

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

Kumala Fiske-Downing

Health Regulation Division Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 08/26/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245232	B. WING			08/	07/2024
	PROVIDER OR SUPPLIER REGIONAL MEDICA	L CENTER		32	TREET ADDRESS, CITY, STATE, ZIP CODE 20 EAST MAIN STREET CROSBY, MN 56441		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	000			
F 000	Appendix Z, Emerg Requirements for L §483.73 was condurecertification surve compliance. The facility's plan of as your allegation of Department's accepenrolled in ePOC, year the bottom of the form. Upon receipt of an onsite revisit of you validate substantial regulation has been INITIAL COMMENT. On 8/5/24 - 8/7/24, survey was complement of 42 CFR Part 483 Long Term Care Facompliance. The facility's plan of as your allegation of Department's accepenrolled in ePOC, year the bottom of the form. Your electronic be used as verificated.	a standard recertification ted at your facility by the nent of Health to determine if compliance with requirements of Subpart B, Requirements for acilities. Your facility was not in the compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 fic submission of the POC will	FO	000			
ADODATOD	-	DER/SUPPLIER REPRESENTATIVE'S SIGN	LATUDE		TITI F		(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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 000	onsite revisit of you	ur facility may be conducted to I compliance with the	F 0	00		
F 684 SS=D	Quality of Care CFR(s): 483.25		F 6	84		9/4/24
	applies to all treatrescility residents. Be assessment of a rethat residents receasing accordance with properties, the composer plan, and the This REQUIREME by: Based on observative review, the facility monitoring and wo	fundamental principle that nent and care provided to ased on the comprehensive esident, the facility must ensure ive treatment and care in rofessional standards of rehensive person-centered residents' choices. NT is not met as evidenced tion, interview and document failed to perform ongoing und care, as ordered, for a gwound for 1 of 2 residents		Cuyuna Regional Medical C to ensure residents receive t care in accordance with prof standards of practice, using person-centered approach.	reatment and essional	
	7/1/24, identified Rincluded peripheral slow and progressivessels. PVD may of the heart. This is lymphatic vessels, such as the enough blood flow and feet are most pressure, and cord one unhealed vended.	nimum Data Set (MDS) dated 34 had diagnoses that I vascular disease (PVD) (a ve disorder of the blood affect any blood vessel outside ncludes the arteries, veins, or Organs supplied by these he brain or legs, may not get for healthy function. The legs often affected), high blood onary artery disease. R34 had ous or arterial ulcer (a ct of skin, most frequently in		The procedure for Wound are Protocols was revised by the Nursing on August 19, 2024, the procedure included need documentation of the wound including description and wormeasurements. R34s primary physician evaluated wound on August 7, 2024, with WOCN follow up. R34s care plan was updated 19, 2024, to reflect a chronic wound with need for daily woweekly wound measurement.	Director of Revisions to for weekly condition, und und the ith referral for left ankle and care and	

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CUYUNA	REGIONAL MEDICA	L CENTER		320 EAST MAIN STREET CROSBY, MN 56441		
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F 684	Continued From pa	age 2	F6	884		
	the ankle region, the and is sustained by	at fails to heal spontaneously chronic venous disease, uplex ultrasound testing).		administration record (TAR) values August 20, 2024, for weekly values measurements on bath day.	•	
	a potential alteration risk factors associated recent right below to ischemic limb, peribilateral lower extra Interventions included Perform a skin as a Wound care nurse ankle venous ulcer left ankle vascular foam border dressing. Wound care: apply one time a day for Paint daily with beta for protection. Office with pillow under care. R34's Skin/Comfor a.m., identified R34 to follow up on vasce malleolus (a bony performent to a hammer head, either side of the air on the old dressing centimeters (cm). Surrounding tissue Foot had a purple front to paint so	e (WCN) assessed left lateral. Staff were directed to paint wound with betadine and applying for protection. ders dated 6/18/24, identified to left lateral ankle topically left ankle vascular wound. adine, cover with foam border and at all times while in bed alf. It note dated 7/16/24 at 10:50 was seen on wound rounds cular wound to left lateral projection with a shape likened especially each of those on inkle). No drainage was noted in Wound measured 1.0 x 0.6 Thin, dry scab noted. blanchable erythema/redness. The while dependent. Will cab with betadine and cover		On August 20, 2024, treatmer in TAR for all residents with a wounds, with prompt for nurse document progress note, with description and measurement. Nurses will be educated on the revised procedure for Wound Protocols during team huddle of August 26- September 1, 2 Education will include proceed documenting wound descript measurements, at a minimur in the resident's clinical recorn not in attendance during tear will be required to complete feducation by September 3, 2 Wound audits will be conducted for six weeks by the Director designee, to ensure wound documentation, including me has been completed at least compliance is achieved, audichanged to monthly. Results of audits will be reviet the Facility's quarterly QAPI of meeting for further recomme	chronic se to h wound hts weekly. he facility's d and Skin es the week 2024. lure for ion, including h of weekly, d. Nurses h huddles, follow up 024. ted weekly of Nursing or asurements weekly. If ts will be ewed during committee	
	with foam border a	dhesive dressing for uld be seen on wound rounds				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 684	Continued From pa	age 3	F 6	84		
	a.m., identified R34 note failed to identified wound and its condes R34's Electronic Transcord (ETAR) data R34 received wound 8/6/24, the ETAR identification of the ETAR identification of the dressing between the trash. LPN-A stropen and there was wound in the dressing between the trash. LPN-A stropen and there was wound in the wound bed a border dressing. LF and initial the foam the dressing should 8/6/24, but the dressing should 8/6/24 by the wound she did not know word on 8/6/24. During an interview stated she was unawound. RN-A under wound.	eatment Administration and 7/16/24- 8/7/24, identified and care daily. Additionally, on dentified RN-B signed off R34's bund care as complete. Sion on 8/7/24 at 10:36 a.m., aurse (LPN)-A applied gloves imborder dressing from R34's cular wound. LPN-A stated amount of serosanguineous (a nage, or exudate, secreted by response to tissue) drainage fore throwing the dressing in ated the vascular wound was is "slough" (dead tissue within a nd bed.LPN-A applied betadine and, once dried, applied a foam PN-A used a marker to date border dressing. LPN-A stated if have been changed on asing LPN-A removed was should have been assessed on dicare WCN. LPN-A stated thy R34 did not receive wound are R34 had an open restood R34's wound was R34 was no longer followed				

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F 684	R34's physician star vascular wound. Pridentified the wound opened which was not show signs/syn WCN should evaluate for the wound as be leg because it was During an interview director of nursing of R34's wound as co- only assume RN-B change R34's dress were expected to for document accurate were expected to d	ge 4 on 8/7/24 at 11:28 a.m., ted R34 had a chronic evious nursing reports d was scabbed over but had expected. R34's wound did aptoms of infection but the ate R34. Staff wanted to care est as possible to protect the the only leg R34 had. on 8/7/24 at 12:55 p.m., the (DON) stated RN-B did sign off mplete on 8/6/24 and could believed the WCN would sing that day. Nursing staff ollow wound care orders and ly. Additionally, nursing staff ocument a description of the kly and/or if a change		584		
	On 8/7/24 at 1:45 p RN-B was attempted. The facilty policy Wayndated, identified a documentation at many wound appearance. Food Procurement, CFR(s): 483.60(i)(1) §483.60(i) Food sat The facility must -	Yound and Skin Care Protocols wounds required weekly ninimum and with changes in /condition. Store/Prepare/Serve-Sanitary)(2) fety requirements. Sure food from sources ered satisfactory by federal,	F &	312		9/4/24

