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

Electronically delivered
September 28, 2020

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

RE: CCN: 245232
Cycle Start Date: July 21, 2020

Dear Administrator:

On August 3, 2020, we notified you a remedy was imposed. On August 27, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 21, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 24, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 3, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 24, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 21, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

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

Electronically delivered
August 3, 2020

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

RE: CCN: 245232
Cycle Start Date: July 21, 2020

Dear Administrator:

On July 21, 2020, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

This survey also found deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 24, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 24, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effectiveAugust 24, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is

your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION (Delete this section if SQC tags are cited and this note)

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 24, 2020., the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Cuyuna Regional Medical Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 24, 2020.. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.
However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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, Unit Supervisor
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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 January 21, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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.

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 07/21/2020

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 7/20/20 to 7/21/20, an abbreviated standard survey was completed by surveyors of this Department's staff to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. Complaint H5232047C was substantiated at F689 at past non-compliance. Although the provider had implemented corrective action prior to survey, harm was sustained prior to the correction. The following complaint was found to be unsubstantiated: H5232042C However, as a result of the investigation a deficiency was identified at F609. 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. No plan of correction is required for a finding of past non-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	Past noncompliance: no plan of correction required.	

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

Electronically Signed — 08/06/2020

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 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of abuse to the State agency (SA)within the required two hour time frame for 1 of 3 residents (R2) reviewed. Findings include:	F 609	Cuyuna Medical Regional Center strives to provide a safe living environment for all residents of the facility, ensuring all residents will be protected from abuse, neglect, exploitation and maltreatment. Any allegation of abuse, neglect, exploitation and maltreatment will be	8/21/20

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F 609 Continued From page 2

R2's Entry Tracking Record Minimum Data Set (MDS) indicated he admitted to the facility on 6/26/20. R2's care plan dated 7/13/20, identified an alteration in independence related to activities of daily living. The care plan indicated R2's level of assistance fluctuated depending on his mood, behavior and willingness to participate in care. The care plan indicated R2 was at risk for feelings of paranoia/suspicious behavior related to like experiences. R2's Individualized Resident Care Plan ("closet care plan") indicated on 7/7/20, female caregivers only for cares and medication pass.

R2's facility Progress Note dated 7/6/20, indicated R2 "continued" to report that a male staff on the overnight shift was mistreating him and that he feared for his life and feared retaliation.

On 7/21/20, at 11:37 a.m. R2 was observed lying in bed. When asked about the incident with the male staff member, R2 stated, "the nurse manager and I have handled it now, things are better, but I am glad you came."

On 7/21/20, at 12:22 p.m. the director of nursing (DON) stated when R2 reported the allegation regarding the male staff member, he had been talking about a guy on the night shift and then R2 said it was another nursing assistant (NA). The DON stated they did not report the allegation to the SA immediately because they thought R2 just wanted to get out of the facility. However, the next day, the interdisciplinary team discussed the allegation and determined it should have been reported to the SA immediately, as required.

The facility's Abuse Prevention Plan policy dated 2/13/20, indicated all allegations of abuse shall be

F 609

reported within 2 hours to the state agency, if allegation involves abuse or results in serious bodily harm; and no later than 24 hours if allegation does not involve abuse or result in bodily harm.

The facility policy for Abuse Prevention was reviewed by the Director of Nursing and the facility Administrator on August 5, 2020 and remains appropriate.

The Abuse Prevention/Vulnerable Adult Reporting Checklist was updated on August 5, 2020 to include the website link for reporting allegations to the state agency within 2 hours, if involving abuse or bodily harm.

The care plan for R2 was reviewed on August 6, 2020 by the interdisciplinary team and remains appropriate, including level of nursing care and support needed to meet the resident's individualized needs.

Care Center RNs were added as facility reporters on the MDH OHFC reporting site on July 31, 2020. An icon for the link to the website to the state agency for vulnerable adult reporting was added as a shortcut on Care Center desktops.

Reports of abuse, neglect, exploitation or maltreatment will be reported immediately to the Administrator or designee and within 2 hours to OHFC.

