk for falls due to medication use, wandering and impaired balance. The 7/30/14 Fall Risk Assessment indicated R52 remained at high risk for additional falls.<br><br>Nursing progress notes on 9/6/14, described R52's last fall. R52 fell out of the wheel chair in the activity room. | 2 830 | | |

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| 2 830 | Continued From page 8<br><br>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.<br><br>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.<br><br>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.<br><br>R37 was observed, on 10/15/14, at 7:50 a.m. during transfer out of bed with a mechanical lift and assistance of NA-E and NA-F assisted R37 out of bed with a mechanical lift. NA-E unclipped the alarm from R37's bed sheet and applied the clip alarm with a Velcro strap on to the arm of the wheel chair. NA-E stated R37 did not have side rails so they clipped the alarm to the bed sheet.<br><br>The 5/16/14 Fall Comprehensive Assessment indicated R37 was at risk for falls due to incontinence, physical and cognitive deficits. The 5/21/14, annual MDS Fall CAA indicated R37 had balance problems.<br><br>R37's 8/14/14, quarterly MDS indicated diagnoses that included cardiovascular attack (CVA) and dementia. The MDS indicated R37 required total assist for bed mobility, transfers, dressing, toilet use, personal hygiene, and was | 2 830 | | |

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| 2 830 | Continued From page 9<br>non-ambulatory.<br><br>Based on observation, interview, and document review, the facility failed to consistently monitor pulse oximetry (PO) (non-invasive method for monitoring a person's oxygen saturation level in their blood) for 1 of 1 resident (R206) reviewed for respiratory services.<br><br>Findings include:<br><br>R206's admission Minimum Data Set (MDS) dated 10/7/14, indicated severe cognitive impairment and chronic obstructive pulmonary (lung) disease (COPD).<br><br>R206's physician's orders dated 10/1/14, indicated oxygen therapy at 2 liters per nasal cannula (oxygen delivered through the nose at a flow rate of 2 liters). The temporary care plan dated 10/2/14, did not address oxygen therapy.<br><br>R206's treatment medication administration record (MAR) indicated R206 required PO checks on evenings and nights. There was no documented evidence that PO checks were provided on 10/1/14.<br><br>The treatment MAR for 10/2/14, through 10/8/14, was unable to be located by facility staff. The treatment MAR for 10/9/14, through 10/15/14, indicated PO was evaluated only 12 of 21 times ordered by the physician.<br><br>On 10/14/14, at 9:12 a.m. R206 was observed on her back in bed with oxygen at 2 liters per nasal cannula.<br><br>On 10/15/14, at 7:21 a.m. R206 was observed in | 2 830 | | |

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| 2 830 | Continued From page 10<br>bed with the oxygen cannula off to the side of the face instead of into the nares. R206 wanted to get up for the day. At 7:23 a.m. nursing assistant (NA)-I was informed that R206 wanted to get up. At 7:29 a.m. NA-I came to the room to provide a.m. cares for R206.<br>At 7:34 a.m. NA-I removed R206's oxygen cannula when R206 washed her face. R206 stated she was dizzy when she was seated on the edge of the bed. At 7:35 a.m. R206 was transferred to the commode with the assist of licensed practical nurse (LPN)-C and NA-I. At 7:37 a.m. NA-I applied the oxygen to R206 at 2 liters. At 11:35 a.m. R206 was up in the wheelchair with her oxygen on.<br><br>LPN-D, interviewed on 10/16/14, at 9:27 a.m., stated they do not check R206's PO because in the past the PO was 92-93 % (normal for chronic respiratory disease was above 90%).<br><br>Registered nurse (RN)-B, was interviewed on 10/16/14, at 9:28 a.m. and stated that when resident was admitted with oxygen orders, they would automatically write on the MAR to check the POs every shift. At 10:45 a.m. RN-B verified the PO levels were not documented as directed on the treatment MAR.<br><br>On 10/16/14, at 10:29 a.m. the nurse practitioner (NP) stated she would like the PO checked 2-3 times during the day and once at night for R206.<br><br>The Oxygen Delivery System policy dated 11/29/95, indicated the following parameters should be evaluated with oxygen therapy and documented, pulse oximetry (should be above 90% with chronic respiratory disease). | 2 830 | | |