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉ		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG	` '	E SURVEY IPLETED
NAME OF PROVIDER OR SUPPLIER CUYUNA REGIONAL MEDICAL CENTER (X4) ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 812 Continued From page 5 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 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. STREET ADDRESS, CITY, STATE, ZIP CODE 320 EACH MAIN STREET CROSBY, MIN 56441 PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 812 Cuyuna Regional Medical Center's Culinary team is dedicated to storing food consumed by residents in accordance with professional standards for food service safety.			245232	B. WING _		08/	07/2024
F 812 Continued From page 5 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 proclude 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.					320 EAST MAIN STREET		
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.	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
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 temperature was out of the set range of the automated monitoring system, an alert would be sent out to the culinary director. The culinary director could not identify the temperature range or what temp she would 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.	F 812	from local produce and local laws or re (ii) This provision of facilities from using gardens, subject to safe growing and for (iii) This provision of from consuming for \$483.60(i)(2) - Stor serve food in according to standards for food This REQUIREME by: Based on observation refrigerator maintains storage of food. The residents who receively the facility for frigerator. Findings include: During observation unit refrigerator and a reculinary director log month of August 20. During an interview culinary director star range the unit refrigerator star range the unit refrigulation. The set range of the system, an alert word director, bio-med to director. The culinary director.	does not prohibit or prevent g produce grown in facility of compliance with applicable food-handling practices. It does not preclude residents foods not procured by the facility. The prepare, distribute and redance with professional service safety. That is not met as evidenced attion, interview and document failed to ensure a unit ined a safe temperature for his had the potential to affect all eived food from unit. The on 8/7/24 at 11:06 a.m., the intained milk, cheese, and hermometer was not in the unit request was made to the g of temperatures for the one of temperature for the one of temperature was out of the automated monitoring fould be sent out to the culinary echnician, and the executive for the order of the out of the culinary echnician, and the executive for the out of the culinary echnician, and the executive for the out of the culinary echnician, and the executive for the out of the culinary echnician, and the executive for the out of the culinary echnician, and the executive for the out of the culinary echnician, and the executive for the out of the culinary echnician are the out of the culinary echnician, and the executive for the outer of		Cuyuna Regional Medical Cent Culinary team is dedicated to stronsumed by residents in accorwith professional standards for service safety. On August 7, 2024, the unit fridge for storing items for easy access resident use, was adjusted to 4. (colder) on the adjustable temperinside the fridge. A portable ther was added for ease in spot cheet temperature of the fridge on August 2024. The milk, cheese and yogurt prette fridge was removed and throus Director of Nursing and the Facilitation on August 7, 2024. The policy followed by the facilitation of Storage, from 2021 Becky Dorn Associates was reviewed by the Director and the Director of Nursing and the Director of Nursing and the Director of Nursing and the Director and the Director of Nursing and Director of	oring food dance food ge, used s for 5 setting erature mometer cking the gust 8, esent in own by the lity y for Food er and e	

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				320 EAST MAIN STREET		
CUYUNA	REGIONAL MEDIC	AL CENTER		CROSBY, MN 56441		
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F 812	Continued From p	age 6	F 81	2		
	refrigerator dated 12:00 a.m. throug temperatures in the monitored every 1 monitoring system temperatures were Fahrenheit (F) for -8/1/24 at 12:00 at (75 hours (hr), 15 -8/4/24 at 5:45 a.m. (2 hr, 00 m) -8/4/24 at 12:45 pt (13 hr, 00 m) -8/5/247 at 2:15 at (60 hr, 15 m) The total time the range was 6 days	Report for Skyview unit 8/7/24, identified from 8/1/24 at h 8/7/24 at 2:30 p.m. he unit refrigerator were 5 minutes via an automated h. The report identified e at or above 41 degrees the following timesm., through 8/4/24 at 3:15 a.m, minutes (m) h. through 8/4/24 at 7:45 a.mm. through 8/5/24 at 1:45 a.mm. through 8/7/24 at 2:30 p.m. unit refrigerator was out of 6 hours, and 30 minutes of a hours, and 30 minutes.		The parameters outlined in the time/temperature control (TC food safety includes: All TCS be maintained in refrigerators temperature between 35-39 and not exceed 41'F. The unit fridge is set up on the an electronic monitoring systemanaged by Technical Life S (Biomed). The range parameters Care Center unit fridge were Versatrak to 35-39 degrees F exceed 41'F on August 12, 20 Temp Track system is set to to the Director of Culinary, if the total control of the parameters. Culinary and nursing staff will on the policy for safe food started.	foods for foods should at a degrees F' We versatrak, em, upport eters of the adjusted in 5, not to 1024. The send an alert the fridge is 1 be educated 1 be	
	During an interview bio-med technician temperature range kept at nor did he range the automa. An email was received technician identify system was set to 48.2 degrees F. During an interview director of nursing refrigerator would 41 degrees F to express to express to express the second s	w on 8/7/24 at 2:19 p.m., the n stated he was unaware of the e the unit refrigerator was to be know the temperature alert ted monitoring system had. eived from the bio-med ring the automated monitoring a range of 33.8 degrees F to w on 8/7/24 at 2:50 p.m., the g (DON) stated the unit be kept at a temperature below nsure safe storage temperature not spoil. If the food was		foods at a temperature between the week of August 26-Sept of Culinary will conduct audits to day to monitor the unit fridge using the portable thermome weeks. Versatrak daily report reviewed by the Culinary Directly designee) to ensure the fridge maintaining 35-39 degrees Fexceed 41'F in 24-hour perioding temp remains within reparameters for two weeks, as changed to weekly for four will fridge temps are not able to	een 35-39'F, eam huddles I, 2024. No times per temperature, ter for two s will be ector (or e is not to od. If the equired udit will be eeks.	
	· ·	ave caused illness in residents		mainatined within required pa	•	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION ((X3) DATE SURVEY COMPLETED		
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F 812	Continued From pa	ige 7	F 8	312			
	-	cheese, or yogurt. Food ccording to the food storage			35-39' F, not exceeding 41 ', the frid be removed from service.	ge will	
F 880 SS=D	The facility's Food sidentified time/temp (TCS) foods must be degrees F. Temper be between 35-39 of	n & Control	F 8	880	Results of the audits will be reviewed during the facility's quarterly QAPI meeting for further recommendation		9/4/24
	infection prevention designed to provide comfortable environ	tablish and maintain an and control program a safe, sanitary and nent and to help prevent the ansmission of communicable					
	program. The facility must es	n prevention and control stablish an infection prevention n (IPCP) that must include, at owing elements:					
	reporting, investigation and communicable staff, volunteers, visit providing services arrangement based	stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessment to §483.70(e) and following standards;					
	• • • • • • • • • • • • • • • • • • • •	en standards, policies, and program, which must include, to:					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE	DING	· /	OMPLETED
		245232	B. WING		(8/07/2024
	PROVIDER OR SUPPLIER A REGIONAL MEDICA	L CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 320 EAST MAIN STREET CROSBY, MN 56441	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
F 880	possible communication infections before the persons in the facilia (ii) When and to who communicable diserported; (iii) Standard and the tobe followed to provide (iv) When and how resident; including (A) The type and depending upon the involved, and (B) A requirement to least restrictive possicircumstances. (v) The circumstances. (v) The circumstances. (v) The circumstances. (vi) The circumstances (vi) The circumstances (vi) The hand hygien by staff involved in §483.80(a)(4) A systidentified under the corrective actions to §483.80(e) Linens. Personnel must have transport linens so infection.	eillance designed to identify able diseases or ey can spread to other ity; nom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility by ees with a communicable skin lesions from direct into or their food, if direct it the disease; and the procedures to be followed direct resident contact. Stem for recording incidents facility's IPCP and the taken by the facility. Indie, store, process, and as to prevent the spread of		880		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	` '	E SURVEY IPLETED
		245232	B. WING		08/	07/2024
	PROVIDER OR SUPPLIER	L CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 320 EAST MAIN STREET CROSBY, MN 56441		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
F 880	review, the facility fibarrier precautions (R34) reviewed for Findings include: R34's quarterly Min 7/1/24, identified R3 included peripheral slow and progressivessels. PVD may of the heart. This in lymphatic vessels, such as the enough blood flow and feet are most of and coronary artery unhealed venous of defect of skin, most that fails to heal specified by chronic venous of duplex ultrasound to R34's care plan reviational alteration risk factors associated a potential alteration risk factors associated are most of the potential alteration risk factors associated assessment weekly (WCN) assessed less that were directed wound with betading dressing for protected wound protecte	tion, interview and document ailed to implement enhanced (EBP) for 1 of 2 residents chronic wounds. imum Data Set (MDS) dated 34 had diagnoses that vascular disease (PVD) (a ve disorder of the blood affect any blood vessel outside cludes the arteries, veins, or Organs supplied by these e brain or legs, may not get for healthy function. The legs often affected), hypertension, verdisease. R34 had one or arterial ulcer (a full-thickness at frequently in the ankle region, contaneously and is sustained disease, based on venous esting). Issed 7/3/24, identified R34 had on in skin integrity related to ted with limited mobility and the knee amputation for coheral arterial disease to emities and poor appetite. Ited: Perform a skin or and wound care nurse eft lateral ankle venous ulcer. Ito paint left ankle vascular e and apply foam border iton. It to direct staff to implement or	F 8	Cuyuna Regional Medical Cemestablished an infection preven control program to provide a sa sanitary, and comfortable envirour residents and to help preve development and transmission communicable disease and infection The procedure for Wound and Protocols was revised by the Di Nursing on August 19, 2024. Read the procedure included need for implementation of Enhanced Barrier Precautions (EBP) for new and wounds. The Enhanced Barrier Precauti and Procedure was reviewed by Director of Nursing and the Infection of Preventionist on August 22, 202 does outline need to place resid wounds that require dressing of EBP for duration of stay or until is resolved. On August 7, 2024, R34 was plenhanced Barrier Precautions (R34's care plan was updated to need to wear gown and gloves providing high-contact care (incomound care), due to open wour ankle. Nursing staff will receive educate revised procedure for Wound at Protocols during team huddles of August 26- September 1, 202 Education will include the need implement and follow EBP with	ion and fe, onment for nt the of ction. Skin Care rector of evisions to arrier or chronic ons Policy the ction 4. Policy lents with nanges in the wound aced in EBP). reflect when luding d on left ion on the nd Skin che week 4.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG	 \ 	E SURVEY PLETED
		245232	B. WING		08/0	07/2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 320 EAST MAIN STREET CROSBY, MN 56441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 880	the following: Wound care: applione time a day for Paint daily with befor protection. Off with pillow under a staff regarding EB wound. R34's Skin/Comformal, identified R3 that morning to for left lateral malleons hape likened to a of those on either noted on old dress 0.6 centimeters (a Surrounding tissurfoot had a purple continue to paint swith foam border a protection. R34 womonthly. The note chronic vascular with foam border and its continue to iden wound and its continue to identification.	rders dated 6/18/24, identified y to left lateral ankle topically r left ankle vascular wound. readine, cover with foam border load at all times while in bed calf. The order did not direct BP for R34's chronic vascular ort note dated 7/16/24 at 10:50 B4 was seen on wound rounds llow up on vascular wound to us (a bony projection with a a hammer head, especially each side of the ankle). No drainage sing. Wound measured 1.0 x cm). Thin, dry scab noted. be blanchable erythema/redness. hue while dependent. Will scab with betadine and cover adhesive dressing for ould be seen on wound rounds be did not identify EBP for R34's wound. vation dated 7/27/24 at 9:20 B4's skin integrity, however, the tify R34's left lateral ankle addition. Treatment Administration ated 7/16/24 - 8/7/24, identified	F 8	identification of a new would staff not in attendance dur huddles, will be required to follow up education by Sep 2024. Audits will be conducted de Infection Preventionist or of weeks to ensure staff are fourth use of gown and glow high-contact cares for resion place. Audits will also include reversident(s) identified with rensure EBP implementation compliance is achieved, Ebe conducted weekly for fourther or further recommittee for further recommittee for further recommendation of the provided that is a subject to the provided to the provided that is a subject to the provide	ing team complete ctember 3, aily by the designee for two following EBP ves) during dents with EBP iew of new wound(s) to on. If BP audits will our weeks, then by QAPI mmendations. be reviewed committee	

