Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 15, 2024

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

RE: CCN: 245232
Cycle Start Date: August 7, 2024

Dear Administrator:

On August 7, 2024, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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 an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 November 7, 2024 (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 February 7, 2025 (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.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 ______	08/07/2024

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
E 000	Initial Comments On 8/5/24 - 8/7/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was not in compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
F 000	INITIAL COMMENTS On 8/5/24 - 8/7/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was not in compliance. 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/23/2024

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 000	Continued From page 1 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to perform ongoing monitoring and wound care, as ordered, for a chronic reoccurring wound for 1 of 2 residents (R34) reviewed for wound care. Findings include: R34's quarterly Minimum Data Set (MDS) dated 7/1/24, identified R34 had diagnoses that included peripheral vascular disease (PVD) (a slow and progressive disorder of the blood vessels. PVD may affect any blood vessel outside of the heart. This includes the arteries, veins, or lymphatic vessels. Organs supplied by these vessels, such as the brain or legs, may not get enough blood flow for healthy function. The legs and feet are most often affected), high blood pressure, and coronary artery disease. R34 had one unhealed venous or arterial ulcer (a full-thickness defect of skin, most frequently in	F 684	Cuyuna Regional Medical Center strives to ensure residents receive treatment and care in accordance with professional standards of practice, using a person-centered approach. The procedure for Wound and Skin Care Protocols was revised by the Director of Nursing on August 19, 2024. Revisions to the procedure included need for weekly documentation of the wound condition, including description and wound measurements. R34s primary physician evaluated the wound on August 7, 2024, with referral for WOCN follow up. R34s care plan was updated on August 19, 2024, to reflect a chronic left ankle wound with need for daily wound care and weekly wound measurements. Treatment	9/4/24

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F 684 Continued From page 2

the ankle region, that fails to heal spontaneously and is sustained by chronic venous disease, based on venous duplex ultrasound testing).

R34's care plan revised 7/3/24, identified R34 had a potential alteration in skin integrity related to risk factors associated with limited mobility and recent right below the knee amputation for ischemic limb, peripheral arterial disease to bilateral lower extremities and poor appetite. Interventions included:
- Perform a skin assessment weekly
- Wound care nurse (WCN) assessed left lateral ankle venous ulcer. Staff were directed to paint left ankle vascular wound with betadine and apply foam border dressing for protection.

R34's physician orders dated 6/18/24, identified the following:
Wound care: apply to left lateral ankle topically one time a day for left ankle vascular wound. Paint daily with betadine, cover with foam border for protection. Offload at all times while in bed with pillow under calf.

R34's Skin/Comfort note dated 7/16/24 at 10:50 a.m., identified R34 was seen on wound rounds to follow up on vascular wound to left lateral malleolus (a bony projection with a shape likened to a hammer head, especially each of those on either side of the ankle). No drainage was noted on the old dressing. Wound measured 1.0 x 0.6 centimeters (cm). Thin, dry scab noted. Surrounding tissue blanchable erythema/redness. Foot had a purple hue while dependent. Will continue to paint scab with betadine and cover with foam border adhesive dressing for protection. R34 would be seen on wound rounds monthly.

F 684

administration record (TAR) was set up on August 20, 2024, for weekly wound measurements on bath day.

On August 20, 2024, treatment was set up in TAR for all residents with chronic wounds, with prompt for nurse to document progress note, with wound description and measurements weekly.

Nurses will be educated on the facility’s revised procedure for Wound and Skin Protocols during team huddles the week of August 26- September 1, 2024. Education will include procedure for documenting wound description, including measurements, at a minimum of weekly, in the resident’s clinical record. Nurses not in attendance during team huddles, will be required to complete follow up education by September 3, 2024.

Wound audits will be conducted weekly for six weeks by the Director of Nursing or designee, to ensure wound documentation, including measurements has been completed at least weekly. If compliance is achieved, audits will be changed to monthly.

Results of audits will be reviewed during the Facility’s quarterly QAPI committee meeting for further recommendations.

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Continued From page 3

R34's Skin Observation dated 7/27/24 at 9:20 a.m., identified R34's skin integrity; however, the note failed to identify R34's left lateral ankle wound and its condition.

R34's Electronic Treatment Administration Record (ETAR) dated 7/16/24- 8/7/24, identified R34 received wound care daily. Additionally, on 8/6/24, the ETAR identified RN-B signed off R34's left lateral ankle wound care as complete.

During an observation on 8/7/24 at 10:36 a.m., licensed practical nurse (LPN)-A applied gloves and removed a foam border dressing from R34's left outer ankle vascular wound. LPN-A stated there was a small amount of serosanguineous (a type of wound drainage, or exudate, secreted by an open wound in response to tissue) drainage on the dressing before throwing the dressing in the trash. LPN-A stated the vascular wound was open and there was "slough" (dead tissue within a wound) in the wound bed.LPN-A applied betadine to the wound bed and, once dried, applied a foam border dressing. LPN-A used a marker to date and initial the foam border dressing. LPN-A stated the dressing should have been changed on 8/6/24, but the dressing LPN-A removed was dated 8/5/24. R34 should have been assessed on 8/6/24 by the wound care WCN. LPN-A stated she did not know why R34 did not receive wound care on 8/6/24.

During an interview on 8/7/24 at 10:46 a.m., RN-A stated she was unaware R34 had an open wound. RN-A understood R34's wound was scabbed over and R34 was no longer followed during wound rounds.