Care Center RNs received training on timely reporting, including how to file initial

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F 609	Continued From page 3 reported to the SA immediately, defined as no later than two hours after the allegation was made.	F 609	vulnerable adult reports to the state agency on MDH OHFC website within 2 hours, if the allegation involves abuse or significant bodily harm. Training on reporting was conducted on August 5, 2020 and August 6, 2020 with additional session scheduled for August 17, 2020. Mandatory Vulnerable Adult training will be conducted for Care Center nursing team from August 10 through August 21, 2020 in team huddles. 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. Random audits will be conducted to assess staff's knowledge of definitions of abuse and timely reporting requirements weekly x 4 weeks or until compliance is achieved. Audits will vary to cover all shifts. Social worker will conduct five-six resident interviews weekly for next 4 weeks with specific questions focused on resident satisfaction with care. Any concerns identified during interview process will be brought to the attention of the facility's Administrator and Director of Nursing for further investigation. All vulnerable adult reports and results of resident interviews will be reviewed by the facility's Quality Assurance Committee for	

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F 609	Continued From page 4	F 609	further action.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement fall interventions and equipment guidelines for 1 of 1 resident (R3) reviewed for falls. This failure resulted in actual harm to R3 who fell from her recliner after it had been identified as malfunctioning which was not reported, and incorrectly using the recliner's control buttons resulting in the fall and R3 subsequently sustaining a hematoma to her forehead resulting in a visit to the emergency department (ED). Although noncompliance was present at the time of the events, the facility had implemented appropriate corrective action prior to the survey, resulting in a finding of past-noncompliance for R3. Findings include: R3's significant change Minimum Data Set (MDS) dated 5/19/19, indicated she was moderately cognitively impaired and required extensive assistance from two staff for bed mobility, transfers and toileting. The MDS also indicated R3 had one fall since the previous assessment	F 689	Past noncompliance: no plan of correction required.	8/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 5	F 689		

that did not result in injury. R3's Falls Care Area Assessment (CAA) dated 5/19/20, indicated on 4/5/20, staff had entered her room and found her supine on the floor in front of her recliner chair. Staff to place recliner remote (adjusts movement/position) out of reach on right side of recliner.

R3's Closet Care Plan titled Fall Interventions indicated on 4/6/20, "per resident and daughter request, clip recliner remote to upper right side of recliner out of residents reach."

R3's care plan revised 7/20/20, identified a self care deficit related to cognitive impairment and impaired mobility. The care plan identified a risk for falls related to a history of falls, impaired cognition, impaired balance and incontinence. The care plan directed staff to place call light and commonly used items within reach and indicated R3's recliner chair was removed on 7/15/20, because it was broken.

On 7/20/20, at 1:29 p.m. R3 was observed in bed with her eyes closed. R3's forehead was noted to have a large blue/black bruise on it.

On 7/21/20, at 8:24 a.m. R3 was observed in bed. The right side of R3's face was bruised and was black/green in color.

A review of R3's facility incident reports and correlating Progress Notes dated April 2020 to July 2020, indicated the following:

Progress Note (PN) dated 4/5/20, at 8:50 p.m. indicated staff entered R3's room and found her laying supine on the floor in front of her recliner chair with fall mat partially under her. R3 indicated

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F 689	Continued From page 6	F 689		

she was trying to sit up and had pushed the wrong button on the remote. Incident report indicated a wider fall mat was provided with non-skid strips underneath and indicated recliner remote placement to be discussed with daughter that day.

PN dated 7/14/20, 6:34 p.m. indicated staff entered R3's room and found her laying on the floor on her right side with her "face to the floor." Recliner was in its highest position, and remote for recliner was hanging down from chair on the floor. R3 was calling out for help. Large hematoma noted to right side of forehead extending into her hair line. Hematoma was blue/purple in color with an opening measuring 0.5 centimeters (cm) x 0.5 cm. Open area was bleeding. R3 was noted to be slurring her words and was confused as to location and situation. R3 was transferred to the ED per provider order.

PN dated 7/14/20, 9:51 p.m. indicated R3 was tired, confused and complained of pain to head and neck. Pressure bandage remained in place from hospital.

PN dated 7/15/20, indicated writer spoke with R3's daughter to update her on condition. R3 was complaining of pain to head and right shoulder.

An incident report dated 7/14/20, indicated the interdisciplinary team reviewed on 7/15/20. The report indicated investigation initiated as to whether care plan of keeping recliner remote out of reach was followed. The report indicated R3's recliner chair had been removed from her room as nursing assistant (NA)-A reported it had not been working at the time of the fall and indicated the leg rest would not go up. The report indicated

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F 689	Continued From page 7	F 689		

R3's remote was behind her back when the NA left the room to report the broken chair and R3 had fallen after NA-A left the room.