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE	DING	` '	OATE SURVEY OMPLETED
		245232	B. WING	.	(08/07/2024
	PROVIDER OR SUPPLIER A REGIONAL MEDICA	L CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 320 EAST MAIN STREET CROSBY, MN 56441	<u>-</u> =	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE	(X5) COMPLETION DATE
F 880	border dressing fro vascular wound. LF amount of serosang drainage, or exudatin response to tissubefore throwing the stated the vascular was "slough" (dead wound bed. LPN-A hand sanitizer and did not implement ELPN-A applied beta once dried, applied LPN-A used a mark border dressing. LF gloves, removed thand left R34's room know why R34 was an open chronic wound and determinated she did not keep. RN-A stated swound and determinated and R34 was no lor rounds. RN-A had an open wounderstood was R3 and R34 wa	oves and removed a foam m R34's left outer ankle PN-A stated there was a small guineous (a type of wound te, secreted by an open wound te) drainage on the dressing dressing in the trash. LPN-A wound was open and there tissue within a wound) in the removed her gloves, used applied clean gloves. LPN-A EBP nor applied a gown. Indine to the wound bed and, a foam border dressing. Seer to date and initial the foam PN-A removed the soiled the trash, used hand sanitizer in LPN-A stated she did not not on EBP because R34 had bound. Ton 8/7/24 at 10:46 a.m., RN-A know why R34 was not on the would need to look into his ne what it was. -A stated she was unaware		880		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245232	B. WING _		08/	07/2024
	PROVIDER OR SUPPLIER	L CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 320 EAST MAIN STREET CROSBY, MN 56441		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	R34's physician starvascular wound. Pridentified the wound opened which was for the wound as belieg because it was a surface of nursing (expected to implement until healed. The facility's undate Barrier Precautions identified residents becoming colonized Resistant Organism of MDROs was high the policy of this face Barrier Precautions approach, to help retransmission of MD Precautions involve high-contact residents.	on 8/7/24 at 11:28 a.m., ted R34 had a chronic evious nursing reports was scabbed over, but had expected. Staff wanted to care est as possible to protect the the only leg R34 had. on 8/7/24 at 11:31 a.m., the DON) stated staff were ent EBP for chronic wounds and infection with Multidrug is (MDROs) as the prevalence in this care setting. It was cility to implement Enhanced, using PPE, as a preventative educe and prevent the ROs. Enhanced Barrier d gown and glove use during int care activities such as in opening requiring a	F 8	80		
F 883 SS=D	S483.80(d) Influenze immunizations §483.80(d)(1) Influence policies and proced (i) Before offering the each resident or the	mococcal Immunizations 1)(2) a and pneumococcal enza. The facility must develop ures to ensure that- ne influenza immunization, e resident's representative regarding the benefits and	F 88	83		9/4/24

