Electronically delivered
May 13, 2019

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

RE: Project Number H5232029C

Dear Administrator:

On May 1, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Departments of Health, to investigate complaint number H5232029C. In addition 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. The following complaint number H5232029C was found to be substantiated.

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is June 10, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- 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 (488.456(b)).

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by August 1, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 1, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. BUILDING _____ B. WING _____	C 05/01/2019

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 On 4/30/19 - 5/1/19, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5232029C. Deficiency issued at F609 & F610. 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		6/3/19

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

Electronically Signed | 05/20/2019

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

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F 609	Continued From page 1 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of abuse was reported immediately to the State agency for 2 of 3 abuse allegations which involved 2 of 2 residents (R1, R4) reviewed for allegations of rough handling by a staff member. Findings include: R1's progress note dated 3/2/19 at 1:51 p.m. indicated staff reported R1 had complained a staff member was rushing her in the morning when getting her up for the day and R1 was upset about this. R1 stated the staff member was rough putting on her stockings. Registered nurse (RN)-B noted she would talk with the nursing assistant to address the issue. On 4/30/19 at 2:44 p.m. registered nurse (RN)-A	F 609	Cuyuna Medical Regional Center strives to provide a safe living environment for all residents of the facility, ensuring all residents will be protected from abuse, neglect, exploitation and maltreatment. All allegations of abuse, neglect, exploitation and maltreatment will be reported within 2 hours if allegation involves abuse or results in serious bodily harm; and no later than 24 hours if allegation does not involve abuse or result in bodily harm. The facility policy for Abuse Prevention was reviewed by the Director of Nursing and Director of Social Service on May 10, 2019 and remains appropriate. If an employee is identified as alleged perpetrator of abuse, neglect, exploitation	

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F 609	Continued From page 2 stated she was not aware of the 3/2/19 incident. - At 3:28 p.m. The director of nursing (DON stated they were not aware of the 3/2/19, incident identified in the progress note until the surveyor brought it to their attention. The DON contacted RN-B, the author of the 3/2/19, progress note and RN-B confirmed the incident and identified nursing assistant (NA)-A as having been involved. RN-B stated she had talked with NA-A at the time of the incident, but did not report the incident any further. Review of NA-A's performance report dated 12/7/18, revealed staff complaints of NA-A swearing in resident rooms and being rough with residents. The report indicated NA-A acknowledged he got frustrated at times and at times forgot his own strength which could appear as being rough when he was assisting residents. On 4/30/19 at 2:44 p.m. RN-A indicated the NA-A's performance report dated 12/7/18, was in response to complaints from staff regarding the care provided to R4 by by NA-A. RN-A could not remember if the reports had been reported however, stated she would expect it to have been reported, as required. Review of facility incident reports between 12/5/18, through 12/11/18, lacked any evidence the allegations of potential abuse identified NA-A's performance report had been reported or investigated by the facility to ensure it's residents were free from abuse. - At 3:28 p.m. DON-A stated the incident on 12/7/18, regarding R4 was not reported because they had not observed any bruising or injury to	F 609	or maltreatment through reporting chain, the employee will be immediately placed on leave. Reports of abuse, neglect, exploitation or maltreatment will be reported immediately to the Administrator and within 2 hours to OHFC. An Abuse Prevention/Vulnerable Adult Reporting Checklist was developed on May 21, 2019 to assist in identifying steps required for reporting concerns of abuse. A Vulnerable Adult incident report template was added to the facility's risk management system on May 21, 2019. Licensed nurses will receive training on use of new Abuse Prevention/Vulnerable Adult Reporting Checklist and the Vulnerable Adult incident template in risk management at the team meetings on May 28, May 30 and May 31, 2019. The Abuse Prevention/Vulnerable Adult Checklist includes a line item that all allegations of abuse will be reported immediately to the Administrator and within 2 hours to OHFC. The care plan for R1 and R4 was reviewed by the interdisciplinary team on May 20, 2019 and remains appropriate including level of nursing care and support required to meet each residents' individualized needs. Mandatory Vulnerable Adult training for all Care Center staff will be provided by the Director of Nursing and the Director of	