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F 684	Continued From page 4 During an interview on 8/7/24 at 11:28 a.m., R34's physician stated R34 had a chronic vascular wound. Previous nursing reports identified the wound was scabbed over but had opened which was expected. R34's wound did not show signs/symptoms of infection but the WCN should evaluate R34. Staff wanted to care for the wound as best as possible to protect the leg because it was the only leg R34 had. During an interview on 8/7/24 at 12:55 p.m., the director of nursing (DON) stated RN-B did sign off R34's wound as complete on 8/6/24 and could only assume RN-B believed the WCN would change R34's dressing that day. Nursing staff were expected to follow wound care orders and document accurately. Additionally, nursing staff were expected to document a description of the wound at least weekly and/or if a change occurred. On 8/7/24 at 1:45 p.m., a phone interview with RN-B was attempted. The facilty policy Wound and Skin Care Protocols undated, identified wounds required weekly documentation at minimum and with changes in wound appearance/condition.	F 684		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		9/4/24

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F 812	Continued From page 5	F 812		

from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure a unit refrigerator maintained a safe temperature for storage of food. This had the potential to affect all residents who received food from unit refrigerator.

Findings include:

During observation on 8/7/24 at 11:06 a.m., the unit refrigerator contained milk, cheese, and yogurt. A regular thermometer was not in the unit refrigerator and a request was made to the culinary director log of temperatures for the month of August 2024.

During an interview on 8/7/24 at 2:12 p.m., the culinary director stated she did not know the range the unit refrigerator should be set at. When the unit refrigerator temperature was out of the set range of the automated monitoring system, an alert would be sent out to the culinary director, bio-med technician, and the executive director. The culinary director could not identify the temperature range or what temp she would

Cuyuna Regional Medical Center's Culinary team is dedicated to storing food consumed by residents in accordance with professional standards for food service safety.

On August 7, 2024, the unit fridge, used for storing items for easy access for resident use, was adjusted to 4.5 setting (colder) on the adjustable temperature inside the fridge. A portable thermometer was added for ease in spot checking the temperature of the fridge on August 8, 2024.

The milk, cheese and yogurt present in the fridge was removed and thrown by the Director of Nursing and the Facility Administrator on August 7, 2024.

The policy followed by the facility for Food Storage, from 2021 Becky Dorner and Associates was reviewed by the Culinary Director and the Director of Nursing on August 12, 2024.

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F 812

Continued From page 6
be notified at.

The History Detail Report for Skyview unit refrigerator dated 8/7/24, identified from 8/1/24 at 12:00 a.m. through 8/7/24 at 2:30 p.m. temperatures in the unit refrigerator were monitored every 15 minutes via an automated monitoring system. The report identified temperatures were at or above 41 degrees Fahrenheit (F) for the following times.
-8/1/24 at 12:00 a.m., through 8/4/24 at 3:15 a.m, (75 hours (hr), 15 minutes (m)
-8/4/24 at 5:45 a.m. through 8/4/24 at 7:45 a.m. (2 hr, 00 m)
-8/4/24 at 12:45 p.m. through 8/5/24 at 1:45 a.m. (13 hr, 00 m)
-8/5/247 at 2:15 a.m. through 8/7/24 at 2:30 p.m. (60 hr, 15 m)
The total time the unit refrigerator was out of range was 6 days, 6 hours, and 30 minutes of a total of 6 days, 14 hours, and 30 minutes.

During an interview on 8/7/24 at 2:19 p.m., the bio-med technician stated he was unaware of the temperature range the unit refrigerator was to be kept at nor did he know the temperature alert range the automated monitoring system had.

An email was received from the bio-med technician identifying the automated monitoring system was set to a range of 33.8 degrees F to 48.2 degrees F.

During an interview on 8/7/24 at 2:50 p.m., the director of nursing (DON) stated the unit refrigerator would be kept at a temperature below 41 degrees F to ensure safe storage temperature of food, so it does not spoil. If the food was spoiled, it could have caused illness in residents

F 812

The parameters outlined in the policy for time/temperature control (TCS) foods for food safety includes: All TCS foods should be maintained in refrigerators at a temperature between 35-39 degrees F' and not exceed 41'F.

The unit fridge is set up on the Versatrak, an electronic monitoring system, managed by Technical Life Support (Biomed). The range parameters of the Care Center unit fridge were adjusted in Versatrak to 35-39 degrees F, not to exceed 41'F on August 12, 2024. The Temp Track system is set to send an alert to the Director of Culinary, if the fridge is not within set parameters.

Culinary and nursing staff will be educated on the policy for safe food storage of TCS foods at a temperature between 35-39'F, not exceeding 41' F, during team huddles the week of August 26-Sept 1, 2024.

Culinary will conduct audits two times per day to monitor the unit fridge temperature, using the portable thermometer for two weeks. Versatrak daily reports will be reviewed by the Culinary Director (or designee) to ensure the fridge is maintaining 35-39 degrees F, not to exceed 41' F in 24-hour period. If the fridge temp remains within required parameters for two weeks, audit will be changed to weekly for four weeks.

If fridge temps are not able to be safely mainatined within required parameters of

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F 812	Continued From page 7 who received milk, cheese, or yogurt. Food should be stored according to the food storage policy. The facility's Food Storage policy dated 2021 identified time/temperature control for safety (TCS)foods must be maintained below 41 degrees F. Temperatures for refrigerators should be between 35-39 degrees F.	F 812	35-39' F, not exceeding 41 ', the fridge will be removed from service. Results of the audits will be reviewed during the facility's quarterly QAPI meeting for further recommendations.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		9/4/24

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F 880	Continued From page 8	F 880		

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:

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	245232	A. BUILDING ______ B. WING ______	08/07/2024

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 880	Continued From page 9	F 880		

Based on observation, interview and document review, the facility failed to implement enhanced barrier precautions (EBP) for 1 of 2 residents (R34) reviewed for chronic wounds.