An untitled facility document dated 7/16/20, indicated NA-A removed R3's meal tray after dinner and attempted to elevate the legs of the recliner chair, however, NA-A indicated the recliner was not working correctly. The document indicated NA-A went to find the nurse to report the chair, but did not immediately find the nurse and went to help another resident. When NA-A finished with the other resident, R3 was found on the floor. NA-A further reported not being sure where the recliner remote had been left and indicated it may have been left along side R3 in the chair. NA-A reported being aware that the remote was to be kept out of R3's reach when seated in the recliner.

On 7/21/20 at 11:19 a.m. R3 was observed seated in a recliner in her room. When asked how she obtained the bruises on her face, R3 stated she had fallen but was not sure how it happened.

At 12:36 p.m. the director of nursing (DON) stated at the time of R3's fall, she had been seated in her recliner chair having just finished the supper meal. The DON stated after the meal, R3's chair would not recline. The DON stated when interviewed, NA-A stated she had tried to find a nurse to report the broken chair but was unable to find the nurse. The DON stated she told NA-A broken equipment needed to be removed from use, but stated that was not what caused the fall. Rather, the DON stated R3's fall occurred because R3 was able to get hold of the recliner remote and did not know how to use it. The DON stated had the been positioned where it was

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	245232	A. BUILDING ______ B. WING ______	C 07/21/2020

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 689	Continued From page 8	F 689		

supposed to be, she did not think R3 would have been able to access it, raise the chair and fall.

The facility's Care Center Fall Prevention policy dated 21/20/17, indicated a fall care plan was to be placed in each residents closet and all staff were responsible to follow resident specific fall interventions identified.

The facility's Equipment Related Incidents policy dated 12/21/17, indicated any employee who became aware of any information that suggested medical equipment malfunction may cause, if malfunction were to reoccur: death, serious injury or adverse experience was required to report the event immediately.

The past non-compliance that began on 7/16/20, was verified during an on-site visit 7/20/20 - 7/21/20. The past non-compliance was reviewed to be corrected by 7/16/20, after the facility implemented the following action plan:

- Education provided to NA-A regarding following the pan of care.
- Policy and procedures related to equipment reviewed and education provided.
- R3's recliner chair was removed and replaced with a facility chair until R3's chair was fixed.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 3, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: QROP11

Dear Administrator:

The above facility was surveyed on July 20, 2020 through July 21, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Lyla Burkman, Unit Supervisor
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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 07/21/2020

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2 000	Initial Comments	2 000		

*****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 7/20/20 - 7/21/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found not to be in compliance with the MN State Licensure.

The following complaint found to be UNSUBSTANTIATED: H5232042C.

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2 000	Continued From page 1 However, as a result of the investigation a deficiency was identified at F609. The following complaint was found to SUBSTANTIATED: H5232047C, however, no deficiency was cited. 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		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).	21980		8/21/20

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21980	Continued From page 2 (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of abuse to the State agency (SA)within the required two hour time frame for 1 of 3 residents (R2) reviewed. Findings include: R2's Entry Tracking Record Minimum Data Set (MDS) indicated he admitted to the facility on	21980	Corrected	

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21980	Continued From page 3 6/26/20. R2's care plan dated 7/13/20, identified an alteration in independence related to activities of daily living. The care plan indicated R2's level of assistance fluctuated depending on his mood, behavior and willingness to participate in care. The care plan indicated R2 was at risk for feelings of paranoia/suspicious behavior related to like experiences. R2's Individualized Resident Care Plan ("closet care plan") indicated on 7/7/20, female caregivers only for cares and medication pass. R2's facility Progress Note dated 7/6/20, indicated R2 "continued" to report that a male staff on the overnight shift was mistreating him and that he feared for his life and feared retaliation. On 7/21/20, at 11:37 a.m. R2 was observed lying in bed. When asked about the incident with the male staff member, R2 stated, "the nurse manager and I have handled it now, things are better, but I am glad you came." On 7/21/20, at 12:22 p.m. the director of nursing (DON) stated when R2 reported the allegation regarding the male staff member, he had been talking about a guy on the night shift and then R2 said it was another nursing assistant (NA). The DON stated they did not report the allegation to the SA immediately because they thought R2 just wanted to get out of the facility. However, the next day, the interdisciplinary team discussed the allegation and determined it should have been reported to the SA immediately, as required. The facility's Abuse Prevention Plan policy dated 2/13/20, indicated all allegations of abuse shall be reported to the SA immediately, defined as no later than two hours after the allegation was made.	21980		

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21980	Continued From page 4 SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and/or designee could review policy and provide education for staff regarding the timing requirements of reporting of abuse allegations. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		