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F 609	Continued From page 3 R4. The DON-A verified there was no documentation of an incident in the R4's medical record. On 5/1/19 at 9:00 a.m. family member (FM)-B stated she visited her mother frequently at the facility and had heard NA-A could get rough with the residents. FM-B stated he/she had received a call a little while ago about NA-A lifting on my mom's arms, pulling on her and seating her on the toilet roughly. FM-B stated she had never personally witnessed rough treatment from the staff. Review of the facility's Abuse and Prevention Plan indicated all residents residing in the facility would be protected from maltreatment and abuse. The plan indicated suspected maltreatment would be reported to the State agency no later than two hours after the allegation was made if the allegation involved abuse or injury. The plan also indicated all staff were required to report to their immediate supervisor suspected maltreatment of a vulnerable adult at the time of the suspicion.	F 609	Social Services at staff meetings scheduled on May 28, May 30, and May 31, 2019. Training content will include review of the definitions of abuse, neglect, exploitation and maltreatment; how to protect residents when abuse is suspected, who to report concerns to and need for immediate reporting to the facility's Administrator and Director of Nursing. Huddles on vulnerable adult reporting requirements will be conducted with Nursing, Environmental Services, Culinary, Activities and Plant Operations teams the week of May 21- May 28, 2019. Nursing competencies for NAR, LPN, and RN were updated on May 20, 2019 to include definitions of abuse, neglect, exploitation, maltreatment and reporting requirements. Residents and/or resident representatives will also be asked specific questions regarding safe and appropriate care delivery during each care conference to ensure safe and appropriate care delivery. Social worker will conduct six-seven resident interviews weekly (10% of population) for next 4 weeks with specific questions focused on resident satisfaction with care, respect and dignity. Any concerns identified during interview process will be brought to the attention of the facility's Administrator and Director of Nursing for further investigation.	

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F 609	Continued From page 4	F 609	All vulnerable adult reports and results of resident interviews will be reviewed by the facility's Quality Assurance Committee Quarterly for further action.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were thoroughly investigated for 2 of 2 residents (R1, R4) whose allegations were reviewed. Findings include: R1's progress note dated 3/2/19 at 1:51 p.m. indicated staff reported R1 had complained a staff member was rushing her in the morning when getting her up for the day and R1 was upset	F 610	Cuyuna Regional Medical Center strives to provide a safe living environment for all residents of the facility, ensuring all residents will be protected from abuse, neglect, exploitation and maltreatment. All allegations of abuse, neglect, exploitation and maltreatment will be reported and thoroughly investigated by the facility's interdisciplinary team to ensure resident's safety is maintained.	6/3/19

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F 610	Continued From page 5 about this. R1 stated the staff member was rough putting on her stockings. Registered nurse (RN)-B noted she would talk with the nursing assistant to address the issue. On 4/30/19 at 2:44 p.m. registered nurse (RN)-A stated she was not aware of the 3/2/19 incident. - At 3:28 p.m. The director of nursing (DON) stated they were not aware of the 3/2/19, incident identified in the progress note until the surveyor brought it to their attention. The DON contacted RN-B, the author of the 3/2/19, progress note and RN-B confirmed the incident and identified nursing assistant (NA)-A as having been involved. RN-B stated she had talked with NA-A at the time of the incident, but had not conducted a thorough investigation of the incident. Review of NA-A's performance report dated 12/7/18, revealed staff complaints of NA-A swearing in resident rooms and being rough with residents. The report indicated NA-A acknowledged he got frustrated at times and at times forgot his own strength which could appear as being rough when he was assisting residents. On 4/30/19 at 2:44 p.m. RN-A indicated the NA-A's performance report dated 12/7/18, was in response to complaints from staff regarding the care provided to R4 by by NA-A. RN-A could not remember if the reports had been investigated or not. Review of facility incident reports between 12/5/18, through 12/11/18, lacked any evidence the allegations of potential abuse identified in NA-A's performance report had been investigated by the facility to ensure it's residents were free	F 610	The Director of Nursing and Director of Social Services are responsible for leading investigation efforts under the guidance of the facility's Administrator. Facility investigation of potential abuse, neglect exploitation or maltreatment will include resident interview(s) when applicable, observation, staff interviews, other interviews of witnesses as appropriate, review of the resident's care plan, resident representative notification, and review of facility policies and procedures. If an employee is identified as alleged perpetrator of abuse, neglect, exploitation or maltreatment through reporting chain, the employee will be immediately placed on leave. Any allegations of abuse, neglect, exploitation or maltreatment will be reported to OHFC within 2 hours. On May 2, 2019, The Director of Social Services and RN, LTC Nurse Manager met with NA-A to review initial concerns identified during survey on May 1, 2019. Standards for safe resident care were reinforced, including the need to explain tasks, move slowly, and use appropriate language in resident areas. NA-A completed dementia care training on April 9, 2019. The facility policy for Abuse Prevention was reviewed by the Director of Nursing and Director of Social Service on May 10, 2019 and remains appropriate.	

