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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QQZQ

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 **05/12/2014** (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):
See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor — 05/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Heath
Enforcement Specialist — 06/25/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/21/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5232

On May 12, 2013 a Post Certificaiton Revisit (PCR) was completed by review of the facility's plan of correction. Based on our PCR we have determined the facility is compliance, effective April 25, 2014. refer to the CMS 2567b for the results of this visit.

Effective April 25, 2014, the facility is certified for 117 skilled nursing facilty beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5232

June 25, 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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective April 25, 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
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 21, 2014

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

RE: Project Number S5232021

Dear Ms. Stratman:

On April 8, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 27, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 12, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 27, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 25, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 27, 2014, effective April 25, 2014 and therefore remedies outlined in our letter to you dated April 8, 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
Minnesota Department of Health
mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

5232r14epoc.rtf

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 B. Wing	5/12/2014

Name of Facility	Street Address, City, State, Zip Code
CUYUNA REGIONAL MEDICAL CENTER	320 EAST MAIN STREET CROSBY, MN 56441

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/25/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/25/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **04/25/2014**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **04/25/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **04/25/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **04/25/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/25/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **04/25/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **04/25/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **04/25/2014**	ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **04/25/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/LB	05/21/2014	28035	05/12/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/27/2014

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: QQZQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00091

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/27/2014** (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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Yvonne Switajewski, HFE NEII 0418/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/21/2014 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5232

On March 27, 2014, a standard survey was completed. Deficiencies were found whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. Post Certificaiton Revisit (PCR) to follow. Refer to the CMS 2567 for both health and life safety code, along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 8, 2014

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

RE: Project Number S5232021

Dear Ms. Stratman:

On March 27, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the 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:

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Lyla Burkman 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 May 6, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 6, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 27, 2014 (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 September 27, 2014 (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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

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

cc: Licensing and Certification File 5232s14.rtf

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 _____	03/27/2014

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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		4/25/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/17/2014

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.

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 _____	03/27/2014

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
F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive plan of care to include the emergency care of an internal jugular left chest venous dialysis access site for 1 of 1 resident (R64) reviewed for dialysis. In addition, the facility failed to develop a plan of care (POC) to identify the use, symptoms for use and non-pharmacological interventions to be attempted prior to the administration of anti-anxiety medication for 1 of 3 residents (R77) in the sample who received as needed anti-anxiety medication. Findings include: R64 had a left chest venous catheter (a tube with two chambers, inserted into a vein) dialysis access site and the facility failed to develop a plan of care (POC) to include directives related to the emergency care interventions of the access site. R64's Medication Administration Record dated 3/25/14, indicated R64's diagnoses included end stage renal disease with dialysis treatments. R64's quarterly Minimum Data Set (MDS) indicated R64 had intact cognition and received dialysis services. R64's POC dated 1/9/14, indicated R64 received dialysis services two times per week via a left	F 279	F279 CRMC strives to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. Resident R64's care plan was reviewed and revised, in collaboration with our agreement with Centracare Kidney Program, on 4-1-2014 to include emergency care interventions of the access site. In case of bleeding from the access site, the care plan instructs nursing to apply pressure to the site and call 911 per the facility's policy and procedure. Resident R77's care plan was reviewed and revised by interdisciplinary team on 4-1-14 to include non pharmacologic interventions to treat the resident's anxiety prior to administering the as needed anti-anxiety medication. These interventions include to allow resident to vent feelings and frustrations, provide support and reassurance, encourage resident to deep breath and try to relax when feeling anxious/short of breath, provide calm approach and support during periods of high stress, facility psychologist visits as needed, facility psychiatric visits as needed, observe for adverse effects of anti-anxiety medication and update physician as needed. The facility's Psychotropic medication policy was reviewed and revised by the	

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 _____	03/27/2014

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
F 279	Continued From page 2 chest dialysis access catheter. The POC directed staff to observe for signs and symptoms of infection and to notify the dialysis center of any redness, pain or drainage. The POC lacked directive for emergency care in case of accidental removal and / or bleeding. On 3/26/14, at 8:40 a.m. R64 was observed seated in a scooter, in his own room. R64 stated he had a chest dialysis port which was observed loosely covered with a clear dressing. On 3/26/14, at 8:30 a.m. nursing assistant (NA)-A verified R64 had a left chest dialysis access catheter and stated she did not do much with it and neither did the nurses. NA-A stated if there was any swelling or discharge she would report it to the nurse. On 3/27/14 at 1:51 p.m. trained medication aide (TMA)-A stated she was unaware of any emergency procedures related to the dislodgment of R64's chest catheter and stated she did not know what she would do other than get the registered nurse (RN). At 2:15 p.m. the dialysis center RN-C stated emergency procedures for the catheter should include holding pressure to the site and if not resolved within 10 minutes to send R64 to the emergency room or call the dialysis center, if open. RN-C confirmed R64's POC should include the emergency care of R64's acess site catheter.	F 279	Interdisciplinary team. As needed psychotropic medications are not to be given unless non-pharmacological interventions are attempted first and were unsuccessful. Mandatory inservices will be held on April 21st, 22nd, 23rd for the Nursing staff in regards to the facility's Policy and Procedure for as needed Psychotropic medications. The inservice to include documentation and care planning of non-pharmacologic interventions to use prior to use of as needed psychotropic medications and appropriate indication for use of these medications. All care plans and physician orders for residents receiving as needed psychotropic medications will be audited with each quarterly assessment to ensure appropriate indication for use and non-pharmacologic interventions per facility policy and federal regulations. The DON or designee will complete Quarterly audits to ensure continued compliance for 6 months or until compliance is reached. Results of these audits will be reported at the facilities QAPI meetings. Completion date: 4-25-2014	

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 _____	03/27/2014

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
F 279	Continued From page 3 At 2:31 p.m. RN-B confirmed R64's POC lacked identification and direction of emergency care for the central catheter access site. At the same time, the assistant director of nursing confirmed R64's POC lacked direction of emergency care of the dialysis catheter. However, the ADON stated she would not necessarily expect to see the directive on the POC as staff were knowledgeable as to what to do during in an emergency. At 4:36 p.m. the director of nursing (DON) confirmed R64's POC lacked an emergency care directive, however, stated she would not expect to see it on the care plan as all staff should know to call 911 in the case of an emergency. The Agreement To Provide Dialysis Services To End Stage Renal Disease Patients Between Centracare Kidney Program And Crosby Care Center dated 2/20/14, indicated a combined POC will be established, maintained, reviewed and modified which included an assessment of each patients needs including the management of the access site. The facility's Care Planning and Conference policy and procedure reviewed 6/29/12, indicated each resident will have an individualized overall POC which emphasized the care and development of the whole person to ensure each resident received the care and services most appropriate to meet his/her needs.	F 279		

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 _____	03/27/2014

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
F 279	Continued From page 4	F 279		

R77's POC lacked identification and indication for the use of non-pharmacological interventions prior to the administration of as needed (PRN) anti-anxiety medications.