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| 2 830 | Continued From page 11<br>SUGGESTED METHOD OF CORRECTION:<br><br>The director of nursing (DON) could meet with the physical therapy department to develop a system for on-going communication. The DON could provide education to the staff regarding the proper use of clip alarms to alert staff of resident movement. The DON could schedule a meeting for the licensed nurses to establish a system for checking pulse oximetry on residents. In addition, the DON could review and revise the oxygen use policy. The quality assessment and assurance committee could establish systems to audit oxygen documentation, clip alarm use for residents, and communication between departments.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |
| 21426 | MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control<br><br>(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. | 21426 | | 11/5/14 |

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| 21426 | Continued From page 12<br><br>(b) Written compliance with this subdivision must be maintained by the nursing home.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to complete a tuberculosis (TB) risk assessment according to the current Centers for Disease Control (CDC) guidelines for preventing the transmission of tuberculosis for 1 of 5 residents (R78) reviewed for TB screening. In addition, screening for active TB symptoms was not provided for 1 of 5 residents (R136) reviewed for TB screening.<br><br>Findings include:<br><br>R78 was admitted to the facility on 9/4/14. Review of the Care Center Baseline TB Screening Tool for Residents dated 9/4/14, revealed R78's symptoms of active TB disease and history and risk factors sections were blank. A hand written note on the form read, "*not eligible has hx [history] of exposure".<br><br>R136 was admitted to the facility on 5/23/14. Review of the undated Care Center Baseline TB Screening Tool for Residents revealed R136's symptoms of active TB disease section was blank. The resident's history and risk factors section indicated R136 had a negative TB skin test on 4/7/14, however, the remainder of the history and risk factors questions were blank.<br><br>On 10/16/14, at 2:16 p.m. the assistant director of | 21426 | Corrected | |

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| 21426 | Continued From page 13<br>nursing (ADON) confirmed assessments for history and risk factors and screening for symptoms of active TB disease had not been completed upon admission to the facility for R78 or R136.<br><br>The Resident Tuberculosis Screening policy dated 8/3/13 directed staff to assess each resident for signs and symptoms of TB upon admission. The policy also directed staff to complete the Care Center Baseline TB Screening Tool and assessment for all new admissions.<br><br>SUGGESTED METHOD OF CORRECTION:<br><br>The director of nursing or designee could provide education to staff to address the importance of tuberculosis monitoring for residents. The quality assessment and assurance committee could establish a system to audit tuberculosis screening to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-one (21) days. | 21426 | | |
| 21805 | MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document | 21805 | Corrected | 11/5/14 |

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| 21805 | Continued From page 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.

During observation on 10/15/14, at 8:15 a.m., residents R36, R53, R65, R93, R114, R129, R135, and R142 ate independently from meals served on trays. Residents R30, R87, R112, were assisted by staff seated next to them. R150 was assisted by a family member. LPN-A stated,"I think they have always served the meals on trays, I don't know why." On 10/15/14, at 11:27 a.m. the Assistant Director of Nutritional Services did not know why trays were used. The Culinary director

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| 21805 | Continued From page 15<br>stated, "I am not sure why they do that like that, you could ask nursing."<br><br>On 10/16/14, at 8:33 a.m. the meal was again observed to be served on trays. The director of nurses (DON), interviewed on 10/16/14, at 10:32 a.m., stated, "I asked why the residents were being served their meals on trays when I came here eight years ago." The DON verified that the process did not provide a homelike dining experience.<br><br>On 10/16/14, at 10:16 a policy titled "Dining Room- Nursing service Reviewed 1/18/13 indicated: Residents in the Care Center have the right to eat with dignity and have each meal be a pleasurable experience. Each resident's needs are considered when creating a dining program for the resident. Residents will be assessed on admission as to which dining program will meet the resident's needs and functional capacity. Dementia unit: Residents requiring a reduced stimuli environment or special behavior interventions. The assistant director of nurses (ADON) verified the policy did not direct meals to be served on trays in the dementia care area.<br><br>SUGGESTED METHOD OF CORRECTION:<br><br>The director of nursing (DON )and the director of nutritional services could meet and develop a system for a dignified dining experience on the Lakeview unit. The DON could provide education to staff to address the importance of dignity with dining for all residents. The quality assessment and assurance committee could establish a system to audit to ensure compliance. | 21805 | | |

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| 21805 | Continued From page 16<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-one (21) days. | 21805 | | |