Findings include:

R34's quarterly Minimum Data Set (MDS) dated 7/1/24, identified R34 had diagnoses that included peripheral vascular disease (PVD) (a slow and progressive disorder of the blood vessels. PVD may affect any blood vessel outside of the heart. This includes the arteries, veins, or lymphatic vessels. Organs supplied by these vessels, such as the brain or legs, may not get enough blood flow for healthy function. The legs and feet are most often affected), hypertension, and coronary artery disease. R34 had one unhealed venous or arterial ulcer (a full-thickness defect of skin, most frequently in the ankle region, that fails to heal spontaneously and is sustained by chronic venous disease, based on venous duplex ultrasound testing).

R34's care plan revised 7/3/24, identified R34 had a potential alteration in skin integrity related to risk factors associated with limited mobility and recent right below the knee amputation for ischemic limb, peripheral arterial disease to bilateral lower extremities and poor appetite. Interventions included: Perform a skin assessment weekly and wound care nurse (WCN) assessed left lateral ankle venous ulcer. Staff were directed to paint left ankle vascular wound with betadine and apply foam border dressing for protection.
The care plan failed to direct staff to implement or follow EBP during wound care.

Cuyuna Regional Medical Center has established an infection prevention and control program to provide a safe, sanitary, and comfortable environment for our residents and to help prevent the development and transmission of communicable disease and infection.

The procedure for Wound and Skin Care Protocols was revised by the Director of Nursing on August 19, 2024. Revisions to the procedure included need for implementation of Enhanced Barrier Precautions (EBP) for new and/ or chronic wounds.

The Enhanced Barrier Precautions Policy and Procedure was reviewed by the Director of Nursing and the Infection Preventionist on August 22, 2024. Policy does outline need to place residents with wounds that require dressing changes in EBP for duration of stay or until the wound is resolved.

On August 7, 2024, R34 was placed in Enhanced Barrier Precautions (EBP). R34’s care plan was updated to reflect need to wear gown and gloves when providing high-contact care (including wound care), due to open wound on left ankle.

Nursing staff will receive education on the revised procedure for Wound and Skin Protocols during team huddles the week of August 26- September 1, 2024. Education will include the need to implement and follow EBP with

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F 880	Continued From page 10 R34's physician orders dated 6/18/24, identified the following: Wound care: apply to left lateral ankle topically one time a day for left ankle vascular wound. Paint daily with betadine, cover with foam border for protection. Offload at all times while in bed with pillow under calf. The order did not direct staff regarding EBP for R34's chronic vascular wound. R34's Skin/Comfort note dated 7/16/24 at 10:50 a.m., identified R34 was seen on wound rounds that morning to follow up on vascular wound to left lateral malleolus (a bony projection with a shape likened to a hammer head, especially each of those on either side of the ankle). No drainage noted on old dressing. Wound measured 1.0 x 0.6 centimeters (cm). Thin, dry scab noted. Surrounding tissue blanchable erythema/redness. Foot had a purple hue while dependent. Will continue to paint scab with betadine and cover with foam border adhesive dressing for protection. R34 would be seen on wound rounds monthly. The note did not identify EBP for R34's chronic vascular wound. R34's Skin Observation dated 7/27/24 at 9:20 a.m., identified R34's skin integrity, however, the note failed to identify R34's left lateral ankle wound and its condition. R34's Electronic Treatment Administration Record (ETAR) dated 7/16/24 - 8/7/24, identified R34 received wound care daily. During an observation on 8/7/24 at 10:36 a.m., R34's door contained no signage regarding EBP nor was personal protective equipment (PPE) available for use. Licensed practical nurse	F 880	identification of a new wound. Nursing staff not in attendance during team huddles, will be required to complete follow up education by September 3, 2024. Audits will be conducted daily by the Infection Preventionist or designee for two weeks to ensure staff are following EBP (with use of gown and gloves) during high-contact cares for residents with EBP in place. Audits will also include review of resident(s) identified with new wound(s) to ensure EBP implementation. If compliance is achieved, EBP audits will be conducted weekly for four weeks, then bi-monthly until reviewed by QAPI committee for further recommendations. Results of EBP audits will be reviewed during the quarterly QAPI committee meeting for further recommendations.	

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F 880	Continued From page 11 (LPN)-A applied gloves and removed a foam border dressing from R34's left outer ankle vascular wound. LPN-A stated there was a small amount of serosanguineous (a type of wound drainage, or exudate, secreted by an open wound in response to tissue) drainage on the dressing before throwing the dressing in the trash. LPN-A stated the vascular wound was open and there was "slough" (dead tissue within a wound) in the wound bed. LPN-A removed her gloves, used hand sanitizer and applied clean gloves. LPN-A did not implement EBP nor applied a gown. LPN-A applied betadine to the wound bed and, once dried, applied a foam border dressing. LPN-A used a marker to date and initial the foam border dressing. LPN-A removed the soiled gloves, removed the trash, used hand sanitizer and left R34's room. LPN-A stated she did not know why R34 was not on EBP because R34 had an open chronic wound. During an interview on 8/7/24 at 10:46 a.m., RN-A stated she did not know why R34 was not on EBP. RN-A stated she would need to look into his wound and determine what it was. - At 11:01 a.m., RN-A stated she was unaware R34 had an open wound. The last she understood was R34's wound was scabbed over and R34 was no longer followed during wound rounds. RN-A had previously set up a group email that included herself, administration, the physicians, and nursing to ensure everyone was updated with changes and staff were expected to report changes in resident conditions timely. There was signage and supplies available and nursing was expected to implement EBP as soon as possible to prevent a potential for infection transmission in chronic wounds and should have done so.	F 880		