R77's POC dated 12/18/13, indicated R77 was diagnosed with depression. However, the POC lacked indication R77 was also diagnosed with anxiety and was administered antianxiety medication PRN and did not identify non-pharmacological interventions to be attempted prior to the use of the medication.

R77's current physicians orders dated 3/22/14, included an order for Ativan 0.5 mg to be given two times a day PRN for an anxiety state.

Review of R77's Medication Administration Records (MAR) revealed the following information:
-On 12/19/113 at 900 a.m. Ativan PRN was given for anxiety.
-On 12/20/13, at 1:00 p.m. Ativan PRN was given for anxiety.
-On 3/15/14, at 11:20 p.m. Ativan PRN was given for anxiety. Results, documented: "helping-anxiety reduced."

R77's medical record record did not include documentation of non-pharmacological interventions attempted prior to the administration of the medication.

On 3/27/14, at 1:55 p.m. RN-A confirmed R77 received PRN anti-anxiety medications and R77's

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 _____	03/27/2014

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
F 279	Continued From page 5 POC did not identify any type of non-pharmacological interventions to be attempted prior to administration. .	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide oral hygiene services for 1 of 3 residents (R83) who was dependent on staff for oral hygiene and failed to provide shaving assistance for 1 of 1 resident (R173) who required assistance with shaving as directed by their individual written plan of care. Findings include: R83 was not provided oral hygiene services as directed by R83's plan of care (POC). R83's POC dated 1/30/14, directed staff: "See closet care plan for assistance need with ADL's" [activities of daily living]. R83's The Individual Resident Care Plan dated 3/24/14, posted to the inside of R83's closet door, indicated R83 had her own teeth and required total staff assistance for oral care and directed staff to brush R83's teeth	F 282	F282 CRMC strives to provide and arrange for services by qualified persons in accordance with each resident's plan of care. Education and revisions have been made to assure that this is being addressed. Resident R173 care plan was reviewed on 4-1-2014 and no revisions were required. R83's care plan was reviewed and revised on 4-1-14 and 4-13-14 to include the use of a toothette for oral cares as resident allows. Resident receiving Hospice services and will not allow the use of a toothbrush. Oral care to be completed with use of a toothette before and after meals and with HS cares as resident allows. All Nursing staff will be re-inserviced at mandatory inservices regarding following the care plan, proper oral care and shaving on 4-21-2014, 4-22-2014 and 4-23-2014. Inservice to include	4/25/14

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 _____	03/27/2014

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
F 282	Continued From page 6 four times per day. On 3/25/14 at approximately 8:10 a.m. R83 was observed to have a foul odor to her breath. On 3/27/14, at 9:58 a.m. nursing assistant (NA)-E stated R83 was provided oral cares twice a day. NA-D stated R83's mouth would bleed when brushing teeth. NA-E stated she used toothettes for R83's oral cares. NA-D and NA-E indicated directions for individual care are posted on the inside of the residents' closet doors. Both indicated the expectation was they checked the "closet" care plan daily and they both stated they should have checked it. On 3/27/14, at 1:48 p.m. registered nurse (RN)-D stated her expectation was the closet care plan would be followed. RN-D stated routine oral cares were provided twice a day. RN-D further stated R83 received hospice care and she would expect R83's condition warranted oral care be provided more often, as indicated on her closet care plan. RN-D indicated R83's 4x per day oral cares directed by the closet care plan was a family request. The Daily Resident Cares procedure dated 5/16/2011, directed staff: "1. Consult the closes [sic] care plan for specific needs of resident." R173 did not receive assistance with shaving as directed by his individual POC.	F 282	immediately reporting to your supervisor when equipment is not available for grooming needs when required, updating the Charge Nurse, team leader or MDS nurse when resident refusing cares. The DON or designee will complete weekly random audits for completion of grooming needs 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. Completion date: 4-25-14	

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 _____	03/27/2014

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
F 282	Continued From page 7	F 282		

R173's POC dated 1/20/14, directed staff to set up R173 for oral and hair care, shaving and washing his hands and face to maintain his current level of activities of daily living (ADL) function.

On 3/25/14, at 9:00 a.m. R173 was observed wheeling himself back to his room in his wheelchair. His face was noted to be unshaven with stubble on his chin, cheeks and upper lip.

On 3/26/14, at 7:37 a.m. R173 was observed to leave his room via wheelchair and wheel himself down the hall. He was dressed but unshaven.

At 2:11 p.m. R173 stated he would like to figure out how to get shaved. He stated he did not have a razor so would have to ask how he could get that done.

On 3/27/14, at 9:54 a.m. nursing assistant (NA)-E identified herself as R173's primary caregiver. NA-E confirmed R173 was not shaved that week. NA-E stated R173 usually shaved himself after she had provided set up for him. However, she had noticed a couple of days previous his razor was missing. She stated she had not notified anyone of the missing razor nor provided an alternative shaving method for R173.

On 3/27/14, at 1:45 p.m. registered nurse (RN)-D stated she would expect R173 to be offered daily

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 _____	03/27/2014

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
F 282	Continued From page 8 shaving as directed by his POC. The Daily Resident Cares procedure dated 5/16/11 directed staff: "17. Assist resident with shaving as needed".	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor a daily fluid restriction for 1 of 1 resident (R64) reviewed for dialysis with a daily fluid restriction. In addition, the facility failed to monitor and report elevated blood pressures for 1 of 1 resident (R195) reviewed with documented uncontrolled blood pressure. Findings include: R64 was on a daily 1500 milliliter (ml) fluid restriction and the facility failed to monitor R64's total daily fluid intake.	F 309	F309 CRMC strives to provide each resident 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 and will educate and review processes to assure that this is addressed. R64's care plan was reviewed and remains current. Resident R64 is non-compliant with fluid restrictions and independent with mobility in the facility. Resident obtains fluids without notifying nursing and becomes verbally aggressive toward staff when confronted. Resident is aware of risks of not maintaining fluid	4/25/14