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F 610	Continued From page 6 from abuse. - At 3:28 p.m. the DON stated the incident on 12/7/18, regarding R4 was not investigated because they had not observed any bruising or injury to R4. The DON verified there was no documentation of an incident in the R4's medical record. The facility's Abuse Prevention Plan indicated the facility would investigate all incidents/allegations after they have been reported, as required. The investigation would include resident interview, observation, assessment, staff interviews, review of the resident's plan of care and facility policy and procedures. The plan further directed staff to report any incidents or unusual resident occurrences in the electronic reporting system and report any potential vulnerable adult situations immediately to the administrator or DON for follow up.	F 610	The care plan for R1 and R4 was reviewed by the interdisciplinary team on May 20, 2019 and remains appropriate including level of nursing care and support required to meet each resident's individualized needs. On May 21 and May 23, 2019, residents on the Woodview and Parkview units were interviewed by the Social Worker regarding any concern with care provided by NA-A. Residents were also interviewed regarding concerns of rough care from any other employees. No concerns were identified by residents regarding care received by NA-A or other employees. Mandatory Vulnerable Adult training for all Care Center staff will be provided by the Director of Nursing and the Director of Social Services at staff meetings scheduled on May 28, May 30, and May 31, 2019. Training content will include review of the definitions of abuse, neglect, exploitation and maltreatment; how to protect residents when abuse is suspected, who to report concerns to and need for immediate reporting to the facility's Administrator and Director of Nursing. Huddles on vulnerable adult reporting requirements will be conducted with Nursing, Environmental Services, Culinary, Activities and Plant Operations teams the week of May 21- May 28, 2019. Nursing competencies for NAR, LPN, and	

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F 610	Continued From page 7	F 610	RN were updated on May 20, 2019 to include definitions of abuse, neglect, exploitation, maltreatment and reporting requirements. Residents and/or resident representatives will also be asked specific questions regarding safe and appropriate care delivery during each care conference to ensure safe and appropriate care delivery. Social worker will conduct six-seven resident interviews weekly (10% of population) for next 4 weeks with specific questions focused on resident satisfaction with care, respect and dignity. Any concerns identified during interview process will be brought to the attention of the facility's Administrator and Director of Nursing for follow up and will be reported to OHFC within 2 hours if abuse is suspected. All vulnerable adult reports, including investigative findings, will be reviewed by the facility's Interdisciplinary Team for further action and will be reviewed quarterly by the facility's Quality Assurance Committee.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 13, 2019

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

Re: State Nursing Home Licensing Orders - Complaint Number H5232029C

Dear Administrator:

A complaint investigation was completed on May 1, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all licensing orders are corrected, the form should be signed and returned electronically to:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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

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

Sincerely,

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

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00091	A. BUILDING: _____ B. WING _____	C 05/01/2019

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/30/19 & 5/1/19, an abbreviated survey was conducted to determine compliance of state licensure. Your facility was found to be in compliance with the MN state licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 substantiated: H5232029C was substantiated with no licensing orders issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		