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F 880	Continued From page 12	F 880		
	During an interview on 8/7/24 at 11:28 a.m., R34's physician stated R34 had a chronic vascular wound. Previous nursing reports identified the wound was scabbed over, but had opened which was expected. Staff wanted to care for the wound as best as possible to protect the leg because it was the only leg R34 had.			
	During an interview on 8/7/24 at 11:31 a.m., the director of nursing (DON) stated staff were expected to implement EBP for chronic wounds until healed.			
	The facility's undated Care Center Enhanced Barrier Precautions Policy and Procedure policy, identified residents were at higher risk of becoming colonized and infection with Multidrug Resistant Organisms (MDROs) as the prevalence of MDROs was higher in this care setting. It was the policy of this facility to implement Enhanced Barrier Precautions, using PPE, as a preventative approach, to help reduce and prevent the transmission of MDROs. Enhanced Barrier Precautions involved gown and glove use during high-contact resident care activities such as wound care (any skin opening requiring a dressing).			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		9/4/24
	§483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and			

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F 883	Continued From page 13 potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		

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F 883 Continued From page 14

was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to provide and document the most recent Centers for Disease Control (CDC) education regarding the potential risks and benefits of the pneumococcal vaccine for 3 of 5 residents (R20, R39, R42) reviewed for immunizations.

Findings include:

R20's significant change Minimum Data Set (MDS) dated 7/11/24, identified R20 was 68 years old and had diagnoses that included diabetes mellitus, and hypertension.

R20's immunization record dated 8/7/24, identified R20 refused a pneumococcal conjugate (PCV20) vaccination.

R20's admission note dated 6/20/24 at 12:48 p.m., identified R20 declined when offered pneumonia vaccine. However, the admission note failed to identify what education, if any, education R20 received regarding pneumococcal vaccination.

R20's Care Center Pneumococcal Immunization Consent dated 6/20/24, identified R20's signed refusal of a pneumococcal vaccination. However, the document failed to identify which

F 883

Cuyuna Regional Medical Center strives to offer and provide our residents and/or their representatives education on the risks and benefits of immunizations, per CDC guidance, including the pneumococcal vaccinations. Procedures are in place to ensure pneumococcal vaccinations are offered to all eligible residents, including education on the benefits of vaccination and potential side effects.

R20 discharged from the facility on August 6, 2024.

R39’s representative was provided education on the Pneumococcal Conjugated Vaccine with Vaccine Information Statement (VIS) dated 5/12/23 on August 21, 24. R39’s representative declined the vaccination following receiving the VIS statement and education.

R42’s resident representative was provided education on the Pneumococcal Conjugated Vaccine with Vaccine Information Statement (VIS) dated 5/12/23 on August 23, 2034. R39’s representative declined the vaccination

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F 883	Continued From page 15 pneumococcal vaccine R20 was offered and/or what education was provided. During a phone interview on 8/7/24 at 10:52 a.m., family member (FM)-A stated R20 a pneumococcal vaccination when offered by the facility but could not recall what education, if any, R20 received. R39's admission MDS dated 5/28/24, identified R39 was 89 years old and had diagnoses that included coronary artery disease, hypertension, dementia and renal insufficiency. R39's immunization record dated 8/7/24, identified R39 refused a PCV20. R39's Care Center Pneumococcal Immunization Consent dated 5/23/24, identified R39's family representative signed refusal of a pneumococcal vaccination. However, the document failed to identify which pneumococcal vaccine R39 was offered and/or what education was provided. R39's nursing progress note dated 6/6/24, identified R39's family represenative was provided education regarding a respiratory syncytial virus (RSV) vacccine, however, did not identify if R39's family representative was provided education regarding pneumococcal vaccination. During a phone interview on 8/7/24 at 11:08 a.m., FM-B stated she believed vaccinations were discussed during R39's care conference but could not recall what education had been provided. R42's admission MDS dated 7/1/24, identified	F 883	following receiving the VIS and education. All resident pneumococcal consents were audited by the Quality Coordinator the week of August 19, 2024, to ensure any resident or representative that had decline the pneumococcal vaccination received education on benefits and potential side effects of the pneumococcal vaccine with VIS dated 5/12/23. Residents and/or their representatives identified as missing documentation for education on pneumococcal vaccinations will be provided the Pneumococcal Conjugated VIS dated 5/12/23 by September 3, 2024. The facility procedure titled Care Center Pneumococcal Immunizations for Residents was reviewed by the Director of Nursing and the Infection Preventionist on August 22, 20234. The consent form for pneumococcal vaccinations was revised, to include a prompt on the form for nurses to document the specific VIS and education provided to the resident and/or their representative, for making an informed decision for the pneumococcal vaccination. Education will be shared with nurses on the revisions to the Care Center Pneumococcal Immunization procedure, included revised pneumococcal consent form, through team huddles the week of August 26-September 1, 2024. Nurses not in attendance at team huddles will be required to complete follow up education by September 23, 2024.	

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F 883	Continued From page 16 R42 was 76 years old and had diagnoses that included hypertension, Diabetes Mellitus, and dementia. R42's immunization record dated 8/7/24, identified R42's family representative refused pneumococcal vaccination. R42's Care Center Pneumococcal Immunization Consent dated 6/24/24, identified R42's family representative signed refusal of a pneumococcal vaccination. However, the document failed to identify which pneumococcal vaccine R42 was offered and/or what education was provided. During a phone interview on 8/7/24 at 2:17 p.m., R42's family representative did not recall what education was provided regarding vaccinations. During an interview on 8/6/24 at 4:19 p.m., registered nurse (RN)-A stated she created a form for documentation of offering, education and acceptance/refusal of pneumococcal immunizations. However, RN-A stated nursing did not complete the forms as directed and RN-A could not confirm what education R20, R39 and R42 or their family representative had been provided. RN-A stated nursing staff were expected to fully complete the forms for documentation to ensure residents and their family representatives were fully and accurately informed. During an interview on 8/7/24 at 12:55 p.m., the director of nursing (DON) stated RN-A had been working diligently to update vaccination documenation forms to ensure correct documentation of offer, education and acceptance/refusal of vaccinations. The DON	F 883	Audits will be conducted by the Infection Preventionist (or designee) weekly for one month (or until compliance is achieved) for all new residents, to ensure the pneumococcal consent form is completed in its entirety, including documentation of education provided on benefits and potential side effects of pneumococcal vaccination and specific vaccination offered. If compliance is achieved, further audits will be conducted monthly for two months. Results of the audits will be reviewed during the facility’s quarterly QAPI meeting for further recommendations.	