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245232	B. WING			08/07/2024	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 320 EAST MAIN STREET CROSBY, MN 56441	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 883	(ii) Each resident is immunization Octo annually, unless the contraindicated or immunized during (iii) The resident or has the opportunity (iv) The resident's redocumentation that following: (A) That the reside was provided educand potential side eximmunization; and (B) That the reside immunization or dicimmunization due to refusal. §483.80(d)(2) Pneumust develop policithat— (i) Before offering to immunization, each representative receives and potential immunization; (ii) Each resident is immunization; (iii) Each resident is immunization, unlemedically contrained already been immunication that the opportunity (iv) The resident's redocumentation that following:	ts of the immunization; offered an influenza ber 1 through March 31 e immunization is medically the resident has already been this time period; the resident's representative to refuse immunization; and nedical record includes tindicates, at a minimum, the nt or resident's representative ation regarding the benefits effects of influenza to medical contraindications or umococcal disease. The facility ies and procedures to ensure the pneumococcal nesident or the resident's eives education regarding the tial side effects of the soffered a pneumococcal ses the immunization is licated or the resident has	F 8	33			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	`	(X3) DATE SURVEY COMPLETED	
		245232	B. WING		08/07/2024	
	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 20 EAST MAIN STREET CROSBY, MN 56441		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPI	(5) LETION ATE
F 883	and potential side of immunization; and (B) That the reside pneumococcal immunization or the pneumococcal contraindication or This REQUIREMED by: Based on interview facility failed to provere cent Centers for education regarding benefits of the pneurosidents (R20, R3 immunizations. Findings include: R20's significant che (MDS) dated 7/11/2 old and had diagnormellitus, and hyperediction R20's immunization identified R20 refuse (PCV20) vaccination (PCV20) vaccination R20's admission not p.m., identified R20 refuse (PCV20) received regard vaccination.	ation regarding the benefits effects of pneumococcal and either received the nunization or did not receive immunization due to medical refusal. Note is not met as evidenced and document review, the vide and document the most Disease Control (CDC) go the potential risks and aumococcal vaccine for 3 of 5 of 5, R42) reviewed for The angle Minimum Data Set 24, identified R20 was 68 years are set that included diabetes tension. The record dated 8/7/24, seed a pneumococcal conjugate on. The dated 6/20/24 at 12:48 of declined when offered at education, if any, education reding pneumococcal. Pneumococcal Immunization	F 883	Cuyuna Regional Medical Center strito offer and provide our residents and their representatives education on the risks and benefits of immunizations, procedurate in place to ensure pneumococcal vaccinations. Procedurate in place to ensure pneumococcal vaccinations are offered to all eligible residents, including education on the benefits of vaccination and potential seffects. R20 discharged from the facility on A 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 education. R42's resident representative was provided education on the Pneumococconjugated Vaccine with Vaccine	d/or e per ures side ugust	
		0/24, identified R20's signed ococcal vaccination. However, d to identify which		Information Statement (VIS) dated 5/12/23 on August 23, 2034. R39's representative declined the vaccination	on	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245232	B. WING		08/	07/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 320 EAST MAIN STREET CROSBY, MN 56441	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
F 883	During a phone into family member (FN pneumococcal vactacility but could not R20 received. R39's admission MR39 was 89 years included coronary adementia and renarman R39's immunization identified R39 refusivacination. However, identify which pneudoffered and/or what R39's nursing programmential virus (RS) identify if R39's far provided education syncytial virus (RS) identify if R39's far provided education vaccination. During a phone into FM-B stated she be discussed during F could not recall who provided.	cine R20 was offered and/or s provided. erview on 8/7/24 at 10:52 a.m., /l)-A stated R20 a cination when offered by the of recall what education, if any, /l IDS dated 5/28/24, identified old and had diagnoses that cartery disease, hypertension, I insufficiency. In record dated 8/7/24, sed a PCV20. Pneumococcal Immunization 3/24, identified R39's family red refusal of a pneumococcal ver, the document failed to imococcal vaccine R39 was at education was provided. Press note dated 6/6/24, mily representative was a regarding a respiratory (V) vacccine, however, did not nily representative was a regarding pneumococcal vaccine was a regarding pneumococcal derview on 8/7/24 at 11:08 a.m., elieved vaccinations were 39's care conference but at education had been	F 8	following receiving the VIS All resident pneumococcal audited by the Quality Coor week of August 19, 2024, to resident or representative to the pneumococcal vaccinate education on benefits and perfects of the pneumococcal vaccinations provided the pneumococcal vaccinations provided the Pneumococcal vaccinations provided the Pneumococcal VIS dated 5/12/23 by September 1, 20234. The conpneumococcal vaccinations to include a prompt on the following and the Infection Pheumococcal vaccinations to include a prompt on the following and the specific VI education provided to the retheir representative, for mainformed decision for the provided to the retheir representative, for mainformed decision for the provided to the retheir representative, for mainformed decision for the provided revisions to the Care Consumption. Education will be shared with the revisions to the Care Consumer to	consents were redinator the o ensure any hat had decline tion received potential side al vaccine with hits and/or their is missing on on swill be al Conjugated ember 3, 2024. Care Center ons for the Director of Preventionist on is sent form for swas revised, form for nurses is and esident and/or iking an ineumococcal with nurses on enter on procedure, occal consent is the week of 024. Nurses not alles will be	
		IDS dated 7/1/24 identified			up education	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245232	B. WING		08/0	07/2024	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 320 EAST MAIN STREET CROSBY, MN 56441	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 883	included hypertens dementia. R42's immunization identified R42's fan pneumococcal vac R42's Care Center Consent dated 6/24 representative sign vaccination. Howevidentify which pneudoffered and/or what During a phone into R42's family representation was provided and coumentations. How registered nurse (Form for documentations. How not complete the form the could not confirm where the could not confirm w	old and had diagnoses that ion, Diabetes Mellitus, and in record dated 8/7/24, mily representative refused cination. Pneumococcal Immunization 4/24, identified R42's family red refusal of a pneumococcal ver, the document failed to amococcal vaccine R42 was at education was provided. Priview on 8/7/24 at 2:17 p.m., sentative did not recall what vided regarding vaccinations. On 8/6/24 at 4:19 p.m., RN)-A stated she created a pation of offering, education and	F 88	Audits will be conducted by Preventionist (or designee) month (or until compliance if for all new residents, to ensigne pneumococcal consent form in its entirety, including docteducation provided on bene potential side effects of pne vaccination and specific vac offered. If compliance is acted audits will be conducted momonths. Results of the audits will be during the facility's quarterly meeting for further recomm	weekly for one is achieved) ure the n is completed umentation of eits and contain individual for two reviewed QAPI		

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER CUYUNA REGIONAL MEDICAL CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 320 EAST MAIN STREET CROSBY, MN 56441 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPANDED TO THE APPROPRIATE)			245232	B. WING		08	/07/2024
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE					320 EAST MAIN STREET	•	
DEFICIENCY)	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
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	stated nursing staf the documentation A facility pneumoce	f were expected to complete accurately and fully.	F 8	383		



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 <u>only a suggestion</u> 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

Kumalu Fiske-Downing

Health Regulation Division Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00091	B. WING		08/07/2024
	PROVIDER OR SUPPLIER	L CENTER 320 EAST	DRESS, CITY, S MAIN STRE MN 56441	TATE, ZIP CODE ET	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
2 000	2 000 Initial Comments		2 000		
	****ATTEN	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this corrected pursuant to a survey found that the deficit herein are not corrected shall I with a schedule of the Minnesota Departments of the number and MN Rule When a rule contain	nether a violation has been			
	lack of compliance. re-inspection with a result in the assess	Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item tring the initial inspection was			
	that may result from orders provided that the Department with	hearing on any assessments non-compliance with these ta written request is made to hin 15 days of receipt of a nt for non-compliance.			
M:	conducted at your facility was not in conducted at your facility was not in conducted and the facility was an accordance with the facility was an accordance was accorda	TS: a licensing survey was acility by surveyors from the nent of Health (MDH). Your empliance with the MN State ollowing correction orders are cate in your electronic plan of reviewed these orders and			

Minnesota Department of Health

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

TITLE

Electronically Signed

08/23/24

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
			A. BOILDING	71. DOILDING.		
		00091	B. WING		08/0	07/2024
NAME OF	PROVIDER OR SUPPLIER	STREE	TADDRESS, CITY,	STATE, ZIP CODE		
CUYUNA	A REGIONAL MEDICA	L CENTER	AST MAIN STRE	ET		
			BY, MN 56441			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 000	Continued From pa	ige 1	2 000			
	identify the date wh	en they will be completed.				
	the State Licensing federal software. To assigned to Minnes Nursing Homes. The appears in the far leading." The state state listed in the "Summ column and replace the correction order the findings which a statute after the state as evidence by." For	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for ne assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is nary Statement of Deficiencies the "To Comply" portion or This column also includes are in violation of the state atement, "This Rule is not mollowing the surveyors finding Method of Correction and trection.	et			
	receipt of State lice the Minnesota Department of Heal orders are delineate Department of Heal you electronically. A is necessary for State enter the word "context. You must then State licensure proceeding to electronically then Corrected prior to element of the Minnesota Department of the PLEASE DISREGA	state.mn.us/facilities/regulate_1.html The State licensing ed on the attached Minneso alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. ARD THE HEADING OF THE	io ta o on for			
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE		S .			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00091	B. WING		08/07/2024	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
CUYUNA	REGIONAL MEDICA	L CENTER	T MAIN STRE ', MN 56441	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From page 2		2 000			
	CORRECTION FOI	ENT TO SUBMIT A PLAN OF R VIOLATIONS OF E STATUTES/RULE				
2 830	MN Rule 4658.0520 Proper Nursing Car	Subp. 1 Adequate and e; General	2 830			9/4/24
	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.					
	by: Based on observation review, the facility fa	ent is not met as evidenced on, interview and document ailed to perform ongoing and care, as ordered, for a wound for 1 of 2 residents wound care.		Corrected		
	Findings include:					
	7/1/24, identified R3 included peripheral slow and progressives vessels. PVD may a of the heart. This in	imum Data Set (MDS) dated 34 had diagnoses that vascular disease (PVD) (a re disorder of the blood affect any blood vessel outside cludes the arteries, veins, or Organs supplied by these				