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 _____	03/27/2014

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
F 309	Continued From page 9 R64's Medication Administration Record dated 3/25/14, indicated R64's diagnoses included end stage renal disease with dialysis treatments twice per week. R64's quarterly Minimum Data Set (MDS) indicated R64 had intact cognition, was independent with eating and received dialysis services. R64's Nutritional Care Area Assessment (CAA) dated 4/11/13, indicated R64 was independent with eating, preferred to eat in his own room and was on a 1500 ml fluid restriction diet. R64's Dehydration / Fluid Maintenance CAA dated 4/11/13, indicated R64 had a history of being non-compliant with dialysis and the prescribed fluid restriction and was at risk for fluid imbalance. The CAA also indicated staff would monitor and encourage R64 to be compliant with the restriction. R64's Hospital Discharge Summary dated 1/30/14, indicated R64 was hospitalized due to refusal to have dialysis which resulted in an altered mental status, volume overload and decreased level of consciousness. R64's current physician's orders dated 3/25/14, indicated an order for a 1500 ml fluid restriction and directed staff to give R64 360 mls of fluid with each meal, 120 ml with medication passes and 120 ml at night. R64's plan of care (POC) dated 1/9/14, indicated R64 was independent with eating, preferred to eat in his own room and was on a 1500 ml fluid daily restriction. The POC also indicated R64's fluid plan was placed on R64's Medication	F 309	restrictions, is reminded by staff of health risks of non-compliance yet continues to be non compliant. Fluid intake is now being totaled daily and reviewed by the Charge Nurse on a weekly basis. Resident is encouraged to maintain fluid restriction. On 3-27-2014 resident R195's blood pressures, pain control and current medications were reviewed by resident's primary physician. Resident's primary physician stated at this time he did not want to change anything due to the resident just restarting the antihypertensive after the resident's recent hospitalization and it can take a while for it to take effect but to continue to monitor the blood pressures. No changes have been made in resident's current drug regimen. All nurses will be re-inserviced on 4-21, 22 1nd 23 on following the facilities policy to report blood pressures higher than 140/100 to the RN for further assessment. If using an electronic B/P cuff, recheck with a manual cuff and report both findings to the RN. If blood pressure greater than 140/100 report to the resident's physician unless there are written orders for other perimeters. CRMC is upgrading our electronic clinical record in July with an add-on component that will electronically alert staff if vitals are outside the established perimeters to assist in capturing this type of outlier readings in a more timely manner. The DON or designee to complete random weekly audits for four weeks of Vital signs to ensure the facility policy is	

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 _____	03/27/2014

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
F 309	Continued From page 10 Administration Record (MAR). The POC directed staff to remind and encourage R64 to follow the restrictions. The POC also directed staff to monitor R64's fluid intake. On 3/26/14, at 8:40 a.m. R64 was observed seated in a scooter in his own room eating an open faced egg sandwich. Four empty soda cans were observed in R64's garbage can. R64 confirmed he received dialysis services twice a week. As far as his diet, R64 stated he needed to stay away from peanuts and pasta. R64 also stated he liked to drink soda. R64 did not indicate any fluid restrictions. R26's monthly MARs for February 2014, and March 2014, the 1st through the 26th indicated a 1500 ml fluid restriction and directed staff to give R64 360 ml of fluid on days and evening with each meal and 120 ml at night. The MAR identified the amount of fluid R64 consumed each shift, however, lacked a total amount per day. On 3/26/14, at 8:30 a.m. nursing assistant (NA)-A stated R64 was on a special diet, however, R64 ate and drank whatever he wanted. NA-A stated R64 drank soda "like it was going out of style." At 12:04 p.m. licensed practical nurse (LPN)-C confirmed R64 was on a fluid restriction diet in which staff tracked, however, R64 ate and drank what he wanted too. LPN-C stated R64 would eat in house or order take out and have delivered to his room. LPN-C added, R64 liked soda and coffee.	F 309	being followed. Audits will be completed quarterly thereafter for 6 months or until compliance has been reached. Completion date: 4-25-2014	

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 _____	03/27/2014

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
F 309	Continued From page 11	F 309		

On 3/27/14, registered nurse (RN)-B confirmed R64 received dialysis services and was on a 1500 ml daily fluid restriction. RN-B stated she was not sure if staff monitored R64's intake and was not sure if the facility utilized a documentation form to determine how much fluid R64 consumed in a day. RN-B stated R64 was knowledgeable of the fluid restriction and drank as often and as much as he wanted.

At 10:40 a.m. NA-C and NA-M both stated R64 drank whatever he wanted which was too difficult to monitor. Both NA's denied documenting R64's fluid intake.

At 11:00 a.m. during review of R64's MARs with the assistant director of nursing (ADON), the ADON confirmed the MARs identified per shift fluid intake, however, verified the total daily intake was not added nor recorded in order to monitor fluid consumption within the prescribed restrictions.

At 1:51 p.m. trained medication aid (TMA)-A stated R64 used to be on a fluid restriction, however, she was not sure. She stated she was not sure what staff did with the fluid restriction because R64 drank what he wanted too.

At 1:58 p.m. LPN-D verified R64 was on a fluid restriction. LPN-D also stated everyone monitored R64's intake to ensure R64 stayed within the 500 ml per shift maximum. LPN-D

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 _____	03/27/2014

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
F 309	Continued From page 12 confirmed staff documented per shift fluid intake and stated there was no formal document / documentation which identified the total daily fluid intake, rather, stated "it's just basic mathematics." At 2:15 p.m. the dialysis center RN-C confirmed R64 received dialysis services and was on a prescribed 1500 ml fluid restriction per day and stated the facility should have some way of monitoring R64's total intake. At 2:31 p.m. the ADON stated she had added a line on R64's current MAR for the documentation of R64's total daily fluid intake for improved monitoring and also stated R64's daily fluid intake totals will now be reviewed weekly by the registered nurse. The Agreement To Provide Dialysis Services To End Stage Renal Disease Patients Between Centracare Kidney Program [dialysis center] And Crosby Care Center signed 2/2014, on page 3, bullet 4.1 under "services to be provided by skilled facility" indicated the facility will perform the monitoring of fluid gain / loss including the assessment of a resident's intake. R195 had documented high blood pressure readings and the facility failed to monitor and inform R195's physician. R195's Care Center History and Physical report	F 309		

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 _____	03/27/2014

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
F 309	Continued From page 13 dated 3/18/14, indicated R195's diagnoses included hypertension and post operative surgical repair of a left wrist and hip fracture. The report also indicated R195 was alert and oriented, blood pressure readings 150-180's / 70's and indicated R195 would be restarted on amlodipine (antihypertensive) due to poorly controlled blood pressure. R195's current physician orders dated 3/19/14, indicated an order for amlodipine 5mg daily and metoprolol 100 mg daily both for hypertension. The orders directed staff to check R195's vital signs daily. No blood pressure perimeters were identified which directed staff when to call the physician. R195's admission POC dated 3/17/14, lacked identification of hypertension. Review of R195's Weights and Vitals Summary dated 3/27/14, revealed the following daily blood pressure readings: -3/17/14, at 8:00 p.m.: 151/75 -3/17/14, at 10:00 p.m.: 156/71 -3/18/14, at 1:00 a.m.: 189/82 -3/18/14, at 5:00 a.m.: 185/76 -3/18/14, at 10:11 a.m.: 178/76 -3/19/14, at 8:24 a.m.: 197/81 -3/20/14, at 10:41 a.m.: 190/77 -3/20/14, at 2:09 p.m.: 129/69 -3/21/14, at 8:18 a.m.: 170/65 -3/22/14, at 2:26 p.m.: 134/64 -3/23/14, at 10:49 a.m.: 168/68 -3/24/14, at 2:21 p.m.: 157/69	F 309		