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F 883	Continued From page 17 stated nursing staff were expected to complete the documentation accurately and fully. A facility pneumococcal policy was requested but not received.	F 883		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 15, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: NT1E11

Dear Administrator:

The above facility was surveyed on August 5, 2024 through August 7, 2024 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:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED 08/07/2024

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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 8/5/24 - 8/7/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and

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2 000	Continued From page 1	2 000		

identify the date when they will be completed.

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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

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

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 ______	08/07/2024

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	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULE	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to perform ongoing monitoring and wound care, as ordered, for a chronic reoccurring wound for 1 of 2 residents (R34) reviewed for wound care. Findings include: R34's quarterly Minimum Data Set (MDS) dated 7/1/24, identified R34 had diagnoses that included peripheral vascular disease (PVD) (a slow and progressive disorder of the blood vessels. PVD may affect any blood vessel outside of the heart. This includes the arteries, veins, or lymphatic vessels. Organs supplied by these	2 830	Corrected	9/4/24

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2 830	Continued From page 3	2 830		

vessels, such as the brain or legs, may not get enough blood flow for healthy function. The legs and feet are most often affected), high blood pressure, and coronary artery disease. R34 had one unhealed venous or arterial ulcer (a full-thickness defect of skin, most frequently in the ankle region, that fails to heal spontaneously and is sustained by chronic venous disease, based on venous duplex ultrasound testing).

R34's care plan revised 7/3/24, identified R34 had a potential alteration in skin integrity related to risk factors associated with limited mobility and recent right below the knee amputation for ischemic limb, peripheral arterial disease to bilateral lower extremities and poor appetite.
Interventions included:
- Perform a skin assessment weekly
- Wound care nurse (WCN) assessed left lateral ankle venous ulcer. Staff were directed to paint left ankle vascular wound with betadine and apply foam border dressing for protection.

R34's physician orders dated 6/18/24, identified the following:
Wound care: apply to left lateral ankle topically one time a day for left ankle vascular wound. Paint daily with betadine, cover with foam border for protection. Offload at all times while in bed with pillow under calf.

R34's Skin/Comfort note dated 7/16/24 at 10:50 a.m., identified R34 was seen on wound rounds to follow up on vascular wound to left lateral malleolus (a bony projection with a shape likened to a hammer head, especially each of those on either side of the ankle). No drainage was noted on the old dressing. Wound measured 1.0 x 0.6 centimeters (cm). Thin, dry scab noted. Surrounding tissue blanchable erythema/redness.

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2 830	Continued From page 4 Foot had a purple hue while dependent. Will continue to paint scab with betadine and cover with foam border adhesive dressing for protection. R34 would be seen on wound rounds monthly. R34's Skin Observation dated 7/27/24 at 9:20 a.m., identified R34's skin integrity; however, the note failed to identify R34's left lateral ankle wound and its condition. R34's Electronic Treatment Administration Record (ETAR) dated 7/16/24- 8/7/24, identified R34 received wound care daily. Additionally, on 8/6/24, the ETAR identified RN-B signed off R34's left lateral ankle wound care as complete. During an observation on 8/7/24 at 10:36 a.m., licensed practical nurse (LPN)-A applied gloves and removed a foam border dressing from R34's left outer ankle vascular wound. LPN-A stated there was a small amount of serosanguineous (a type of wound drainage, or exudate, secreted by an open wound in response to tissue) drainage on the dressing before throwing the dressing in the trash. LPN-A stated the vascular wound was open and there was "slough" (dead tissue within a wound) in the wound bed.LPN-A applied betadine to the wound bed and, once dried, applied a foam border dressing. LPN-A used a marker to date and initial the foam border dressing. LPN-A stated the dressing should have been changed on 8/6/24, but the dressing LPN-A removed was dated 8/5/24. R34 should have been assessed on 8/6/24 by the wound care WCN. LPN-A stated she did not know why R34 did not receive wound care on 8/6/24. During an interview on 8/7/24 at 10:46 a.m., RN-A stated she was unaware R34 had an open	2 830		

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CUYUNA REGIONAL MEDICAL CENTER	**320 EAST MAIN STREET CROSBY, MN 56441**

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2 830	Continued From page 5	2 830		

wound. RN-A understood R34's wound was scabbed over and R34 was no longer followed during wound rounds.

During an interview on 8/7/24 at 11:28 a.m., R34's physician stated R34 had a chronic vascular wound. Previous nursing reports identified the wound was scabbed over but had opened which was expected. R34's wound did not show signs/symptoms of infection but the WCN should evaluate R34. Staff wanted to care for the wound as best as possible to protect the leg because it was the only leg R34 had.

During an interview on 8/7/24 at 12:55 p.m., the director of nursing (DON) stated RN-B did sign off R34's wound as complete on 8/6/24 and could only assume RN-B believed the WCN would change R34's dressing that day. Nursing staff were expected to follow wound care orders and document accurately. Additionally, nursing staff were expected to document a description of the wound at least weekly and/or if a change occurred.

On 8/7/24 at 1:45 p.m., a phone interview with RN-B was attempted.

The facilty policy Wound and Skin Care Protocols undated, identified wounds required weekly documentation at minimum and with changes in wound appearance/condition.