Minnesota Department of Health

STATE FORM NT1E11 If continuation sheet 3 of 13

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	 ` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00091	B. WING		08/0	7/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CUYUNA REGIONAL MEDICA	LCENTER	MAIN STRE MN 56441	ET		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
enough blood flow to and feet are most of pressure, and coror one unhealed veno full-thickness defect the ankle region, the and is sustained by based on venous defect the ankle region, the and is sustained by based on venous defect the ankle region, the apotential alteration risk factors associated recent right below the ischemic limb, periphilateral lower extremely limb, periph	e brain or legs, may not get for healthy function. The legs often affected), high blood hary artery disease. R34 had us or arterial ulcer (a t of skin, most frequently in at fails to heal spontaneously chronic venous disease, uplex ultrasound testing). ised 7/3/24, identified R34 had in in skin integrity related to ted with limited mobility and he knee amputation for otheral arterial disease to emities and poor appetite. Ied: sessment weekly (WCN) assessed left lateral staff were directed to paint wound with betadine and applying for protection. Iers dated 6/18/24, identified to left lateral ankle topically eft ankle vascular wound. Eadine, cover with foam border and at all times while in bed				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			D WING			
		00091	B. WING		08/0	7/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CUYUNA	A REGIONAL MEDICA	L CENTER	MAIN STRE MN 56441	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 4	2 830			
	Foot had a purple he continue to paint so with foam border ac	ue while dependent. Will ab with betadine and cover dhesive dressing for uld be seen on wound rounds				
	a.m., identified R34	ation dated 7/27/24 at 9:20 's skin integrity; however, the fy R34's left lateral ankle lition.				
	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.					
	licensed practical nand removed a foar left outer ankle vase there was a small at type of wound drain an open wound in ron the dressing bef the trash. LPN-A state open and there was wound) in the wound to the wound bed a border dressing. LF and initial the foam the dressing should 8/6/24, but the dress dated 8/5/24. R34 stated 8/5/24. R34 stated 8/5/24 by the wound she did not know we care on 8/6/24.	ion on 8/7/24 at 10:36 a.m., urse (LPN)-A applied gloves in border dressing from R34's cular wound. LPN-A stated amount of serosanguineous (a nage, or exudate, secreted by esponse to tissue) drainage fore throwing the dressing in ated the vascular wound was a "slough" (dead tissue within a nd bed.LPN-A applied betadine nd, once dried, applied a foam PN-A used a marker to date border dressing. LPN-A stated I have been changed on sing LPN-A removed was should have been assessed on d care WCN. LPN-A stated hy R34 did not receive wound				
		on 8/7/24 at 10:46 a.m., RN-A ware R34 had an open				

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	COMPLETED			
		00091	B. WING		08/07/	2024
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
CUYUNA	A REGIONAL MEDICA	L CENTER	T MAIN STRE Y, MN 56441	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 5	2 830			
	scabbed over and F during wound round					
	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.					
	director of nursing (R34's wound as coronly assume RN-B change R34's dress were expected to followere expected to document accurate were expected to detect	on 8/7/24 at 12:55 p.m., the (DON) stated RN-B did sign of mplete on 8/6/24 and could believed the WCN would sing that day. Nursing staff ollow wound care orders and ly. Additionally, nursing staff ocument a description of the kly and/or if a change	ff			
	On 8/7/24 at 1:45 p RN-B was attempte	.m., a phone interview with ed.				
	undated, identified	ound and Skin Care Protocols wounds required weekly hinimum and with changes in condition.	S			
	The DON or design policies and system are monitored and assessment, care part of their train all staff and their trains are trained and their trains and their trains are trained and their trained and train	HOD OF CORRECTION: nee could review facility ns to ensure chronic wounds cared for according to residen plan and physician orders. and perform audits to ensure ceiving appropriate nursing	t			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00091	B. WING		08/0	7/2024
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
CUYUNA	REGIONAL MEDICA	L CENTER	MN 56441			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 6	2 830			
	care and monitoring	j .				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
21100	MN Rule 4658.0650 Storage of Perishab	Subp. 5 Food Supplies; ole food	21100			9/4/24
	perishable food muswashable, corrosion	of perishable food. All st be stored off the floor on n-resistant shelving under and at temperatures which spoilage.				
	by: Based on observation review, the facility fa	ent is not met as evidenced on, interview and document ailed to ensure a unit ned a safe temperature for is had the potential to affect all wed food from unit		Corrected		
	Findings include:					
	unit refrigerator con yogurt. A regular the refrigerator and a re	on 8/7/24 at 11:06 a.m., the tained milk, cheese, and ermometer was not in the unit equest was made to the of temperatures for the 24.				
	culinary director star range the unit refrig When the unit refrig the set range of the system, an alert wo	on 8/7/24 at 2:12 p.m., the ted she did not know the erator should be set at. gerator temperature was out of automated monitoring uld be sent out to the culinary echnician, and the executive				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMF		E SURVEY PLETED	
		00091	B. WING		08/	07/2024
	PROVIDER OR SUPPLIER	320 EAS	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21100	the temperature range the notified at. The History Detail Frefrigerator dated 8. 12:00 a.m. through temperatures in the monitored every 15 monitoring system. temperatures were Fahrenheit (F) for the 18/1/24 at 12:00 a.m. (75 hours (hr), 15 m. (2 hr, 00 m) -8/4/24 at 5:45 a.m. (2 hr, 00 m) -8/5/247 at 2:15 a.m. (60 hr, 15 m) The total time the urange was 6 days, 6 total of 6 days, 14 h. During an interview bio-med technician temperature range kept at nor did he krange the automate. An email was received the technician identifying system was set to a 48.2 degrees F. During an interview director of nursing (refrigerator would be 41 degrees F to enserted the system.)	ry director could not identify age or what temp she would Report for Skyview unit 7/24, identified from 8/1/24 at 8/7/24 at 2:30 p.m. unit refrigerator were minutes via an automated The report identified at or above 41 degrees are following times. h., through 8/4/24 at 3:15 a.m,				

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STATE FORM NT1E11 If continuation sheet 8 of 13

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
		00091	B. WING		08/0	07/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CUYUNA	REGIONAL MEDICA	I CENTER	MAIN STRE MN 56441	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21100	Continued From pa	ge 8	21100			
	who received milk,	re caused illness in residents cheese, or yogurt. Food cording to the food storage				
	identified time/temp (TCS) foods must b	Storage policy dated 2021 berature control for safety be maintained below 41 atures for refrigerators should degrees F.				
	The dietary manage develop and implement train staff, assure remanner to minimize food borne illness. ensure ongoing cor	HOD OF CORRECTION: er or designee (s) could nent policies and procedures, efridgerated food is stored in a e the possible development of Develop monitoring systems to appliance and report the lity Assurance Committee.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			9/4/24
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to implement enhanced (EBP) for 1 of 2 residents chronic wounds.		Corrected		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ER. ` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00091	B. WING		08/	07/2024
NAME OF	PROVIDER OR SUPPLIER		TREET ADDRESS, CITY,	,		
CUYUNA	A REGIONAL MEDICA	L CENTER	20 EAST MAIN STRE ROSBY, MN 56441	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATION		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
21375	Continued From pa Findings include:	ge 9	21375			
	7/1/24, identified R3 included peripheral slow and progressivessels. PVD may a of the heart. This in lymphatic vessels, such as the enough blood flow fand feet are most of and coronary artery unhealed venous of defect of skin, most that fails to heal spot by chronic venous of duplex ultrasound to R34's care plan revalential alteration	ised 7/3/24, identified Finishing in skin integrity related	outside ns, or se t get e legs nsion, ckness region, ained ous			
	recent right below the ischemic limb, perignostic limb, perignosti	and wound care nurse eft lateral ankle venous to paint left ankle vascu	o e. e ulcer. ular			
	dressing for protect	d to direct staff to imple				
	the following: Wound care: apply one time a day for I Paint daily with beta	to left lateral ankle topic eft ankle vascular wour adine, cover with foam b ad at all times while in b	cally nd. border			

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		` ′	DATE SURVEY COMPLETED	
		00091	B. WING		08/0	7/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 320 EAST MAIN STREET CROSBY, MN 56441							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
21375	staff regarding EBP wound. R34's Skin/Comfort a.m., identified R34 that morning to follow that morning to follow shape likened to a form those on either sincted on old dressing 0.6 centimeters (cm Surrounding tissue Foot had a purple had continue to paint so with foam border as protection. R34 wou monthly. The note of chronic vascular wound and its cond R34's Skin Observation., identified R34 note failed to identify wound and its cond R34's Electronic Transport (ETAR) date R34 received wound R34's door contained nor was personal provided and its cond contained to the protection of	If. The order did not direct for R34's chronic vascular note dated 7/16/24 at 10:50 was seen on wound rounds ow up on vascular wound to a (a bony projection with a nammer head, especially each de of the ankle). No drainage ng. Wound measured 1.0 x n). Thin, dry scab noted. blanchable erythema/redness. ue while dependent. Will ab with betadine and cover the sive dressing for all be seen on wound rounds lid not identify EBP for R34's bund. Attion dated 7/27/24 at 9:20 is skin integrity, however, the sy R34's left lateral ankle ition.					