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 _____	03/27/2014

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
F 309	Continued From page 14 -3/25/14, at 10:12 a.m.: 135/61 -3/26/14, at 9:30 a.m.: 157/71 On 3/24/14, at 6:00 p.m. R195 was observed in bed with a soft cast on left wrist/arm. R195 stated she had fallen and broke some bones. An electronic blood pressure machine was observed in R195's room, left of her bed. On 3/27/14, at 8:32 a.m. registered nurse (RN)-A confirmed R195 had hypertension along with post operative pain which could elevate blood pressure readings. RN-A verified R195's blood pressure was checked daily. When asked how abnormal vital signs were identified and reported, RN-A stated the nursing assistants (NAs) obtained R195's blood pressure daily and reported the results to the nurse working with R195 for that day and if the results were abnormal the nurse would then report the results to the unit RN for further assessment and possible physician notification. RN-A stated, otherwise, if a RN "happened" to be in R195's chart and noticed the abnormal readings they would notify R195's physican at that time. In addition, RN-A stated if a resident was found to have elevated blood pressure she would start the resident on a three day blood pressure monitoring regimen to see if the high blood pressure continued even after the administration of pain medications and / or antihypertensive medication. However, RN-A stated there was no documentation which indicated R195's elevated blood pressure correlated with pain. RN-A stated R195's physican should have been notified of the elevated blood pressures. RN-A stated she was	F 309		

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 _____	03/27/2014

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
F 309	Continued From page 15 administering R195's medications on 3/20/14, therefore, was aware of the 190/77 blood pressure reading and provided R195 pain medication and rechecked the blood pressure which was significantly lower. RN-A stated she would expect staff to recheck a residents blood pressure if got a high reading to begin with. RN-A confirmed R195's elevated blood pressure was not identified, monitored appropriately nor was R195's physician notified. At 8:46 a.m. licensed practical nurse (LPN)-B stated the NA's were responsible to check R195's blood pressure daily and if it was elevated they would report to her right away and if not they would report them to her by 10:00 a.m. LPN-B also stated if R195's blood pressure was elevated she would inform the unit RN. LPN-B reviewed R195's blood pressure readings and stated should would have reported the findings to the RN and would also expect R195's blood pressure to be rechecked after an elevated reading to ensure a return to normal was achieved after the administration of pain and / or antihypertensive medications. LPN-B confirmed R195's elevated blood pressure readings were not reported to the RN. At 10:35 a.m. RN-A stated she had contacted R195's physician who requested no further changes in R195's antihypertensive medication, however suggested a change in R195's pain medication regimen, however, R195 declined any changes. RN-A again confirmed staff had not responded appropriately to R195's elevated blood	F 309		

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 _____	03/27/2014

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
F 309	Continued From page 16 pressure. The facility's Vital Signs / Blood Pressure policy and procedure revised 3/30/12, directed staff to report any blood pressure higher than 140/100 to the nurse immediately. The policy also directed staff, if using an electronic blood pressure machine, to recheck the blood pressure with a manual blood pressure cuff if the electronic reading was higher than 140/100 and to report both findings the the RN for further assessment. In addition, the policy directed staff to report blood pressures greater than 140/100 to the physician unless the physician had written orders for other perimeters.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide shaving services for 1 of 1 resident (R173) who were assessed to require assistance with shaving. Findings include: R173's admission MDS dated 1/8/14, identified R173 had severe cognitive impairment. The	F 311	F311 CRMC strives to provide each resident with the appropriate treatment and services to maintain or improve his or her abilities. Resident R173's care plan was reviewed and remains current. All Nursing staff will be re-inserviced at mandatory inservices regarding following the care plan, proper grooming including shaving on 4-21-2014, 4-22-2014 and	4/25/14

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 _____	03/27/2014

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
F 311	Continued From page 17 MDS further identified R173 was diagnosed with cancer, a history of stroke and required set up assistance for personal hygiene. R173's plan of care (POC) dated 1/20/14, directed staff to set up R173 for oral and hair care, shaving and washing his hands and face to maintain his current level of activities of daily living (ADL) function. On 3/25/14, at 9:00 a.m. R173 was observed wheeling himself back to his room in his wheelchair. His face was noted to be unshaven with stubble on his chin, cheeks, and upper lip. On 3/26/14, at 7:37 a.m. R173 was observed to leave his room via wheelchair and wheel himself down the hall. He was dressed but unshaven. At 2:11 p.m. R173 stated he would like to figure out how to get shaved. He stated he did not have a razor so would have to ask how he could get that done. On 3/27/14, at 9:54 a.m. nursing assistant (NA)-E identified herself as R173's primary caregiver. NA-E confirmed R173 was not shaved that week. NA-E stated R173 usually shaved himself after she had provided set up for him. However, she had noticed a couple of days previous his razor was missing. She stated she had not notified anyone of the missing razor or provided an alternative shaving method for R173.	F 311	4-23-2014. Inservice to include immediately reporting to your supervisor, updating the Charge Nurse, team leader or MDS nurse when resident equipment is missing. The DON or designee will complete weekly random audits for completion of grooming needs 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. Completion date: 4/25/14	

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 _____	03/27/2014

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
F 311	Continued From page 18 On 3/27/14, at 1:45 p.m. registered nurse (RN)-D stated she would expect R173 to be offered daily shaving as directed by his POC. The Daily Resident Cares procedure dated 5/16/11 directed staff: "17. Assist resident with shaving as needed".	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide oral hygiene for 1 of 3 residents (R83) who was dependent on staff to provide oral hygiene care. Findings include: R83's significant change in status Minimum Data Set (MDS) dated 1/22/14, indicated R83 had severe cognitive impairment and was totally dependent on staff for personal hygiene. The MDS further identified R83 was diagnosed with dementia, stroke, chronic pain and received hospice care.	F 312	F312 CRMC strives to provide residents who are unable to carry out activities of daily living the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Education and processes have been addressed to assure that this happens. R83's care plan was reviewed and revised on 4-1-14 and 4-13-14 to include the use of a toothette for oral cares as resident allows. Resident receiving Hospice services and will not allow the use of a toothbrush. Oral care to be completed with use of a toothette before and after meals and with HS cares as resident allows.	4/25/14

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 _____	03/27/2014

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
F 312	Continued From page 19 R83's plan of care (POC) dated 1/30/14 directed staff: "See closet care plan for assistance need with ADL's" [activities of daily living]. R83's Individual Resident Care Plan dated 3/24/14, posted to the inside of R83's closet door indicated R83 had her own teeth and directed one staff to brush R83's teeth four times a day. On 3/25/14, at approximately 8:10 a.m. R83 was observed to have foul odor to her breath. On 3/27/14, at 9:58 a.m. nursing assistant (NA)-E stated R83 was provided oral cares twice a day. NA-D stated R83's mouth would bleed when brushing teeth. NA-E stated she used toothettes for R83's oral cares. NA-D and NA-E indicated directions for individual cares were posted on the inside of the residents' closet doors. Both indicated the expectation was they should check the "closet" care plan daily. On 3/27/14, at 1:48 p.m. registered nurse (RN)-D stated her expectation would be the closet care plan would be followed. RN-D stated routine oral cares would be provided twice a day. RN-D further stated R83 received hospice care and she would expect R83's condition warranted oral care be provided more often as indicated on her closet care plan. RN-D indicated R83's 4x per day oral cares directed by the closet care plan was a family request. The Daily Resident Cares procedure dated 5/16/2011, directed staff: "1. Consult the closest	F 312	All Nursing staff will be re-inserviced at mandatory inservices regarding following the care plan, proper oral care on 4-21-2014, 4-22-2014 and 4-23-2014. Inservice to include immediately reporting to your supervisor, updating the Charge Nurse, team leader or MDS nurse when resident refusing cares. The DON or designee will complete weekly random audits for completion of grooming needs 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. Completion date: 4-25-14	