SUGGESTED METHOD OF CORRECTION:
The DON or designee could review facility policies and systems to ensure chronic wounds are monitored and cared for according to resident assessment, care plan and physician orders. Then train all staff and perform audits to ensure each resident is receiving appropriate nursing

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2 830	Continued From page 6 care and monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a unit refrigerator maintained a safe temperature for storage of food. This had the potential to affect all residents who received food from unit refrigerator. Findings include: During observation on 8/7/24 at 11:06 a.m., the unit refrigerator contained milk, cheese, and yogurt. A regular thermometer was not in the unit refrigerator and a request was made to the culinary director log of temperatures for the month of August 2024. During an interview on 8/7/24 at 2:12 p.m., the culinary director stated she did not know the range the unit refrigerator should be set at. When the unit refrigerator temperature was out of the set range of the automated monitoring system, an alert would be sent out to the culinary director, bio-med technician, and the executive	21100	Corrected	9/4/24

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21100	Continued From page 7	21100		

director. The culinary director could not identify the temperature range or what temp she would be notified at.

The History Detail Report for Skyview unit refrigerator dated 8/7/24, identified from 8/1/24 at 12:00 a.m. through 8/7/24 at 2:30 p.m. temperatures in the unit refrigerator were monitored every 15 minutes via an automated monitoring system. The report identified temperatures were at or above 41 degrees Fahrenheit (F) for the following times.
-8/1/24 at 12:00 a.m., through 8/4/24 at 3:15 a.m, (75 hours (hr), 15 minutes (m)
-8/4/24 at 5:45 a.m. through 8/4/24 at 7:45 a.m. (2 hr, 00 m)
-8/4/24 at 12:45 p.m. through 8/5/24 at 1:45 a.m. (13 hr, 00 m)
-8/5/247 at 2:15 a.m. through 8/7/24 at 2:30 p.m. (60 hr, 15 m)
The total time the unit refrigerator was out of range was 6 days, 6 hours, and 30 minutes of a total of 6 days, 14 hours, and 30 minutes.

During an interview on 8/7/24 at 2:19 p.m., the bio-med technician stated he was unaware of the temperature range the unit refrigerator was to be kept at nor did he know the temperature alert range the automated monitoring system had.

An email was received from the bio-med technician identifying the automated monitoring system was set to a range of 33.8 degrees F to 48.2 degrees F.

During an interview on 8/7/24 at 2:50 p.m., the director of nursing (DON) stated the unit refrigerator would be kept at a temperature below 41 degrees F to ensure safe storage temperature of food, so it does not spoil. If the food was

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21100	Continued From page 8 spoiled, it could have caused illness in residents who received milk, cheese, or yogurt. Food should be stored according to the food storage policy. The facility's Food Storage policy dated 2021 identified time/temperature control for safety (TCS) foods must be maintained below 41 degrees F. Temperatures for refrigerators should be between 35-39 degrees F. SUGGESTED METHOD OF CORRECTION: The dietary manager or designee (s) could develop and implement policies and procedures, train staff, assure refridgerated food is stored in a manner to minimize the possible development of food borne illness. Develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement enhanced barrier precautions (EBP) for 1 of 2 residents (R34) reviewed for chronic wounds.	21375	Corrected	9/4/24

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21375	Continued From page 9	21375		

Findings include:

R34's quarterly Minimum Data Set (MDS) dated 7/1/24, identified R34 had diagnoses that included peripheral vascular disease (PVD) (a slow and progressive disorder of the blood vessels. PVD may affect any blood vessel outside of the heart. This includes the arteries, veins, or lymphatic vessels. Organs supplied by these vessels, such as the brain or legs, may not get enough blood flow for healthy function. The legs and feet are most often affected), hypertension, and coronary artery disease. R34 had one unhealed venous or arterial ulcer (a full-thickness defect of skin, most frequently in the ankle region, that fails to heal spontaneously and is sustained by chronic venous disease, based on venous duplex ultrasound testing).

R34's care plan revised 7/3/24, identified R34 had a potential alteration in skin integrity related to risk factors associated with limited mobility and recent right below the knee amputation for ischemic limb, peripheral arterial disease to bilateral lower extremities and poor appetite. Interventions included: Perform a skin assessment weekly and wound care nurse (WCN) assessed left lateral ankle venous ulcer. Staff were directed to paint left ankle vascular wound with betadine and apply foam border dressing for protection.
The care plan failed to direct staff to implement or follow EBP during wound care.

R34's physician orders dated 6/18/24, identified the following:
Wound care: apply to left lateral ankle topically one time a day for left ankle vascular wound. Paint daily with betadine, cover with foam border for protection. Offload at all times while in bed

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	00091	A. BUILDING: ____ B. WING ____	08/07/2024

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21375	Continued From page 10	21375		

with pillow under calf. The order did not direct staff regarding EBP for R34's chronic vascular wound.

R34's Skin/Comfort note dated 7/16/24 at 10:50 a.m., identified R34 was seen on wound rounds that morning to follow up on vascular wound to left lateral malleolus (a bony projection with a shape likened to a hammer head, especially each of those on either side of the ankle). No drainage noted on old dressing. Wound measured 1.0 x 0.6 centimeters (cm). Thin, dry scab noted. Surrounding tissue blanchable erythema/redness. Foot had a purple hue while dependent. Will continue to paint scab with betadine and cover with foam border adhesive dressing for protection. R34 would be seen on wound rounds monthly. The note did not identify EBP for R34's chronic vascular wound.

R34's Skin Observation dated 7/27/24 at 9:20 a.m., identified R34's skin integrity, however, the note failed to identify R34's left lateral ankle wound and its condition.

R34's Electronic Treatment Administration Record (ETAR) dated 7/16/24 - 8/7/24, identified R34 received wound care daily.

