STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cuyuna Regional Medical Center	320 East Main Street Crosby, MN 56441

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to perform ongoing monitoring and wound care, as ordered, for a chronic reoccurring wound for 1 of 2 residents (R34) reviewed for wound care. Findings include: R34's quarterly Minimum Data Set (MDS) dated [DATE], identified R34 had diagnoses that included peripheral vascular disease (PVD) (a slow and progressive disorder of the blood vessels. PVD may affect any blood vessel outside of the heart. This includes the arteries, veins, or lymphatic vessels. Organs supplied by these vessels, such as the brain or legs, may not get enough blood flow for healthy function. The legs and feet are most often affected), high blood pressure, and coronary artery disease. R34 had one unhealed venous or arterial ulcer (a full-thickness defect of skin, most frequently in the ankle region, that fails to heal spontaneously and is sustained by chronic venous disease, based on venous duplex ultrasound testing). R34's care plan revised 7/3/24, identified R34 had a potential alteration in skin integrity related to risk factors associated with limited mobility and recent right below the knee amputation for ischemic limb, peripheral arterial disease to bilateral lower extremities and poor appetite. Interventions included: - Perform a skin assessment weekly - Wound care nurse (WCN) assessed left lateral ankle venous ulcer. Staff were directed to paint left ankle vascular wound with betadine and apply foam border dressing for protection. R34's physician orders dated 6/18/24, identified the following: Wound care: apply to left lateral ankle topically one time a day for left ankle vascular wound. Paint daily with betadine, cover with foam border for protection. Offload at all times while in bed with pillow under calf. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R34's Skin/Comfort note dated 7/16/24 at 10:50 a.m., identified R34 was seen on wound rounds to follow up on vascular wound to left lateral malleolus (a bony projection with a shape likened to a hammer head, especially each of those on either side of the ankle). No drainage was noted on the old dressing. Wound measured 1.0 x 0.6 centimeters (cm). Thin, dry scab noted. Surrounding tissue blanchable erythema/redness. Foot had a purple hue while dependent. Will continue to paint scab with betadine and cover with foam border adhesive dressing for protection. R34 would be seen on wound rounds monthly. R34's Skin Observation dated 7/27/24 at 9:20 a.m., identified R34's skin integrity; however, the note failed to identify R34's left lateral ankle wound and its condition. R34's Electronic Treatment Administration Record (ETAR) dated 7/16/24- 8/7/24, identified R34 received wound care daily. Additionally, on 8/6/24, the ETAR identified RN-B signed off R34's left lateral ankle wound care as complete. During an observation on 8/7/24 at 10:36 a.m., licensed practical nurse (LPN)-A applied gloves and removed a foam border dressing from R34's left outer ankle vascular wound. LPN-A stated there was a small amount of serosanguineous (a type of wound drainage, or exudate, secreted by an open wound in response to tissue) drainage on the dressing before throwing the dressing in the trash. LPN-A stated the vascular wound was open and there was slough (dead tissue within a wound) in the wound bed.LPN-A applied betadine to the wound bed and, once dried, applied a foam border dressing. LPN-A used a marker to date and initial the foam border dressing. LPN-A stated the dressing should have been changed on 8/6/24, but the dressing LPN-A removed was dated 8/5/24. R34 should have been assessed on 8/6/24 by the wound care WCN. LPN-A stated she did not know why R34 did not receive wound care on 8/6/24. During an interview on 8/7/24 at 10:46 a.m., RN-A stated she was unaware R34 had an open wound. RN-A understood R34's wound was scabbed over and R34 was no longer followed during wound rounds. During an interview on 8/7/24 at 11:28 a.m., R34's physician stated R34 had a chronic vascular wound. Previous nursing reports identified the wound was scabbed over but had opened which was expected. R34's wound did not show signs/symptoms of infection but the WCN should evaluate R34. Staff wanted to care for the wound as best as possible to protect the leg because it was the only leg R34 had. During an interview on 8/7/24 at 12:55 p.m., the director of nursing (DON) stated RN-B did sign off R34's wound as complete on 8/6/24 and could only assume RN-B believed the WCN would change R34's dressing that day. Nursing staff were expected to follow wound care orders and document accurately. Additionally, nursing staff were expected to document a description of the wound at least weekly and/or if a change occurred. On 8/7/24 at 1:45 p.m., a phone interview with RN-B was attempted. The facilty policy Wound and Skin Care Protocols undated, identified wounds required weekly documentation at minimum and with changes in wound appearance/condition.