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 _____	03/27/2014

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
F 312	Continued From page 20 [sic] care plan for specific needs of resident."	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess the effectiveness of a personal clip alarm (alarm which will alert staff when a resident stands) as a fall prevention intervention for 1 of 3 residents (R25) reviewed for falls. Findings include: R25's Diagnosis Report dated 3/27/14, indicated R25's diagnoses included history of traumatic brain injury, history of fall, dementias, anxiety, peripheral neuropathy (result of nerve damage, often causes weakness, numbness and pain, usually in the hands and feet), and enthesopathy of hip region (disorder of the muscular attachments of the hip). R25's quarterly Minimum Data Set (MDS) dated	F 323	F323 CRMC strives to ensure that each resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. Resident R25's care plan was reviewed and revised on 3-31-2014 to discontinue the tab alarm and place a floor mat alarm on top of the fall mat to alert staff if resident attempts to transfer self out of bed. All current residents with a history of falls in the facility will be reviewed for patterns and effectiveness of current fall interventions. All Nursing staff will be re-educated on fall precautions and reporting ineffective interventions to the Charge Nurse for reassessment on 4-21, 22, and 23. All falls will and are reviewed for effectiveness of interventions. The DON	4/25/14

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 _____	03/27/2014

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
F 323	Continued From page 21 1/6/14, identified R25 had moderate cognitive impairment and required extensive assistance of one person for bed mobility, dressing, eating and personal hygiene. The MDS identified R25 was totally dependent with two plus persons physical assistance for transfers and toilet use, required human assistance to stabilize on transfers between bed and chair or wheelchair (w/c) and had lower extremity functional impairment in range of motion, on both sides. The MDS further identified R25 had one fall without injury since admission or prior assessment at the time of the assessment on 1/6/14. R25's Fall Assessment Tool dated 1/6/14, identified R25 had a previous history of a fall on 11/4/13, and a fall risk score of 23 which indicated high risk. R25's plan of care (POC) dated 1/14/14, contained interventions for the preventions of falls which included direction to staff to "see closet care plan". R25's High Fall Risk Interventions dated 12/23/13, posted to the inside of R25's closet door, contained directions to staff that included: "tab alert [personal clip alarm] in bed, left shoulder area and tab alert in w/c." On 3/26/14, at 9:24 a.m. R25 was observed seated in her w/c, in her room which was located at the end of the hall furthest from the nurse's station. A personal clip alarm box was observed on R25's chair and clipped to the right, rear, shoulder area of R25's shirt.	F 323	or designee will complete random weekly audits for effectiveness of interventions for 4 weeks and quarterly thereafter for 6 months or until compliance has been reached. The DON or designee to report on falls at monthly QAPI meetings. Completion date: 4-25-2014	

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 _____	03/27/2014

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
F 323	Continued From page 22 On 3/26/14, at 11:34 a.m. R25 was observed seated in her w/c in the hallway outside her room. A personal clip alarm was observed on her chair clipped the the right, rear, shoulder area of R25's shirt. On 3/26/14, at 2:16 p.m. R25 was observed awake, half seated, half lying in bed with her legs tucked up under her and the head of the bed elevated. R25 was noted to be confused and stated she wanted to get up to move her car off the street. A personal clip alarm was observed clipped to the right, rear, shoulder of her shirt. A fall mat was observed on the floor by the bed, a call light was within reach and R25's w/c was observed stored out of sight, around the wall by the sink. The following facility Fall Reports were reviewed: -On 1/13/14, at 5:00 p.m. "R25 was found laying on floor mat, between end of bed and closet, laying on left side. R25 stated she was trying to get into her closet." The report indicated R25 was uninjured from the fall from her w/c in her room and had fall mat and tab alarm ordered and in place at the time of the fall. The Post Fall "Huddle" identified the following in the situation section: Tab alarm "did not sound-intact. Tested-works. Res [resident] leaning forward enough poss [possible] could have slowly slid off r/t [related to] res unable to ambulate. Tab still better than pressure pad."	F 323		

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 _____	03/27/2014

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
F 323	Continued From page 23 -On 1/22/14, at 5:40 am. "Upon entering resident's room, this writer observed resident laying on her left side on the fall mat located on the floor next to her bed as a safety intervention. Resident stated that she did not fall, did not hit her head, was not hurt anywhere, and did not have to go to the bathroom. Resident stated that she decided to get up out of bed for no reason at all. Resident had removed her tab alert clip from her gown". The report indicated R25 was uninjured from the fall from her bed and had fall mat, tab alert and body pillow equipment ordered at the time of the fall. -On 3/12/14, at 7:00 a.m. "R25 found on knees next to bed, stated was trying to get up for the day. Alarm did not sound - was found unattached and placed inside a pillow case/pillow on res bed." The report indicated R25 was uninjured from the fall from her bed and had fall mat and tab alarm ordered and in place at the time of the fall. Nursing assistants (NA)-D and NA-E were interviewed on 3/27/14, at 9:58 a.m. and stated R25's fall interventions included a personal clip alarm, fall mat and body pillow. NA-D confirmed R25 would remove the personal alarm clip or if she could not reach it would take off her gown when in bed. When asked if the personal clip alarm was an effective intervention for R25 since she could remove it, NA-D stated "not really." NA-D stated when R25 was more confused they would move her w/c closer to the nurse's station. NA-D further stated R25 didn't use her call light but would bang it on the wall or call out and R25's roommate would put her call light on for	F 323		

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 _____	03/27/2014

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
F 323	Continued From page 24 assistance. On 3/27/14, at 3:20 p.m. assistant director of nursing (ADON) stated the majority of R25's falls had been from bed. Registered nurse (RN)-D and ADON both confirmed the personal clip alarm was ineffective for R25 and ADON indicated moving R25 to a room closer to the nurse's station may be beneficial. The Fall Prevention policy dated 3/18/03, specified "7. All falls will be reviewed and compared to previous falls for patterns, similarities, and efficacy to current interventions."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		4/25/14