During an observation on 8/7/24 at 10:36 a.m., R34's door contained no signage regarding EBP nor was personal protective equipment (PPE) available for use. Licensed practical nurse (LPN)-A applied gloves and removed a foam border dressing from R34's left outer ankle vascular wound. LPN-A stated there was a small amount of serosanguineous (a type of wound drainage, or exudate, secreted by an open wound in response to tissue) drainage on the dressing before throwing the dressing in the trash. LPN-A

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21375	Continued From page 11	21375		

stated the vascular wound was open and there was "slough" (dead tissue within a wound) in the wound bed. LPN-A removed her gloves, used hand sanitizer and applied clean gloves. LPN-A did not implement EBP nor applied a gown. LPN-A applied betadine to the wound bed and, once dried, applied a foam border dressing. LPN-A used a marker to date and initial the foam border dressing. LPN-A removed the soiled gloves, removed the trash, used hand sanitizer and left R34's room. LPN-A stated she did not know why R34 was not on EBP because R34 had an open chronic wound.

During an interview on 8/7/24 at 10:46 a.m., RN-A stated she did not know why R34 was not on EBP. RN-A stated she would need to look into his wound and determine what it was.
- At 11:01 a.m., RN-A stated she was unaware R34 had an open wound. The last she understood was R34's wound was scabbed over and R34 was no longer followed during wound rounds. RN-A had previously set up a group email that included herself, administration, the physicians, and nursing to ensure everyone was updated with changes and staff were expected to report changes in resident conditions timely. There was signage and supplies available and nursing was expected to implement EBP as soon as possible to prevent a potential for infection transmission in chronic wounds and should have done so.

During an interview on 8/7/24 at 11:28 a.m., R34's physician stated R34 had a chronic vascular wound. Previous nursing reports identified the wound was scabbed over, but had opened which was expected. Staff wanted to care for the wound as best as possible to protect the leg because it was the only leg R34 had.

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21375	Continued From page 12	21375		

During an interview on 8/7/24 at 11:31 a.m., the director of nursing (DON) stated staff were expected to implement EBP for chronic wounds until healed.

The facility's undated Care Center Enhanced Barrier Precautions Policy and Procedure policy, identified residents were at higher risk of becoming colonized and infection with Multidrug Resistant Organisms (MDROs) as the prevalence of MDROs was higher in this care setting. It was the policy of this facility to implement Enhanced Barrier Precautions, using PPE, as a preventative approach, to help reduce and prevent the transmission of MDROs. Enhanced Barrier Precautions involved gown and glove use during high-contact resident care activities such as wound care (any skin opening requiring a dressing).

SUGGESTED METHOD OF CORRECTION:
The DON or designee could review facility policies and practices for initiating and discontinueing EBP. Then train staff and perform audits to ensure EBP are being followed.

TIME PERIOD FOR CORRECTION: Twenty One (21) days.

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 ______	**08/06/2024**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/06/2024. At the time of this survey, Cuyuna Regional Medical Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC 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. UPON RECEIPT OF AN ACCEPTABLE POC, 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/23/2024

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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	245232	A. BUILDING **02 - 2007 DAYROOM** B. WING	**08/06/2024**

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CUYUNA REGIONAL MEDICAL CENTER	**320 EAST MAIN STREET** **CROSBY, MN 56441**

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Cuyuna Regional Medical Center 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	K 000		

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	245232	A. BUILDING **02 - 2007 DAYROOM** B. WING ______	**08/06/2024**

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K 000	Continued From page 2 main entrance area (dining room) and south wing (dayroom) in 1996 of Type II (111) construction. In 2007 a 10 foot by 30-foot dayroom addition was constructed to the northwest wing, was determined to be Type II (111) construction, and separated with a 2-hour fire barrier. The building is divided into seven smoke compartments by 30 minute and 2- hour fire barriers. The entire building is protected with a complete automatic fire sprinkler system and has a fire alarm system with smoke detection throughout the corridor system, in common areas, and in the hazardous areas that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 50 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or	K 324		8/13/24

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K 324	Continued From page 3 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 08/06/2024, between 10:30am and 2:30pm, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for the semi-annual kitchen hood suppression system inspections for the last 12 months. An interview with the Maintenance Director and the Execive Director of Facilities verified this	K 324	Corrective action: Contractor notified of missing pieces of documentation; these were provided to the Facilities Manager by the Contractor within 1 week of survey. Establishment of new process to ensure all documentation is sent to a single inbox by contractors that can be closely monitored by the Facilities Manager and the Facilities Assistant to ensure all parties have continuous access to incoming documents. Creation and implementation of process that any contractors are completing work that is subject to inspection by Fire Marshal or Joint Commission, will be checked by Facilities Manager prior to departure of contractors completing work. Supervising staff of contractors completing work will be expected to provide documentation necessary before invoice will be paid for services rendered.	

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K 324	Continued From page 4 deficient finding at the time of discovery.	K 324	Facilities Manager will monitor corrective action and ongoing compliance.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 14.2.1.2.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 08/06/2024, between 10:30am and 2:30pm, it was revealed by a review of available documentation that the annual fire alarm inspection report produced by Siemens dated 09/11/2023 that the facility could not provide documentation that a sensitivity testing had been conducted. . An interview with the Maintenance Director and the Executive Director of Facilities verified this	K 345	Corrective action: contractor notified of missing pieces of documentation; these were provided to the Facilities Manager by the contractor with 1 week of survey. Establishment of new process to ensure all documentation is sent to a single inbox by contractors that can be closely monitored by the Facilities Manager and the Facilities Assistant to ensure all parties have continuous access to incoming documents. Establishment of new process to ensure all documentation is sent to a single inbox by contractors that can be closely monitored by the Facilities Manager and the Facilities Assistant to ensure all parties have continuous access to incoming documents.	8/13/24