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STATE FORM NT1E11 If continuation sheet 11 of 13

PRINTED: 08/26/2024 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00091	B. WING		08/	07/2024
	PROVIDER OR SUPPLIER A REGIONAL MEDICA	L CENTER 320 EAS	DDRESS, CITY, ST T MAIN STREE ', MN 56441			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21375	was "slough" (dead wound bed. LPN-A hand sanitizer and did not implement ELPN-A applied beta once dried, applied LPN-A used a mark border dressing. LF gloves, removed the and left R34's room know why R34 was an open chronic wound and determine the At 11:01 a.m., RN R34 had an open wounderstood was R34 and R34 was no lor rounds. RN-A had put that included herse physicians, and nur updated with changer report changes in room the room of the results of th	wound was open and there tissue within a wound) in the removed her gloves, used applied clean gloves. LPN-A EBP nor applied a gown. Idine to the wound bed and, a foam border dressing. Wer to date and initial the foam PN-A removed the soiled trash, used hand sanitizer in LPN-A stated she did not not on EBP because R34 had bound. Ton 8/7/24 at 10:46 a.m., RN-A know why R34 was not on the would need to look into his ne what it was. -A stated she was unaware				
	R34's physician statement vascular wound. Prince identified the wound opened which was for the wound as be	ted R34 had a chronic evious nursing reports was scabbed over, but had expected. Staff wanted to care st as possible to protect the the only leg R34 had.				

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STATE FORM NT1E11 If continuation sheet 12 of 13

PRINTED: 08/26/2024 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	\ \ /	(X3) DATE SURVEY COMPLETED	
		00004		B. WING		004	07/0004
		00091		D. WING		08/	07/2024
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
CUYUNA	REGIONAL MEDICA	L CENTER		MAIN STRE MN 56441			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21375	Continued From pa	ge 12		21375			
	director of nursing expected to implement until healed. The facility's undate Barrier Precautions identified residents becoming colonized Resistant Organism of MDROs was high the policy of this fact Barrier Precautions approach, to help retransmission of MDROs was high-contact reside	on 8/7/24 at 11:31 at (DON) stated staff we nent EBP for chronic ed Care Center Enhanced Procedulation with New (MDROs) as the part of this care setting in this care setting in this care setting educe and prevent the ROs. Enhanced Bared gown and glove using opening requiring the care activities such that care activities ac	ere wounds anced re policy, of fultidrug revalence g. It was hanced eventative re rier se during h as				
	The DON or design policies and practic discontinueing EBF audits to ensure EE	THOD OF CORRECTION COULT THE COURT THE COURT THE COURT TO	lity d perform d.				

Minnesota Department of Health

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PRINTED: 08/26/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NILIMBED.		IPLE CONSTRUCTION IG 02 - 2007 DAYROOM	(X3) DATE SURVEY COMPLETED	
		245232	B. WING _		(08/06/2024
	ROVIDER OR SUPPLIER REGIONAL MEDICAL CE	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 320 EAST MAIN STREET CROSBY, MN 56441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	}	KO	000		
	FIRE SAFETY					
	conducted by the Mir Safety, State Fire Ma At the time of this sur Medical Center was f the requirements for Medicare/Medicaid at Life Safety from Fire, National Fire Protecti Life Safety Code (LS	t 42 CFR, Subpart 483.70(a), and the 2012 edition of on Association (NFPA) 101, C), Chapter 19 Existing 2012 edition of NFPA 99,				
	ALLEGATION OF CO DEPARTMENT'S AC SIGNATURE AT THE	BOTTOM OF THE FIRST -2567 FORM WILL BE USED				
	ONSITE REVISIT OF CONDUCTED TO VACCOMPLIANCE WITH	AN ACCEPTABLE POC, AN YOUR FACILITY MAY BE ALIDATE THAT SUBSTANTIAL THE REGULATIONS HAS ACCORDANCE WITH YOUR				
	PLEASE RETURN T FOR THE FIRE SAFI (K-TAGS) TO:	HE PLAN OF CORRECTION ETY DEFICIENCIES				
		N THE E-POC PROCESS, A HE PLAN OF CORRECTION				
	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE 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.