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40948 Based on observation, interview and document review, the facility failed to ensure a unit refrigerator maintained a safe temperature for storage of food. This had the potential to affect all residents who received food from unit refrigerator. Findings include: During observation on 8/7/24 at 11:06 a.m., the unit refrigerator contained milk, cheese, and yogurt. A regular thermometer was not in the unit refrigerator and a request was made to the culinary director log of temperatures for the month of August 2024. During an interview on 8/7/24 at 2:12 p.m., the culinary director stated she did not know the range the unit refrigerator should be set at. When the unit refrigerator temperature was out of the set range of the automated monitoring system, an alert would be sent out to the culinary director, bio-med technician, and the executive director. The culinary director could not identify the temperature range or what temp she would be notified at. The History Detail Report for Skyview unit refrigerator dated 8/7/24, identified from 8/1/24 at 12:00 a.m. through 8/7/24 at 2:30 p.m. temperatures in the unit refrigerator were monitored every 15 minutes via an automated monitoring system. The report identified temperatures were at or above 41 degrees Fahrenheit (F) for the following times. -8/1/24 at 12:00 a.m., through 8/4/24 at 3:15 a.m, (75 hours (hr), 15 minutes (m) -8/4/24 at 5:45 a.m. through 8/4/24 at 7:45 a.m. (2 hr, 00 m) -8/4/24 at 12:45 p.m. through 8/5/24 at 1:45 a.m. (13 hr, 00 m) -8/5/247 at 2:15 a.m. through 8/7/24 at 2:30 p.m. (60 hr, 15 m) The total time the unit refrigerator was out of range was 6 days, 6 hours, and 30 minutes of a total of 6 days, 14 hours, and 30 minutes. During an interview on 8/7/24 at 2:19 p.m., the bio-med technician stated he was unaware of the temperature range the unit refrigerator was to be kept at nor did he know the temperature alert range the automated monitoring system had. An email was received from the bio-med technician identifying the automated monitoring system was set to a range of 33.8 degrees F to 48.2 degrees F. During an interview on 8/7/24 at 2:50 p.m., the director of nursing (DON) stated the unit refrigerator would be kept at a temperature below 41 degrees F to ensure safe storage temperature of food, so it does not spoil. If the food was spoiled, it could have caused illness in residents who received milk, cheese, or yogurt. Food should be stored according to the food storage policy. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Food Storage policy dated 2021 identified time/temperature control for safety (TCS)foods must be maintained below 41 degrees F. Temperatures for refrigerators should be between 35-39 degrees F.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to implement enhanced barrier precautions (EBP) for 1 of 2 residents (R34) reviewed for chronic wounds. Findings include: R34's quarterly Minimum Data Set (MDS) dated [DATE], identified R34 had diagnoses that included peripheral vascular disease (PVD) (a slow and progressive disorder of the blood vessels. PVD may affect any blood vessel outside of the heart. This includes the arteries, veins, or lymphatic vessels. Organs supplied by these vessels, such as the brain or legs, may not get enough blood flow for healthy function. The legs and feet are most often affected), hypertension, and coronary artery disease. R34 had one unhealed venous or arterial ulcer (a full-thickness defect of skin, most frequently in the ankle region, that fails to heal spontaneously and is sustained by chronic venous disease, based on venous duplex ultrasound testing). R34's care plan revised 7/3/24, identified R34 had a potential alteration in skin integrity related to risk factors associated with limited mobility and recent right below the knee amputation for ischemic limb, peripheral arterial disease to bilateral lower extremities and poor appetite. Interventions included: Perform a skin assessment weekly and wound care nurse (WCN) assessed left lateral ankle venous ulcer. Staff were directed to paint left ankle vascular wound with betadine and apply foam border dressing for protection. The care plan failed to direct staff to implement or follow EBP during wound care. R34's physician orders dated 6/18/24, identified the following: Wound care: apply to left lateral ankle topically one time a day for left ankle vascular wound. Paint daily with betadine, cover with foam border for protection. Offload at all times while in bed with pillow under calf. The order did not direct staff regarding EBP for R34's chronic vascular wound. R34's Skin/Comfort note dated 7/16/24 at 10:50 a.m., identified R34 was seen on wound rounds that morning to follow up on vascular wound to left lateral malleolus (a bony projection with a shape likened to a hammer head, especially each of those on either side of the ankle). No drainage noted on old dressing. Wound measured 1.0 x 0.6 centimeters (cm). Thin, dry scab noted. Surrounding tissue blanchable erythema/redness. Foot had a purple hue while dependent. Will continue to paint scab with betadine and cover with foam border adhesive dressing for protection. R34 would be seen on wound rounds monthly. The note did not identify EBP for R34's chronic vascular wound. R34's Skin Observation dated 7/27/24 at 9:20 a.m., identified R34's skin integrity, however, the note failed to identify R34's left lateral ankle wound and its condition. R34's Electronic Treatment Administration Record (ETAR) dated 7/16/24 - 8/7/24, identified R34 received wound care daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/7/24 at 10:36 a.m., R34's door contained no signage regarding EBP nor was personal protective equipment (PPE) available for use. Licensed practical nurse (LPN)-A applied gloves and removed a foam border dressing from R34's left outer ankle vascular wound. LPN-A stated there was a small amount of serosanguineous (a type of wound drainage, or exudate, secreted by an open wound in response to tissue) drainage on the dressing before throwing the dressing in the trash. LPN-A stated the vascular wound was open and there was slough (dead tissue within a wound) in the wound bed. LPN-A removed her gloves, used hand sanitizer and applied clean gloves. LPN-A did not implement EBP nor applied a gown. LPN-A applied betadine to the wound bed and, once dried, applied a foam border dressing. LPN-A used a marker to date and initial the foam border dressing. LPN-A removed the soiled gloves, removed the trash, used hand sanitizer and left R34's room. LPN-A