DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 26, 2020

Administrator
Cook Community Hospital C&nc
10 Southeast Fifth Street
Cook, MN 55723

RE: CCN: 245392
Cycle Start Date: April 3, 2020

Dear Administrator:

On May 29, 2020, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered
April 22, 2020

Administrator
Cook Community Hospital C&NC
10 Southeast Fifth Street
Cook, MN 55723

SUBJECT: SURVEY RESULTS
CCN: 245392
Cycle Start Date: Cycle Start Date: April 3, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On April 3, 2020, a survey was completed at your facility by the Minnesota Department of Health completed a COVID-19 Focused Survey at Cook Community Hospital C&nc to determine if your facility was in compliance with Federal requirements related to the implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable plan of correction (POC) for the enclosed deficiencies that were cited during the April 3, 2020 survey. Cook Community Hospital C&nc may choose to delay submission of a POC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a POC. An acceptable POC will serve as your

allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC 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; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Please send your POC by fax or email to:

Teresa Ament, Unit Supervisor
Email: teresa.ament@state.mn.us
Fax: (218) 723-2359

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 3, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Teresa Ament, Unit Supervisor
Email: teresa.ament@state.mn.us
Fax: (218) 723-2359

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Cook Community Hospital C&nc may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	04/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK COMMUNITY HOSPITAL C&NC	10 SOUTHEAST FIFTH STREET COOK, MN 55723

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 4/2/20, through 4/3/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was in full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facilty acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted 4/2/20 to 4/3/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined not to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		5/11/20

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

Electronically Signed | 05/04/2020

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F 880	Continued From page 1 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880		

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F 880	Continued From page 2 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to discontinue communal dining and maintain appropriate social distancing for residents. This had the potential to affect all 28 residents who resided at the facility. In addition, the facility failed to ensure an aerosolized nebulizer treatment was administered in a private room for 1 of 1 residents (R1) reviewed for nebulizer administration. In addition, the facility failed to perform hand hygiene after performing perineal cares to prevent cross contamination for 1 of 1 residents (R2) reviewed for personal cares.	F 880	TABLES/SEATING: On 4/2/20 DON immediately added additional tables to accommodate those residents whom changed their previous seating arrangements related to COVID 19, and staff were re-educated as to the required 6 feet social distancing. The floors in the dining/common areas were marked with "X's" for the minimum distances of 6 feet to ensure compliance by residents and to guide the staff as a reference. Audits have been performed daily by DON to ensure proper distancing at meals is	

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F 880	Continued From page 3 Findings include: On 4/2/20, at 9:25 a.m. the north household dining room was observed. Three tables were observed in the dining room. Two square tables measured approximately 4 feet (ft.) x 4 ft., and one rectangular table measured approximately 8 ft. x 4 ft. were located in the commons area. Two place settings at the rectangular table contained dirty dishes, and were observed adjacent to one another. Four place settings, each containing dirty dishes, were observed at each square table. No residents were present in the dining room at this time. On 4/2/20, at 9:33 a.m. the south household commons area was observed. No residents or places settings were observed. On 4/2/20, at 11:34 a.m. three residents were observed at a rectangular table in the south household commons area. One resident was positioned at the end of the table. Two residents were positioned directly across from each other. The residents directly across from each other were approximately 4 ft. apart. On 4/2/20, at 11:36 a.m. two residents were observed positioned adjacent to each other at a square table in the north household commons area. The two residents were approximately 3 ft. from each other. Two other residents were seated at an overhanging countertop which extended from the nursing units kitchenette. These two residents were approximately 2 ft. away from each other. On 4/2/20, at 11:55 a.m. two residents were observed positioned near an overhanging	F 880	achieved. QAPI was created on 4/3/20 by DON to ensure proper social distancing is achieved at all times when residents are in the common areas. Audits will be completed by the DON, Infection Preventionist daily x 2 weeks, then 5 x per week x 2 weeks, then 3x per week ongoing until the social distancing is no longer recommended related to COVID 19. NEBULIZER: on 4/2/20 DON immediately moved R1's nebulizer machine and supplies to her private room. Nursing was immediately re-educated not to provide Nebulizers treatments in the common areas. Plan of Care for R1 was immediately updated to note that resident will have Nebulizer administered in her private room. All other residents treatment records were reviewed, with one other resident receiving Nebulizer treatments at this time. The DON spoke with nursing regarding the location of his nebulizer, he has always had nebulizer treatments in his private room per his request. QAPI: A QAPI was created by the DON to ensure that all Nebulizer treatments are administered in the residents private room. Ongoing audits will be completed by the DON 1x daily 5 days per week x 2 weeks, then 3x weekly x 2 weeks, then weekly x 3 weeks. HAND HYGIENE AND GLOVE USE:	