NAME OF PROVIDER OR SUPPLIER CUYUNA REGIONAL MEDICAL CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 320 EAST MAIN STREET CROSBY, MN 56441 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		ONSTRUCTION 2007 DAYROOM	1` ′	ATE SURVEY OMPLETED
CUYUNA REGIONAL MEDICAL CENTER (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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:			245232	B. WING _				08/06/2024
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			NTER		320	EAST MAIN STREET		
IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETION DATE
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	IS NOT REQUIRED. Healthcare Fire Inspectate Fire Marshal Divalent Minnesota St., St. St. Paul, MN 55101-5. By email to: FM.HC.Inspections@ THE PLAN OF CORFEDEFICIENCY MUST FOLLOWING INFOR. 1. A detailed descriptaken or planned to consure the deficient. 3. Indicate how the performance to ensure the deficient. 4. Identify who is reactions and monitorin. 5. The actual or prother remedy. Cuyuna Regional Mean building with a basem constructed in 1962, a separated with a 2-houdetermined to be of Tomajor addition was constructed in 1962, a separated with a 2-houdetermined to be of Tomajor addition was constructed in 1962, a separated with a 2-houdetermined to be of Tomajor addition was constructed in 1962, a separated with a 2-houdetermined to be of Tomajor addition was constructed in 1962, a separated with a 2-houdetermined to be of Tomajor addition was constructed in 1962, a separated with a 2-houdetermined to be of Tomajor addition was constructed in 1962, a separated with a 2-houdetermined to be of Tomajor addition was constructed in 1962, a separated with a 2-houdetermined to be of Tomajor addition was constructed in 1962, a separated with a 2-houdetermined to be of Tomajor addition was constructed in 1962, a separated with a 2-houdetermined to be of Tomajor addition was constructed in 1962, a separated with a 2-houdetermined to be of Tomajor addition was constructed in 1962, a separated with a 2-houdetermined to be of Tomajor addition was constructed in 1962, a separated with a 2-houdetermined to be of Tomajor addition was constructed in 1962, a separated with a 2-houdetermined to be of Tomajor addition was constructed in 1962, a separated with a 2-houdetermined to be of Tomajor addition was constructed in 1962, a separated with a 2-houdetermined to be of Tomajor addition was constructed in 1962, a separated with a 2-houdetermined to be of Tomajor addition was constructed in 1962, a separated with a 2-houdetermined to 2-houdetermined to 2-houdetermined to 2-houdetermined to 2-houdetermined to 2-houdeterm	ections vision uite 145 5145, OR State.mn.us RECTION FOR EACH INCLUDE ALL OF THE MATION: ption of the corrective action orrect the deficiency. sures that will be put in place acy does not reoccur. facility plans to monitor future are solutions are sustained. sponsible for the corrective ag of compliance. posed date for completion of dical Center is a 1-story and Center is a 1-sto					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND IMPED.		IPLE CONSTRUCTION NG 02 - 2007 DAYROOM	(X3) DATE SURVEY COMPLETED	1 ` '	
		245232	B. WING _		08/06/2024	4	
	ROVIDER OR SUPPLIER REGIONAL MEDICAL C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 320 EAST MAIN STREET CROSBY, MN 56441			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLE	ÉTION	
K 000	main entrance area (dayroom) in 1996 of 2007 a 10 foot by 30 constructed to the not determined to be Type separated with a 2-h divided into seven sometime and 2-hour fit. The entire building is automatic fire sprinkly alarm system with some corridor system, in contact the department notification.	(dining room) and south wing f Type II (111) construction. In a foot dayroom addition was been threat wing, was been in the barrier. The building is make compartments by 30 ire barriers. It is protected with a complete ler system and has a fire make detection throughout the tommon areas, and in the state monitored for automatic fication.	K	000			
	are NOT MET as evil Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is with NFPA 96, Stand Fire Protection of Co- unless: * residential cooking appliances such as re toasters) are used for cooking in accordance * cooking facilities or	42 CFR, Subpart 483.70(a), denced by: Is protected in accordance lard for Ventilation Control and emmercial Cooking Operations, equipment (i.e., small microwaves, hot plates, or food warming or limited ce with 18.3.2.5.2, 19.3.2.5.2 ben to the corridor in smoke 30 or fewer patients comply	K	324	8/13/24	4	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 02 - 2007 DAYROOM 245232 B. WING 08/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **320 EAST MAIN STREET CUYUNA REGIONAL MEDICAL CENTER CROSBY, MN 56441** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 324 | Continued From page 3 K 324 * 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 Corrective action: Contractor notified of interview, the facility failed to test and inspect the missing pieces of documentation; these kitchen hood ventilation and fire suppression were provided to the Facilities Manager by system per NFPA 101 (2012 edition), Life Safety the Contractor within 1 week of survey. Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection Establishment of new process to ensure all of Commercial Cooking Operations, section documentation is sent to a single inbox by 11.2.1. This deficient finding could have an isolated contractors that can be closely monitored by the Facilities Manager and the Facilities impact on the residents within the facility. Assistant to ensure all parties have continuous access to incoming Findings Include: documents. On 08/06/2024, between 10:30am and 2:30pm, it was revealed by a review of available Creation and implementation of process that any contractors are completing work documentation that inspection documentation for the kitchen hood ventilation and fire suppression that is subject to inspection by Fire system was not available. The facility could not Marshal or Joint Commission, will be provide completed test/inspection documentation checked by Facilities Manager prior to for the semi-annual kitchen hood suppression departure of contractors completing work. system inspections for the last 12 months. Supervising staff of contractors completing work will be expected to provide An interview with the Maintenance Director and documentation necessary before invoice the Execive Director of Facilities verified this will be paid for services rendered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION G 02 - 2007 DAYROOM	(X3) DATE SURVEY COMPLETED
		245232	B. WING		08/06/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CO 320 EAST MAIN STREET CROSBY, MN 56441	DE
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COMMERCE (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLÉTION DATE
K 345 SS=F	deficient finding at the		K 3	Facilities Manager will monit action and ongoing complian	
	A fire alarm system is accordance with an a with the requirements Electric Code, and Ni and Signaling Code. acceptance, maintent available. 9.6.1.3, 9.6.1.5, NFP. This REQUIREMENT Based on a review of staff interview, the fact alarm system per NF Safety Code, section edition), National Fire section 14.2.1.2.2. The have a patterned important the facility. Findings include: On 08/06/2024, between was revealed by a residue documentation that the inspection report processing processing in the facility of t	A 70, NFPA 72 T is not met as evidenced by: of available documentation and cility failed to maintain the fire PA 101 (2012 edition), Life 9.6.1.3, and NFPA 72 (2010 e Alarm and Signaling Code hese deficient findings could eact on the residents within		Corrective action: contractor missing pieces of documentation were provided to the Facilities the contractor with 1 week or Establishment of new process documentation is sent to a secontractors that can be closed by the Facilities Manager and Assistant to ensure all partice continuous access to incomit documents. Establishment of new process documentation is sent to a secontractors that can be closed by the Facilities Manager and Assistant to ensure all partice continuous access to incomit documents.	ation; these es Manager by f survey. ss to ensure all ingle inbox by ely monitored d the Facilities es have ng ss to ensure all ingle inbox by ely monitored d the Facilities es have ss have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NILIMBED:		E CONSTRUCTION D2 - 2007 DAYROOM	(X3) DATE SURVEY COMPLETED
		245232	B. WING		08/06/2024
	ROVIDER OR SUPPLIER	ENTER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 820 EAST MAIN STREET CROSBY, MN 56441	-
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION DATE
K 345 K 353 SS=F	deficient finding at the Sprinkler System - M		K 345	Facilities Manager will monitor correct action and ongoing compliance.	tive 8/14/24
	Automatic sprinkler a inspected, tested, an with NFPA 25, Standard and Maintaining of W. Systems. Records of maintenance, inspect	tion and testing are re location and readily			
	b) Who provided sys				
	Provide in REMARKS any non-required or paystem. 9.7.5, 9.7.7, 9.7.8, and This REQUIREMENT 1) Based on a review and staff interview, the automatic sprinkler syledition), Life Safety C. 4.6.12, NFPA 25 (20° Inspection, Testing, and Water-Based Fire Properties of the Properties of t	S information on coverage for partial automatic sprinkler of NFPA 25 It is not met as evidenced by: It of available documentation the facility failed to maintain the system per NFPA 101 (2012) Code Section 19.7.6, and 11 edition), Standard for the		1) Corrective action: contractor notified missing pieces of documentation; these were provided to the Facilities Manage the contractor with 1 week of survey. Establishment of new process to ensure documentation is sent to a single inborcontractors that can be closely monited by the Facilities Manager and the Facilities Manager and the Facilities Manager and the Facilities access to incoming documents.	er by ure all ox by ored

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENITICIONI NILIMPED.		LE CONSTRUCTION 3 02 - 2007 DAYROOM	(X3) DATE SURVEY COMPLETED
		245232	B. WING		08/06/2024
NAME OF PROVIDER OR SUPPLIER CUYUNA REGIONAL MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 320 EAST MAIN STREET CROSBY, MN 56441	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION SHOOT	ULD BE COMPLÉTION
K 353	Continued From pag	je 6	K 35	3	
K 372 SS=F	was revealed by a redocumentation the far quarter sprinkler systems (July - September). 2) Based on observational facility failed to maintain and the sprinkler systems (2011 edition), Standard Maintenance of Systems, Section 5.2 edition), Standard for Systems, Sections 8 deficient findings couresidents within the face of the findings include: On 08/06/2024, between the findings include: On 08/06/2024, between the findings include: On 08/06/2024, between the findings include: An interview with the Executive Director of deficient finding at the Subdivision of Building CFR(s): NFPA 101	acility failed to perform the tem testing in the third quarter ation and staff interview, the tain spacing between storage stem per NFPA 101 (2012 Code, Section 9.7.5, NFPA 25 dard for the Inspection, Testing, Water-Based Fire Protection 2.1.2, and NFPA 13 (2010 r the Installation of Sprinkler .6.5.3.2 and 8.15.9. These ald a patterned impact on the facility. I ween 10:30am and 2:30pm, it revation that storage materials a storage rack, bringing the thin the required 18 inch for the sprinkler heads. These and in 665. Maintenance Director and the facilities verified this	K 37	Establishment of new process to a documentation is sent to a single is contractors that can be closely more by the Facilities Manager and the Assistant to ensure all parties have continuous access to incoming documents. Facilities Manager will monitor con action and ongoing compliance. 2) Corrective action: the maintena manager, along with the director of had a conversation with the individe currently occupies this office about clutter. Clutter, high pile storage, excleaned the next day. This office will be inspected regulatensure compliance is maintained. Offices that are known for this type clutter, high pile storage, etc. will be routinely monitored and will be instituted uning weekly EOC rounds by the Facilities Manager, Safety Officer, Director of Nursing.	inbox by conitored Facilities e rective nce of nursing dual who at the etc. was arly to e of oe spected