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 _____	03/27/2014

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
F 329	Continued From page 25 drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to adequately identify, assess and monitor clinical indications for the continued use of antianxiety medication for 1 of 3 residents (R77) in the sample who received as needed (PRN) antianxiety medication. Findings include: R77's Medical Diagnosis Report dated 12/18/13, indicated R77's diagnoses included depression and chronic pain. R77's quarterly Minimum Data Set (MDS) dated 3/20/14, indicated R77 had intact cognition. The MDS also indicated R77 reported feeling down, depressed or hopeless, feeling bad about himself or was a failure or had let himself or his family down. The MDS indicated R77 had no behavioral symptoms, had used an anti-anxiety medication one time during the MDS 7 day assessment period and reported no hallucination, delusions or behavioral symptoms during the assessment period. R77's admission MDS dated 12/24/13, indicated R77 was alert and oriented, had no behaviors, required extensive assist with bed mobility, dressing, toileting, personal hygiene, had deficit in the lower extremity-with impairment on one side,	F 329	F329 CRMC strives to ensure that each resident's drug regimen is free from unnecessary drugs. Practices have been reviewed and education completed to assure that this standard is met. Resident R77's care plan was reviewed and revised on 4-1-14 to include non pharmacologic interventions to treat the resident's anxiety prior to administering the as needed anti-anxiety medication. These interventions include to allow resident to vent feelings and frustrations, provide support and reassurance, encourage resident to deep breath and try to relax when feeling anxious/short of breath, provide calm approach and support during periods of high stress, facility psychologist visits as needed, facility psychiatric visits as needed, observe for adverse effects of anti-anxiety medication and update physician as needed. The facility's Psychotropic medication policy was reviewed and revised by the interdisciplinary team. As needed psychotropic medications are not to be given unless non-Pharmacological interventions are	

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 _____	03/27/2014

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
F 329	Continued From page 26 and used a wheelchair. R77's Psychotropic Drug Use Care Area Assessment (CAA) dated 12/24/13, indicated R77 had a history of depression and received Celexa on a daily basis and had Ativan PRN to help manage his anxiety associated with his depression. The CAA indicated R77 had used the PRN two times since 12/18/13. R77's plan of care (POC) dated 12/18/13, did not address the use of anti-anxiety medication, non-pharmacological interventions, nor the anxiety symptoms R77 experienced. R77's physician orders dated 3/22/13, indicated Ativan (antianxiety) 0.5 milligrams (mg.) orally twice daily PRN for anxiety state. R77's medication administration record (MAR) indicated: -On 12/19/113 at 900 a.m. Ativan PRN was given for anxiety. -On 12/20/13, at 1:00 p.m. Ativan PRN was given for anxiety. -On 3/15/14, at 11:20 p.m. Ativan PRN was given for anxiety. Results documented: "helping-anxiety reduced." R77's clinical record lacked documentation of non pharmacological interventions attempted prior to R77's receiving the Ativan. Review of R77's Pharmacist Drug Regimen Review forms dated 3/25/13, 2/21/13, and	F 329	attempted first and were unsuccessful. Mandatory inservices will be held on April 21st, 22nd, 23rd for the Nursing staff in regards to the facility's Policy and Procedure for as needed Psychotropic medications. The inservice to include documentation and care planning of non-pharmacologic interventions to use prior to use of as needed psychotropic medications and appropriate indication for use of these medications. All care plans and physician orders for residents receiving as needed psychotropic medications will be audited to ensure appropriate indication for use and non-pharmacologic interventions per facility policy and federal regulations. CRMC's Pharmacy Consultant was notified of this requirement not being met and will assist in monthly audits to ensure continued compliance. The DON or designee will complete Quarterly audits for 6 months and then, if practice is not corrected, continue until compliance is met to ensure continued compliance. Results of these audits will be reported at the facilities QAPI meetings. Completion date: 4-25-2014	

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 _____	03/27/2014

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
F 329	Continued From page 27 12/18/13, revealed a lack of documentation related to the lack of identification and implementation of non-pharmacological interventions to be used by staff prior to the administration of anti-anxiety medications. On 3/26/14, at 2:00 p.m. R77 was observed sitting in his room. He stated he thought he was doing pretty good and was having a good day. R77 stated he planned to go home as soon as the doctor told him he was ready to leave the facility. On 3/27/14, at 9:45 a.m. R77 was observed sitting in his wheelchair listening to music. R77 stated he had the Ativan PRN order for quite awhile. R77 stated he only used the Ativan before a medical procedure such as a MRI or if he got anxious and could not catch his breath. On 3/26/14, at 2:39 p.m. LPN-D stated the last time R77's PRN Ativan was used was 3/15/14, for anxiety. LPN-D stated she was unaware of what symptoms R77 had been experiencing. On 3/27/14, at 1:30 p.m. LPN-A stated she thought the PRN Ativan would be used before R77 had his upcoming MRI. At this time the surveyor and LPN-A reviewed R77's Ativan PRN usage. LPN-A stated she did not know what symptoms R77 was experiencing when the PRN Ativan was administered. At 1:55 p.m. RN-A verified R77's anxiety	F 329		

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 _____	03/27/2014

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
F 329	Continued From page 28 diagnoses, symptoms and non pharmacological interventions to be attempted prior to the administration of the medication was not identified nor addressed on R77's POC. In addition, RN-A stated R77's symptoms of his anxiety should have been identified and documented when the PRN medication was administered. A facility policy was requested, however, no policy on anti-anxiety medication was provided.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community	F 356		4/25/14

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 _____	03/27/2014

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
F 356	Continued From page 29 standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post the total number of actual nursing staff hours worked each shift for each nursing discipline as required. In addition, the facility failed to maintain 18 months of the nurse staff postings for the required 18 months. This had the potential to affect all 107 residents residing in the facility along with family and visitors. Findings include: Upon entrance to the facility on 3/24/2014, at 1:48 p.m., the Cuyuna Regional Medical Center Report of Nursing Staff, dated 3/24/14, listed the current census, and the number of registered nurses (RNs), licensed practical nurses (LPNs), and nursing assistants (NARs) who were currently working. The form did not list the total number of hours each discipline worked every shift. During an interview on 3/27/2014, at 9:59 a.m., the administrator acknowledged the staff posting did not list the actual number of hours worked by the nursing staff. The administrator said the form would "have to be changed."	F 356	F356 On 3-27-2014 the form for posting staff hours was changed to include the total number of hours worked every shift for each nursing discipline. On 3-31-2014 all staff responsible for completing the Nursing staff hour form were inserviced and given an example of the correct procedure for completion of the staffing hours. The DON or designee will complete weekly audits for 4 weeks, quarterly thereafter until compliance has been maintained to ensure continued compliance. Results of these audits will be reported at the facility's QAPI meetings. Completion date 4/25/14	

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 _____	03/27/2014

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
F 356	Continued From page 30 During an interview on 3/27/2014, at 2:50 p.m., the director of nursing (DON) confirmed the form lacked the total hours each nursing discipline worked, and that the person in charge of the posting was informed of its necessary components. The DON stated the facility retained the required daily postings "for at least six months." The DON also said the updated, correct staff posting was already in place.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain kitchen equipment (tilt skillet, convection over, ovens racks), utensils and the food preparation area and the dishwashing area in a clean and sanitary manner in order to prevent food contamination and food borne illnesses. This practice had the potential to affect 105 of 107 residents whose meals were prepared in the facility's main kitchen. In addition, the facility failed to ensure an ice dispensing machine was routinely cleaned and maintained in a sanitized manner. This practice had the potential to affect 81 of 82 residents who	F 371	F371- FOOD SERVICE CRMC strives to store, prepare, distribute and serve food under sanitary conditions. Practices have been reviewed and education completed to assure that this standard is met. The Tilt skillet, wall behind the tilt skillet and two convection ovens and racks were cleaned on 3-24-14 and deep cleaned on 3-29-2014. The tilt skillet has been put on a daily cleaning schedule to be completed by dietary staff. The two convection ovens have been put on a daily cleaning	4/25/14