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K 345	Continued From page 5 deficient finding at the time of discovery.	K 345	Facilities Manager will monitor corrective action and ongoing compliance.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________ b) Who provided system test _____________ c) Water system supply source _____________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: 1) Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 353	1) Corrective action: contractor notified of missing pieces of documentation; these were provided to the Facilities Manager by the contractor with 1 week of survey. Establishment of new process to ensure all documentation is sent to a single inbox by contractors that can be closely monitored by the Facilities Manager and the Facilities Assistant to ensure all parties have continuous access to incoming documents.	8/14/24

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K 353	Continued From page 6 On 08/06/2024, between 10:30am and 2:30pm, it was revealed by a review of available documentation the facility failed to perform the quarter sprinkler system testing in the third quarter (July - September). 2) Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility. Findings include: On 08/06/2024, between 10:30am and 2:30pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in 665. An interview with the Maintenance Director and the Executive Director of Facilities verified this deficient finding at the time of discovery.	K 353	Establishment of new process to ensure all documentation is sent to a single inbox by contractors that can be closely monitored by the Facilities Manager and the Facilities Assistant to ensure all parties have continuous access to incoming documents. Facilities Manager will monitor corrective action and ongoing compliance. 2) Corrective action: the maintenance manager, along with the director of nursing had a conversation with the individual who currently occupies this office about the clutter. Clutter, high pile storage, etc. was cleaned the next day. This office will be inspected regularly to ensure compliance is maintained. Offices that are known for this type of clutter, high pile storage, etc. will be routinely monitored and will be inspected during weekly EOC rounds by the Facilities Manager, Safety Officer, and Director of Nursing.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING	K 372		8/13/24

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K 372	Continued From page 7 Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 08/23/2022 between 9:00am and 12:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above the following doors: 1) Doors L240 ESR 2) FD - 1022 3) Care Center 4) FD - 2032 6) FD - 2036 7) Skyview Wing Enterence An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 372	Corrective action: The facilities department staff corrected/repaired all penetrations listed. All listed penetrations were checked twice with two different engineers to ensure proper completion. Further education/instruction will be provided to contractors performing work that would require any penetrations on this type of critical wall/door/etc. Contractors will be expected to perform this type of work to the proper standards and complete an above ceiling work permit. Any work taking place that involves these types of critical fire assemblies/systems will be monitored by the facilities department to ensure compliant/quality workmanship. The facilities manager will be notified of any work involving these systems at the time of the project start and time of completion to ensure compliant/quality workmanship. Facilities Manager, Facilities Department staff will monitor ongoing compliance.	

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K 751 SS=D	Draperies, Curtains, and Loosely Hanging Fabr CFR(s): NFPA 101 Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/06/2024, between 10:30am and 2:30pm, it was revealed by a review of available documentation that the facility could not provide a fire damper inspection report. An interview with the Maintenance Director and the Executive Director of Facilities verified this deficient finding at the time of discovery.	K 751	Corrective action: Contractor notified of missing pieces of documentation; these were provided to the Facilities Manager by the Contractor within 1 week of survey. Establishment of new process to ensure all documentation is sent to a single inbox by contractors that can be closely monitored by the Facilities Manager and the Facilities Assistant to ensure all parties have continuous access to incoming documents. Creation and implementation of process that any contractors are completing work that is subject to inspection by Fire Marshal or Joint Commission, will be checked by Facilities Manager prior to departure of contractors completing work. Supervising staff of contractors completing work will be expected to provide documentation necessary before invoice	8/9/24

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K 751	Continued From page 9	K 751	will be paid for services rendered. Facilities Manager will monitor corrective action and ongoing compliance.	
K 914 SS=D	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility.	K 914	Corrective action: Contractor notified of missing pieces of documentation; these were provided to the Facilities Manager by the Contractor within 1 week of survey. Establishment of new process to ensure all documentation is sent to a single inbox by contractors that can be closely monitored	8/12/24

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K 914	Continued From page 10 Findings include: On 08/06/2024, between 10:30am and 2:30pm, it was revealed by review of available documentation the required annual receptacle inspection documentation was not available at the time of the survey. Documents were provided, nut were missing the actual receptacle reports. An interview with the Maintenance Director and the Executive Director of Facilities verified this deficient finding at the time of discovery.	K 914	by the Facilities Manager and the Facilities Assistant to ensure all parties have continuous access to incoming documents. Creation and implementation of process that any contractors are completing work that is subject to inspection by Fire Marshal will be checked by Facilities Manager prior to departure of contractors completing work. Supervising staff of contractors completing work will be expected to provide documentation necessary before invoice will be paid for services rendered. Facilities Manager will monitor corrective action and ongoing compliance.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords	K 920		8/7/24

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K 920	Continued From page 11 are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/06/2024, between 10:30am and 2:30pm, it was revealed by observation that there were several electrical appliances plugged into a power strip in the following office: 1) Refrigerator plugged into power strip in 1-517 2) Power strip plugged (Daisy-chained) into another power strip in Office 1-533 3) Power strip plugged (Daisy-chained) into another power strip in Office 1-534 4) Refrigerator plugged into power strip in Bio-Med on lower level. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.	K 920	Power strip in 1-517 was removed and education was given to staff. Daisy-chained power strips in office 1-533 removed and education given to staff. Daisy chained power strips in office 1-534 removed and education given to staff. Refrigerator plugged into power strip in Bio-Med was removed and education given to staff. Findings were addressed by CEO and facilities management at weekly leadership briefing. Findings were addressed by facilities manager at monthly safety committee meeting. Ongoing education/reminders will be provided at the standing monthly safety committee meeting. Offices and appliances will be more thoroughly examined during standing weekly EOC rounds. Facilities management, CRMC leadership will monitor for ongoing compliance.	