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	2) MULTIPLE CONSTRUCTION BUILDING 02 - 2007 DAYROOM		(X3) DATE SURVEY COMPLETED	
		245232	B. WING			08	/06/2024
	NAME OF PROVIDER OR SUPPLIER CUYUNA REGIONAL MEDICAL CENTER			32	TREET ADDRESS, CITY, STATE, ZIP CODE 20 EAST MAIN STREET ROSBY, MN 56441		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
K 372	fire resistance rating permitted to terminal dampers are not required. It is printed to terminal dampers are not required fully ducted HVAC system is insured to sprinkler system is insured to sprinkler. This REQUIREMENT Based on observation facility failed to maintan NFPA 101 (2012 editions 19.3.7.1, 19. These deficient finding impact on the resident findings include: On 08/23/2022 between was revealed by observed to another above the sprinkler. The sprinkler is another above the sprinkler. The sprinkler is another above the sprinkler. The sprinkler is a sprinkler in the sprinkler is a sprinkler in the sprinkler. The sprinkler is a sprinkler in the sprinkler is a sprinkler in the sprinkler in the sprinkler. The sprinkler is a sprinkler in the sprinkler is a sprinkler in the sprinkler in the sprinkler is a sprinkler in the sp	be constructed to a 1/2-hour per 8.5. Smoke barriers shall nate at an atrium wall. Smoke ired in duct penetrations in stems where an approved stalled for smoke ent to the smoke barrier. Inical smoke control system in it is not met as evidenced by: in and staff interview, the ain their smoke barrier per on), Life Safety Code, 3.7.3, 8.5.2.2, and 8.5.6.5. gs could have a widespread its within the facility. It is en 9:00am and 12:00pm, it is ervation that there was a som one smoke compartment following doors:	K	372	Corrective action: The facilities depart staff corrected/repaired all penetration listed. All listed penetrations were chectwice with two different engineers to enproper completion. Further education/instruction will be provided to contractors performing worthat would require any penetrations on type of critical wall/door/etc. Contractor will be expected to perform this type of work to the proper standards and comman above ceiling work permit. Any work taking place that involves the types of critical fire assemblies/system will be monitored by the facilities department to ensure compliant/quality workmanship. The facilities manager where the time of the project start and time of completion to ensure compliant/quality workmanship. Facilities Manager, Facilities Departments the time of the project start and time of completion to ensure compliant/quality workmanship.	s cked nsure rk this rs f plete	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2007 DAYROOM		(X3) DATE SURVEY COMPLETED	
		245232	B. WING _		0	8/06/2024	
NAME OF PROVIDER OR SUPPLIER CUYUNA REGIONAL MEDICAL CENTER				STREET ADDRESS, CITY, STATE 320 EAST MAIN STREET CROSBY, MN 56441	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION 'E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
K 751 SS=D	Draperies, Curtains, a Draperies, curtains in loosely hanging fabric accordance with 10.3 draperies: at showers patient sleeping room compartments; and in in sprinklered compartments; and in in sprinklered compartments are doesn't the wall. 18.7.5.1, 18.3.5.11, 1 This REQUIREMENT Based on a review of staff interview, the fact dampers per NFPA 10 Code, section 8.5.5.4 edition), Standard for Other Opening Protect and 6.5.12. This deficit widespread impact on facility. Findings include: On 08/06/2024, between the damper inspection of the damper inspection in the the fire damper inspection.	s.1. Excluding curtains and and baths; on windows in located in sprinklered non-patient sleeping rooms of the street where individual nels do not exceed 48 square is not exceed 20 percent of 9.7.5.1, 19.3.5.11, 10.3.1 is not met as evidenced by: favailable documentation and cility failed to inspect fire 01 (2012 edition), Life Safety 1.2, and NFPA 105 (2010 Smoke Door Assemblies and ctives, section 6.5.2, 6.5.11, sient finding could have an the residents within the deen 10:30am and 2:30pm, it wiew of available ne facility could not provide an report. Maintenance Director and the Facilities verified this		Corrective action: Cormissing pieces of documentation is sent contractors that can be by the Facilities Manay Assistant to ensure all continuous access to indocumentation. Creation and implementation and implementation and implementation is sent continuous access to indocuments. Creation and implementation is subject to inspending the facilities of contractors and that is subject to inspending the facilities of contractors and the facilities of the facilities of contractors and the facilities of the	ntractor notified of umentation; these facilities Manager by week of survey. process to ensure all to a single inbox by e closely monitored ger and the Facilities parties have incoming Intation of process re completing work ection by Fire mission, will be Manager prior to rs completing work.	8/9/24	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING 02 - 2007 DAYROOM 245232 B. WING 08/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 320 EAST MAIN STREET **CUYUNA REGIONAL MEDICAL CENTER CROSBY, MN 56441** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) 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 8/12/24 K 914 | Electrical Systems - Maintenance and Testing SS=D 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 Corrective action: Contractor notified of missing pieces of documentation; these staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 were provided to the Facilities Manager by Standards for Health Care Facilities 2012 edition, the Contractor within 1 week of survey. 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 Establishment of new process to ensure all on the residents within the facility. documentation is sent to a single inbox by contractors that can be closely monitored

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2007 DAYROOM			(X3) DATE SURVEY COMPLETED			
		245232	B. WING _			08/06/2024
	ROVIDER OR SUPPLIER REGIONAL MEDICAL CE	NTER		32	REET ADDRESS, CITY, STATE, ZIP CODE O EAST MAIN STREET ROSBY, MN 56441	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
K 914	Findings include: On 08/06/2024, between the required annual reduction was not survey. Documents was missing the actual reduction and the reduction was not survey.	een 10:30am and 2:30pm, it ew of available documentation eceptacle inspection of available at the time of the vere provided, nut were ceptacle reports. Maintenance Director and the Facilities verified this	K	914	by the Facilities Manager and the Facilian Assistant to ensure all parties have continuous access to incoming documents. Creation and implementation of process that any contractors are completing worthat is subject to inspection by Fire Marshal will be checked by Facilities Manager prior to departure of contractor completing work. Supervising staff of contractors completing work will be expected to provide documentation necessary before invoice will be paid for services rendered.	ss ork ors
K 920 SS=E				920	Facilities Manager will monitor correctivaction and ongoing compliance.	8/7/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		PLE CONSTRUCTION G 02 - 2007 DAYROOM	(X3) DATE SURVEY COMPLETED
		245232	B. WING _		08/06/2024
NAME OF PROVIDER OR SUPPLIER CUYUNA REGIONAL MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 320 EAST MAIN STREET CROSBY, MN 56441	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLÉTION DATE
K 920	are not used as a substructure. Extension removed immediately purpose for which it viconditions of 10.2.4. 10.2.3.6 (NFPA 99), (NFPA 70), 590.3(D) This REQUIREMENT Based on observation facility failed to maint adaptive devices per Health Care Facilities and 10.2.4.2.1, NFPA Electrical Code, section This deficient finding on the residents within Findings include: On 08/06/2024, betwowas revealed by obsessive and electrical apposition in the following of 1) Refrigerator pluggeranother power strip in 3) Power strip pluggeranother power strip in 4) Refrigerator pluggeran	ostitute for fixed wiring of a cords used temporarily are upon completion of the vas installed and meets the 10.2.4 (NFPA 99), 400-8 (NFPA 70), TIA 12-5 is not met as evidenced by: on and staff interview, the rain the usage of electrical NFPA 99 (2012 edition), a Code, sections 10.5.2.3.1 A 70, (2011 edition), National ons 400-8, and UL 1363. could have an isolated impact in the facility. The end 10:30am and 2:30pm, it ervation that there were office: The end into power strip in 1-517 ed (Daisy-chained) into an Office 1-533 ed (Daisy-chained) into	K 9	Power strip in 1-517 was reme education was given to staff. It power strips in office 1-533 remeducation given to staff. Daisy power strips in office 1-534 remeducation given to staff. Refrig plugged into power strip in Bio removed and education given Findings were addressed by C facilities management at week briefing. Findings were address facilities manager at monthly sommittee meeting. Ongoing education/reminders provided at the standing month committee meeting. Offices an appliances will be more thoroutexamined during standing were rounds. Facilities management, CRMC will monitor for ongoing compli	Daisy-chained moved and chained moved and gerator -Med was to staff. EO and ly leadership sed by afety will be hly safety ad lighly ekly EOC Cleadership