stated she did not know why R34 was not on EBP because R34 had an open chronic wound. During an interview on 8/7/24 at 10:46 a.m., RN-A stated she did not know why R34 was not on EBP. RN-A stated she would need to look into his wound and determine what it was. - At 11:01 a.m., RN-A stated she was unaware R34 had an open wound. The last she understood was R34's wound was scabbed over and R34 was no longer followed during wound rounds. RN-A had previously set up a group email that included herself, administration, the physicians, and nursing to ensure everyone was updated with changes and staff were expected to report changes in resident conditions timely. There was signage and supplies available and nursing was expected to implement EBP as soon as possible to prevent a potential for infection transmission in chronic wounds and should have done so. During an interview on 8/7/24 at 11:28 a.m., R34's physician stated R34 had a chronic vascular wound. Previous nursing reports identified the wound was scabbed over, but had opened which was expected. Staff wanted to care for the wound as best as possible to protect the leg because it was the only leg R34 had. During an interview on 8/7/24 at 11:31 a.m., the director of nursing (DON) stated staff were expected to implement EBP for chronic wounds until healed. The facility's undated Care Center Enhanced Barrier Precautions Policy and Procedure policy, identified residents were at higher risk of becoming colonized and infection with Multidrug Resistant Organisms (MDROs) as the prevalence of MDROs was higher in this care setting. It was the policy of this facility to implement Enhanced Barrier Precautions, using PPE, as a preventative approach, to help reduce and prevent the transmission of MDROs. Enhanced Barrier Precautions involved gown and glove use during high-contact resident care activities such as wound care (any skin opening requiring a dressing).

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review, the facility failed to provide and document the most recent Centers for Disease Control (CDC) education regarding the potential risks and benefits of the pneumococcal vaccine for 3 of 5 residents (R20, R39, R42) reviewed for immunizations. Findings include: R20's significant change Minimum Data Set (MDS) dated [DATE], identified R20 was [AGE] years old and had diagnoses that included diabetes mellitus, and hypertension. R20's immunization record dated 8/7/24, identified R20 refused a pneumococcal conjugate (PCV20) vaccination. R20's admission note dated 6/20/24 at 12:48 p.m., identified R20 declined when offered pneumonia vaccine. However, the admission note failed to identify what education, if any, education R20 received regarding pneumococcal vaccination. R20's Care Center Pneumococcal Immunization Consent dated 6/20/24, identified R20's signed refusal of a pneumococcal vaccination. However, the document failed to identify which pneumococcal vaccine R20 was offered and/or what education was provided. During a phone interview on 8/7/24 at 10:52 a.m., family member (FM)-A stated R20 a pneumococcal vaccination when offered by the facility but could not recall what education, if any, R20 received. R39's admission MDS dated [DATE], identified R39 was [AGE] years old and had diagnoses that included coronary artery disease, hypertension, dementia and renal insufficiency. R39's immunization record dated 8/7/24, identified R39 refused a PCV20. R39's Care Center Pneumococcal Immunization Consent dated 5/23/24, identified R39's family representative signed refusal of a pneumococcal vaccination. However, the document failed to identify which pneumococcal vaccine R39 was offered and/or what education was provided. R39's nursing progress note dated 6/6/24, identified R39's family represenative was provided education regarding a respiratory syncytial virus (RSV) vacccine, however, did not identify if R39's family representative was provided education regarding pneumococcal vaccination. During a phone interview on 8/7/24 at 11:08 a.m., FM-B stated she believed vaccinations were discussed during R39's care conference but could not recall what education had been provided. R42's admission MDS dated [DATE], identified R42 was [AGE] years old and had diagnoses that included hypertension, Diabetes Mellitus, and dementia. R42's immunization record dated 8/7/24, identified R42's family representative refused pneumococcal vaccination. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R42's Care Center Pneumococcal Immunization Consent dated 6/24/24, identified R42's family representative signed refusal of a pneumococcal vaccination. However, the document failed to identify which pneumococcal vaccine R42 was offered and/or what education was provided. During a phone interview on 8/7/24 at 2:17 p.m., R42's family representative did not recall what education was provided regarding vaccinations. During an interview on 8/6/24 at 4:19 p.m., registered nurse (RN)-A stated she created a form for documentation of offering, education and acceptance/refusal of pneumococcal immunizations. However, RN-A stated nursing did not complete the forms as directed and RN-A could not confirm what education R20, R39 and R42 or their family representative had been provided. RN-A stated nursing staff were expected to fully complete the forms for documentation to ensure residents and their family representatives were fully and accurately informed. During an interview on 8/7/24 at 12:55 p.m., the director of nursing (DON) stated RN-A had been working diligently to update vaccination documenation forms to ensure correct documentation of offer, education and acceptance/refusal of vaccinations. The DON stated nursing staff were expected to complete the documentation accurately and fully. A facility pneumococcal policy was requested but not received.