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F 880	Continued From page 4 countertop which extended from the south household kitchenette, approximately 3 ft. away from each other. Lunch was being served. Licensed practical nurse (LPN)-A was interviewed and stated the two residents were seated "too close" together. LPN-A stated residents were supposed to be six feet apart. LPN-A stated she believed the residents seated at the rectangular table were 6 ft. apart. LPN-A stated 14 residents resided on each nursing unit. LPN-A then moved the residents to opposite ends of the overhanging countertop. Seven residents were observed in the dining area during lunch. On 4/2/20, at 11:58 a.m. trained medication assistant (TMA)-A approached the two residents who remained positioned near the overhanging countertop which extended from the north household kitchenette. These residents were approximately 2 ft. away from each other. TMA-A asked one resident if it would be okay to move her because she was "too close" to the other resident. R6 consented and was moved towards the opposite end of the overhanging countertop. TMA-A placed a chair between the residents. A third resident was observed seated at a square table. All three were within a couple feet of each other. TMA-A stated the three were "too close" and estimated the residents were 3 ft. apart. TMA-A stated these seating arrangements were typical the past couple of weeks. TMA-A stated the facility had tried different seating arrangements during dining, but was having difficulty keeping residents apart. The three residents were served their meal. A total of ten residents were observed in the north household commons area. On 4/2/20, at 12:51 p.m. dietary aid (DA)-A was	F 880	on 4/3/20 all staff were re-educated by the DON on proper hand hygiene and glove use as per the Hand Hygiene policy. All staff were instructed to wash hands after removing gloves while providing peri cares, and after gloves are removed. The IP provided additional education on 4/5/20 to all staff regarding the hand hygiene policy and Infection Prevention policies. QAPI: A QAPI was created by the DON to ensure compliance by all nursing staff with Hand Hygiene policies and practices. Audits to be performed by the DON, MDS Coordinator and licensed nursing on all shifts daily x 2 weeks, then 5 x per week x 2 weeks, then 3 x per week x 2 weeks.	

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F 880	Continued From page 5	F 880		

interviewed and stated residents were supposed to be spaced 6 ft. apart during meals.

On 4/2/20, at 1:07 p.m. nursing assistant (NA)-A stated she tried to keep as much spacing as possible between residents during meals. NA-A stated she tried to keep residents a "chair length" apart and estimated this was 2 - 3 ft.

On 4/2/20, at 1:18 p.m. the director of nursing (DON) was interviewed. The DON confirmed she witnessed residents were too close in the dining room. The DON stated staff had changed resident seating arrangements, within the past day, and had not reported it. The DON confirmed the residents were eating in the dining room.

On 4/2/20, at 1:25 p.m. registered nurse (RN)-A stated residents were supposed to be 6 ft. apart during dining. RN-A stated the Minnesota Department of Health (MDH) and Centers for Centers for Disease Control and Prevention (CDC) indicated no communal dining was allowed. RN-A confirmed residents being placed in close proximity of each other was an infection control risk considering COVID-19.

A letter addressed to residents and family members dated 3/23/20, indicated "As much as possible, residents are kept six feet apart at meals. Due to not enough staff to assist with meals, we are unable to discontinue communal dining at this time for the residents' safety."

An email addressed to nursing home staff dated 3/27/20, directed "maintain social distraction of at least 6 feet for our residents."

R1's Diagnoses report undated, indicated R1's

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F 880	Continued From page 6	F 880		

diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and dyspnea (difficulty breathing).

R1's quarterly MDS dated 2/27/20, indicated R1 had short-term and long-term memory problems. The MDS further indicated R1 required extensive assistance with locomotion.

R1's Orders undated, indicated R1 was prescribed an ipratropium/albuterol (DuoNeb) nebulizer four times daily.

R1's care plan reviewed 3/4/20, directed "Due to coronavirus please do nebulizer treatment in room to minimize the risk of disease spread if she was to have symptomatic illness."

R1's Medications report undated, indicated R1 was administered a DuoNeb on 4/3/20, at 9:16 a.m.