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 _____	03/27/2014

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
F 371	Continued From page 31 could have received ice from the east kitchenette. Findings include: Kitchen: On 3/24/14, at 2:03 p.m. during the initial tour of the kitchen with director of nutritional services (DNS), the tilt skillet was observed to have food debris crusted around the knobs and along the front of the unit. The wall behind the tilt skillet was observed soiled with greasy splashes along an approximately 3 foot area. Two convection ovens were observed soiled with charred debris covering the entire floor of each oven. Additionally, the two oven racks inside each oven and an extra two oven racks that were observed stored hanging on the side of the upper oven were encrusted with charred debris. On 3/26/14, at 1:08 p.m. during the kitchen tour with DNS, a drawer in the food preparation area that stored scoops was inspected. When the drawer was opened, liquid was observed dripping from the ledge beneath the countertop into the drawer. A puddle of liquid with white sediment approximately 6 inches in diameter was pooled under the scoops stored in the drawer. DNS stated the drawer needed to be cleaned and removed the scoops and placed in the dishwashing area. At 1:30 p.m. the DNS confirmed the convection ovens, oven racks, tilt skillet, and wall behind the	F 371	schedule for the outside of the ovens and weekly cleaning of the inside of the ovens. The cleaning is to be completed by dietary staff. On 3-26-2014 the drawer in the food preparation area was cleaned and all utensils sent through the dishwasher. The ice machine was put out of service and cleaning and maintenance were completed on 3-28-14. The ice machine has been put on a quarterly cleaning and maintenance schedule to be completed by the Facilities Management department. On 3-26-2014 the pipe above the 3 compartment sink was cleaned and has been put on a once a week cleaning schedule to be completed by housekeeping. Education on proper cleaning and new cleaning schedules was completed on 4-17-2014. The Dietary Manager or designee will be auditing the kitchen daily for cleanliness and completion of assigned cleaning duties. Sanitation Inspections will be completed twice a month by the RD or the Food Service District Manager for a a minimum of four months and thereafter until compliance is maintained. Completion date:4/25/14	

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 _____	03/27/2014

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
F 371	Continued From page 32 tilt skillet were dirty. He was unable to identify when these areas were last cleaned or was due to be cleaned. The DNS stated they were in the process of changing to a new system. He stated he did not have a cleaning schedule for kitchen equipment and currently cleaning tasks were assigned by job description. At 1:40 p.m. the area around the three compartment sink was observed. A pipe was observed to run along an approximate 3 foot length above the sanitizing compartment of the three compartment sink and dish drying area. The top surface of the pipe was noted to be occluded with a thick coating of dust. The DNS confirmed the pipe was dirty and should have been cleaned. The DNS was unable to identify when the area was last cleaned or was due to be cleaned. The undated General Sanitation of Kitchen policy indicated "1. Cleaning and sanitation tasks for the kitchen will be recorded. 2. Tasks will be assigned to the responsibility of specific positions. 3. Tasks will be addressed as to frequency of cleaning." It further indicated "5. A cleaning schedule will be posted and employees will initial and date tasks when completed." East Kitchenette: On 3/26/14, at 2:10 p.m. during a tour of the east kitchenette with DNS, an ice dispensing unit's ice chute was noted to be encrusted with hard water deposits. The DNS stated the maintenance staff	F 371		

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 _____	03/27/2014

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
F 371	Continued From page 33 were responsible to clean the ice machines. The DNS stated he was unaware of when the ice machine was last cleaned. On 3/27/14, at 3:25 p.m. electrician (E) confirmed the maintenance staff were responsible to service the ice dispensing units in the facility. When asked how often the units were cleaned, E responded "whenever we are told they need cleaning." E was unable to identify when the ice dispenser was last cleaned. The Symphony 20 and 50 series Ice and Water Dispensers Installation, Operation and Service Manual recommended cleaning the dispenser hopper's lid, wheel, baffle, inside storage area, and clear plastic chute with a solution of 200 ppm (parts per million) of chlorinated detergent and sanitizing the same areas with a solution of 50 ppm of chlorinated detergent. It indicated cleaning and sanitizing procedures for the ice dispenser should be performed quarterly.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		4/25/14

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 _____	03/27/2014

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
F 428	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting licensed pharmacist reported medication irregularities related to the use of as needed (PRN) anti-anxiety medication without non pharmacological interventions in place to the attending physician and the director of nursing to be acted upon for 1 of 3 residents (R77) in the sample who required a report. Findings include: R77's Medical Diagnosis Report dated 12/18/13, indicated R77's diagnoses included depression and chronic pain. R77's quarterly Minimum Data Set (MDS) dated 3/20/14, indicated R77 had intact cognition. The MDS also indicated R77 reported feeling down, depressed or hopeless, feeling bad about himself or was a failure or had let himself or his family down. The MDS indicated R77 had no behavioral symptoms, had used an anti-anxiety medication one time during the MDS 7 day assessment period and reported no hallucination, delusions or behavioral symptoms during the assessment period. R77's admission MDS dated 12/24/13, indicated R77 was alert and oriented, had no behaviors, required extensive assist with bed mobility, dressing, toileting, personal hygiene, had deficit in the lower extremity-with impairment on one side, and used a wheelchair. R77's Psychotropic Drug Use Care Area Assessment (CAA) dated 12/24/13, indicated R77 had a history of depression and received Celexa on a daily basis	F 428	F428 The drugs for each resident are reviewed monthly by a licensed pharmacist. Practices have been reviewed and education completed to assure that this standard is met. Resident R77's care plan was reviewed and revised on 4-1-14 to include non pharmacologic interventions to treat the resident's anxiety prior to administering the as needed anti-anxiety medication. These interventions include to allow resident to vent feelings and frustrations, provide support and reassurance, encourage resident to deep breath and try to relax when feeling anxious/short of breath, provide calm approach and support during periods of high stress, facility psychologist visits as needed, facility psychiatric visits as needed, observe for adverse effects of anti-anxiety medication and update physician as needed. The facility's Psychotropic medication policy was reviewed and revised. As needed psychotropic medications are not to be given unless non-Pharmacological interventions are attempted first and were unsuccessful. Mandatory inservices will be held on April 21st, 22nd, 23rd for the Nursing staff in regards to the facility's Policy and Procedure for as needed Psychotropic	