On 4/2/20, at 10:13 a.m. R1 was observed in the north household commons area. R1 was seated in a wheelchair and near a square folding table. R1 was wearing a nebulizer mask. The nebulizer mask was connected to a nebulizer machine. The nebulizer machine was running. At 10:20 a.m. TMA-A approached R1 near the folding table. TMA-A asked R1 if she was "finished." TMA-A removed the nebulizer mask from R1's face, and disconnected tubing which was connected to the nebulizer machine. TMA-A held the nebulizer mask in one hand and wheeled R1 towards the activities room.

On 4/2/20, at 10:24 a.m. TMA-A returned to the north household commons area. TMA-A rinsed the nebulizer mask and canister with tap water.

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F 880	Continued From page 7	F 880		

TMA-A placed the nebulizer mask and canister in a drawer. TMA-A performed hand hygiene with soap and water. TMA-A was interviewed and stated R1 was administered a DuoNeb medication within the north household commons area. TMA-A stated R1 preferred to have her nebulizer treatments administered outside of her room.

On 4/2/20, at 1:18 p.m. an interview was conducted with the DON. The DON stated a nebulizer treatment was supposed to be administered in a private room.

On 4/2/20, at 1:25 p.m. RN-A erroneously stated R1 was care planned to have nebulizer treatments outside of her room. RN-A stated she did not recall seeing R1 have nebulizer treatments near another resident in the north household commons area.

R2's Diagnoses report undated, indicated R2 had hemiplegia (paralysis of one side of the body) following a cerebral infarction (stroke).

R2's care plan reviewed 2/24/20, indicated R2 had decreased ability to perform self-care related to right-sided hemiplegia.

R2's quarterly MDS dated 3/18/20, indicated R2 had moderate impaired cognition. The MDS also identified R2 always incontinent of bladder, and frequently incontinent of bowel. R2 required extensive assistance with bed mobility, and was totally dependent upon staff for transfers.

On 4/2/20, at 10:38 a.m. NA-B entered R2's room, performed hand hygiene with soap and water, put on gloves, and asked R2 if she wanted

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F 880	Continued From page 8	F 880		

to get ready for lunch. NA-B approached R2, who was laying on her back in bed, and lowered the resident's blankets and sweatpants. NA-B observed R2's incontinence product and stated it was "wet." NA-B unfastened R2's incontinence product and performed perineal care using wet wipes. The wet wipes and NA-B gloves were disposed of in a garbage can to the immediate left of R2. NA-B then walked to R2's bathroom and opened a cabinet door using a handle. Without performing hand hygiene NA-B donned clean gloves. NA-B returned to R2 and assisted the resident roll to her right side by pushing on the resident's back as R2 pulled on the bed rail. NA-B pulled R2's incontinence product out from underneath her. NA-B rolled the incontinence product and disposed of it in a garbage can. NA-B removed her gloves and performed hand hygiene with soap and water in the bathroom. NA-B put on clean gloves and returned to R2. R2 was asked to roll to her right side and did so without assistance. NA-B tucked a clean incontinence product and lift sheet under R2. NA-B then wiped R2's buttocks with wet wipes. NA-B disposed of her gloves and did not perform hand hygiene. NA-B then attempted to assist R2 roll to her left side by pushing on her side, however, the R2 remained partially on her back. NA-B walked to R2's bathroom and opened a cabinet door using a handle. NA-B put on new gloves and did not perform hand hygiene. NA-B returned to R2, and again attempted to roll the resident to her left side. R2 remained partially on her back. NA-B pulled the lift sheet from under R2. NA-B then reached under R2's buttocks and pulled the incontinence product through. NA-B fastened the incontinence product and put new pants on R2. NA-B removed her gloves and performed hand hygiene with soap and water.

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F 880	Continued From page 9 On 4/2/20, at 11:07 a.m. NA-B confirmed hand hygiene was not performed between glove changes after perineal cares were performed. On 4/2/20, at 1:18 p.m. the DON stated hand hygiene needed to be completed between glove changes. On 4/2/20, at 1:25 p.m. RN-A stated hand hygiene needed to be performed whenever gloves came off an employee. RN-A stated this was an infection control concern. The facility policy Hand Hygiene reviewed 10/19, directed hand hygiene was to be performed before and after touching blood, body fluids, secretions, excretions, or handling any contaminated items such as dressings (even if gloves are used).	F 880		