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 _____	03/27/2014

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
F 428	Continued From page 35 and had Ativan PRN to help manage his anxiety associated with his depression. The CAA indicated R77 had used the PRN two times since 12/18/13. R77's plan of care (POC) dated 12/18/13, did not address the use of anti-anxiety medication, non-pharmacological interventions, nor the anxiety symptoms R77 experienced. R77's physician orders dated 3/22/13, indicated Ativan (antianxiety) 0.5 milligrams (mg.) orally twice daily PRN for anxiety state. R77's medication administration record (MAR) indicated: -On 12/19/113 at 900 a.m. Ativan PRN was given for anxiety. -On 12/20/13, at 1:00 p.m. Ativan PRN was given for anxiety. -On 3/15/14, at 11:20 p.m. Ativan PRN was given for anxiety. Results documented: "helping-anxiety reduced." R77's clinical record lacked documentation of non pharmacological interventions attempted prior to R77's receiving the Ativan. Review of R77's Pharmacist Drug Regimen Review forms dated 3/25/13, 2/21/13, and 12/18/13, revealed a lack of documentation related to the facility's lack of identification and implementation of non-pharmacological interventions to be used by staff prior to the	F 428	medications. The inservice to include documentation and care planning of non-pharmacologic interventions to use prior to use of as needed psychotropic medications and appropriate indication for use of these medications. All care plans and physician orders for residents receiving as needed psychotropic medications will be audited to ensure appropriate indication for use and non-pharmacologic interventions per facility policy and federal regulations. CRMC□s Pharmacy Consultant was notified of this requirement not being met and will assist in monthly audits to ensure continued compliance. The DON or designee will complete Quarterly audits for 6 months and then, if practice is not corrected, continue until compliance is met to ensure continued compliance. Results of these audits will be reported at the facilities QAPI meetings. Completion date: 4-25-2014	

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 _____	03/27/2014

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
F 428	Continued From page 36 administration of anti-anxiety medications. On 3/27/14, at 1:30 p.m. LPN-A stated she thought the PRN Ativan would be used before R77 had his upcoming MRI. At this time the surveyor and LPN-A reviewed R77's Ativan PRN usage. LPN-A stated she did not know what symptoms R77 was experiencing when the PRN Ativan was administered. At 1:55 p.m. RN-A verified R77's anxiety diagnosis, symptoms and non pharmacological interventions to be attempted prior to the administration of the medication was not identified nor addressed on R77's POC. RN-A confirmed staff were to attempt non pharmacological interventions prior to the administration of the Ativan. RN-A stated R77's symptoms of his anxiety should have been identified and documented when the PRN medication was administered. In addition, RN-A confirmed the pharmacist had not identified any concerns related to the use of non pharmacological interventions prior to the administration of the Ativan. A facility policy was requested, however, no policy on anti-anxiety medication was provided.	F 428		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.	F 463		4/25/14

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 _____	03/27/2014

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
F 463	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain and ensure a functioning call system for 2 of 40 residents (R8 and R173) observed with call lights that did not function correctly. Findings include: On 3/24/14, at 7:36 p.m. the call lights for R8 and R173 were checked and found to light up on the wall unit inside the room, however, the light did not display outside the room, nor did an alarm sound to alert staff. R8's quarterly Minimum Data Set (MDS) dated 12/31/13, identified R8 had severe cognitive impairment. The MDS further identified R8 required extensive assistance of two plus persons with bed mobility, transfers and toilet use and extensive assistance of one person for eating, dressing and personal hygiene. R173's admission MDS dated 1/8/14, indicated R173 had severe cognitive impairment and required supervision and physical assistance of one person for transfers and set up assistance for dressing, eating, toilet use and personal hygiene. On 3/24/14, at 7:43 p.m. licensed practical nurse (LPN)-E confirmed both call lights did not display outside the room. LPN-E stated both R8 and R173 used their call lights when needing	F 463	F463 Call Lights CRMC strives to ensure to maintain and ensure a functioning call system. CRMC's Master Electrician checked every individual call light to ensure proper light bulbs and connections. During this process it was noted that there was one improper light bulb that wouldn't allow the proper amperage to pass through it, causing the system not to indicate the light at the nurses station. Light bulbs for the East Care Center call system are different than the bulbs for the West Care Center Call system. Upon completion, the electrician separated the call light bulbs and labeled the specific containers for each area to ensure this would not happen in the future. The Facilities Director educated the Facilities staff on proper light bulb installation in the Care Center on 4-15-2014. The Facilities Director or designee will audit the containers monthly for four months to ensure the light bulbs are in the proper containers. The call light system is on a quarterly preventative maintenance program monitored through the Facility Dude computer program. Completion date: 4-25-2014	

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 _____	03/27/2014

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
F 463	Continued From page 38 assistance to get up, use the bathroom or for other needs as requested. On 3/24/14, at 8:00 p.m. LPN-E stated the call light bulbs had been replaced by the maintenance staff. On 3/25/14, at 8:57 a.m. R8 and R173's call lights were rechecked and again found to light on the wall unit inside the room, but the light did not display outside the room, nor did an alarm sound to alert staff. On 3/25/14, at 9:01 a.m. R173 stated he did use his call light when needing assistance. On 3/25/14, at 11:07 a.m. the facilities director (FD) stated the procedure for requesting repair of equipment was to enter a work order into the facility's computer system. The FD confirmed a work order for R8 and R173's call lights had been placed on 3/24/14. On 3/25/14, at 11:17 a.m. electrician (E) stated he was called in on 3/24/14, at approximately 7:30 p.m. to repair malfunctioning call lights for R8 and R173. E stated he replaced the bulb outside of the room and the call lights were both functioning at that time. He further stated he rechecked the call lights at approximately 9:10 a.m. on 3/25/14, and found them to be malfunctioning again. E indicated he replaced the bulb a second time, as he believed he originally used the incorrect bulb. E demonstrated the call light was functioning.	F 463		

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 _____	03/27/2014

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
F 463	Continued From page 39 On 3/27/14, at 3:25 p.m. E stated he had worked with the facility for five years and did not recall ever doing periodic checks of residents' call lights or any specific maintenance to check call light functionality. He stated he did not know when or if R8 or R173's call lights had ever been checked. The Call Light System procedure dated 1/13/11, directed staff; "if call system is defective, report immediately to maintenance".	F 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. BUILDING **01 - NURSING HOME** B. WING _____	**03/18/2014**

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
K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Cuyuna Regional Medical Center C&NC 01 Main Building was found 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. Cuyuna Regional Medical Center C&NC is a 1-story building with a basement. The original building was constructed in 1962, attached to a hospital, separated with a 2-hour fire rated barrier and was determined to be of Type II (000) construction. The major addition was constructed east of the existing building in 1982, was determined to be of Type II (000) construction with additions to the main entrance area (dining room) and south wing (dayroom) in 1996 of Type II (111) construction. In 2007 a 10 feet by 30 feet dayroom addition was constructed to the north west wing, was determined to be Type II (111) construction and separated with a 2-hour fire barrier. The building is divided into 7 smoke compartments by 30 minute and 2- hour fire barriers. The entire building is protected with a complete automatic fire sprinkler system installed in 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. BUILDING **01 - NURSING HOME** B. WING _____	**03/18/2014**

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

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

F5232023

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 _____	**03/18/2014**

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

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

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 _____	**03/18/2014**

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